

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS
BEFORE THE
SUBCOMMITTEE ON
HEALTH OF THE ELDERLY
OF THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
NINETY-THIRD CONGRESS
FIRST SESSION

PART 5—WASHINGTON, D.C.
Home Health Care

JULY 11, 1973



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Barriers to Health Care for Older Americans :

- Part 1. Washington, D.C., March 5, 1973.
- Part 2. Washington, D.C., March 6, 1973.
- Part 3. Livermore Falls, Maine, April 23, 1973.
- Part 4. Springfield, Ill., May 16, 1973.
- Part 5. Washington, D.C., July 11, 1973.
- Part 6. Washington, D.C., July 12, 1973.
- Part 7. Coeur d'Alene, Idaho, August 4, 1973.

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

CONTENTS

	Page
Opening statement by Senator Edmund S. Muskie, chairman.....	377
Statement by Senator Hiram L. Fong.....	381

CHRONOLOGICAL LIST OF WITNESSES

Hall, Hadley, executive director, San Francisco Home Health Service.....	382
Starr, Mrs. James H. (Janet), executive director of the Coalition for Home Health Services in New York State.....	389
Smith, Henry, M.D., director, Nebraska Department of Health.....	395
Jessiman, Andrew, M.D., associate director of professional services, Peter Bent Brigham Hospital, Boston, Mass.....	402
Trautman, Donald D., National Association of Home Health Agencies.....	409
Winston, Dr. Ellen, National Council for Homemaker-Home Health Aide Services, Inc.....	415
Thomas, Maxine, National League for Nursing.....	424
Weller, Dr. Charles, American Medical Association.....	430

APPENDIXES

Appendix 1.—Additional material from witnesses:

Item 1. Cost Effectiveness—What Does It Mean to a Home Health Agency? by Hadley Dale Hall, executive director, San Francisco Home Health Service.....	439
Item 2. Testimony by Philip L. Pillsbury, M.D., member, board of directors, San Francisco Home Health Service; before the Social Services Commission, June 8, 1972.....	443
Item 3. Steps to bill and receive payment for services under the Medi-Cal program; from the San Francisco Home Health Service, San Francisco, Calif.....	445
Item 4. Laws of New York, chapter 918.....	447
Item 5. Coalition for Home Health Services in New York State, Task Force on Scope of Home Care Services.....	467
Item 6. Improving Home Health Care Services; editorial from the American Medical News, January 8, 1973.....	467
Item 7. Bureau of Health Insurance Intermediary Letter No. 395, Social Security Administration, Baltimore, Md., August 1969.....	468
Item 8. Tabitha Home Health Care (Health On Wheels), Lincoln, Nebr.....	471
Item 9. Health On Wheels, Lincoln, Nebr., report on services provided, March-August 1972.....	472
Item 10. Case studies, Nebraska home health agencies.....	474
Item 11. Statement on the role and responsibilities of hospitals in home care, by the board of directors of the American Hospital Association.....	475
Item 12. American Hospital Association board of trustees approves statement on home health care services, June 25, 1973.....	477
Item 13. Survey of Hospital-Administered Home Care Programs, from the May 1, 1972 issue of Hospitals, the journal of the American Hospital Association.....	479
Item 14. Rescinding current financing; letter to acting commissioner of social security Arthur E. Hess, from Donald D. Trautman, administrator, National Association of Home Health Agencies, dated April 30, 1973.....	484

IV

Appendix 1.—Additional material from witnesses—continued

	Page
Item 15. Letter to Donald D. Trautman, administrator, National Association of Home Health Agencies, from Arthur E. Hess, Acting commissioner of Social Security, dated June 26, 1973.....	489
Item 16. Testimony presented by the National Association of Home Health Agencies to the Health Industries Services Committee, January 15, 1973.....	489
Item 17. Policy statement by the board of directors of the National Council for Homemaker-Home Health Aide Services on safeguards for delivery of homemaker-home health aide services.....	491
Item 18. Tentative draft of possible Federal legislation to provide for homemaker-home health aide services to all individuals and families in need of such care, by the National Council for Homemaker-Home Health Aide Services, Inc.....	491
Item 19. Basic national standards for homemaker-home health aide services; by the National Council for Homemaker-Home Health Aide Services, Inc., New York, N.Y.....	494
Item 20. Home health services, definition and policy statement, submitted by the National Council for Homemaker-Home Health Aide Services, Inc.....	494
Item 21. Success stories—innovative agency programing to meet health needs of the elderly.....	495
Item 22. Reducing costs in providing home and community health services for the elderly.....	496
Statement on home health care, submitted by AMA.....	498
Appendix 2.—Letters from individuals and organizations:	
Item 1. Statement submitted by Allen Lesser, Washington, D.C.....	511
Item 2. Letter and enclosure from Virginia A. Stillman, OTR, chairman, Metropolitan New York Special Interest Group on Occupational Therapy in Home Health Care, to Senator Muskie, dated June 28, 1973.....	513
Item 3. Letter and enclosures from Mathew H. Ahmann, associate director for governmental relations, National Conference of Catholic Charities, to Senator Muskie, dated July 13, 1973.....	516
Item 4. Letter from Harry F. Walker, executive director, Commission on Aging, Department of Employment and Social Services, State of Maryland, to Senator Muskie, dated July 11, 1973.....	522
Item 5. Letter from Edward J. Wilsmann, president, Homemakers Home and Health Care Services, Inc., to Senator Muskie, dated August 16, 1973.....	522

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

(Home Health Care)

WEDNESDAY, JULY 11, 1973

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

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

Present: Senators Muskie, Fong, and Stafford.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Elizabeth M. Heidbreder, professional staff member; John Guy Miller, minority staff director; Robert M. M. Seto, minority counsel; Patricia Oriol, chief clerk; Gerald Strickler, printing assistant; and Yvonne McCoy, clerk.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN

Senator MUSKIE. The subcommittee will come to order.

The Subcommittee on Health of the Elderly today enters a new phase in its inquiry, "Barriers to Health Care for Older Americans."

In prior hearings—in the field, as well as in Washington, D.C.—we have dealt primarily with the harsh problems facing older Americans in need of health and medical care.

We have heard overwhelming opposition to the administration's proposals to increase the cost of Medicare in the name of "cost sharing."

We have listened to older persons with firsthand experience of what it means to go without prescription drugs because of high prices, to go to hospital emergency rooms for hours of waiting because no other help is available, to know of friends and neighbors who daily become more feeble because they can't afford to use the coverage that Medicare is supposed to provide.

The subcommittee must conclude, even at this stage of our inquiry, that an intolerable number of the elderly of the United States today live in pain or in debilitating illness simply because they are priced out of the market, or they can't find the services they need.

I am speaking now not only of those older persons who are obviously ill and in need of direct treatment.

I am speaking also of those who somehow manage to get along each day—to take care of their apartments and homes, to do their shopping, to visit their friends—despite illnesses that are taking hold and that could be, with proper attention, warded off or controlled.

Why in this Nation do we insist on talking only about medical care when we should be at least as concerned about health care?

Why do we wait for the person to become incapacitated, and then insist that the institution is the place for him?

These are not hypothetical questions. They are based upon the growing realization that the United States has to put its health system in order. For those Americans in need of institutional care, there is no substitute for good institutions. But for those who can better be served outside those institutions, options should be available.

PROGRAMS ENDANGERED

The subcommittee has been told, in no uncertain terms, that those options do not exist, or that they exist only on a limited scale, and that even the limited, pioneering programs are endangered.

Home health agencies today are relegated to an almost insignificant role in Medicare. If current trends continue, their role will diminish still further. The number of home health agencies certified by Medicare dropped from 2,350 in 1970 to 2,221 in 1972. They receive less than 1 percent of reimbursements under Medicare. Reimbursement policies have been so restrictive that dollar amounts have dropped from about \$80 million in 1969 to \$59 million in 1972. But at the same time, the amount spent for hospitalization under Medicare has been rising.

The Federal Government should be encouraging, not handicapping, effective innovations in health care for the elderly. The figures showing declining use under Medicare suggest that in this field we are, in fact, headed in the wrong direction.

Recently, when the subcommittee took testimony in Livermore Falls, Maine, I was impressed by the earnest, grassroots efforts that were taking place in a three-county area of my home State. There, citizens have organized themselves, with the help of the State office on aging, in what they called Project Independence. Their purpose is to provide the services needed by older persons, not only for survival, but for well-being.

Health care does not stand alone as a separate, detached component of the program; it is built into almost everything that is done through Project Independence. There is a screening program to detect incipient or even acute health problems. There is a pioneering home health program which has been linked to Project Independence, with good results for all. The transportation problem is dealt with, to a large degree, by oncall buses. A health maintenance organization is also helping to solve problems caused in part by the rural nature of much of the area served.

But shifts or reversals of Federal policy could endanger the achievements of Project Independence and other similar programs.

For example, I received a letter from Mr. Richard Hooper, executive director of the Androscoggin Home Health Services*. His agency is one which is working so well with Project Independence. Yet, his letter vividly describes the problems faced by home health project directors. Not the least of these problems are those caused by congressional or administration policies which severely restrict home health care under Medicare.

I am impressed, not only by the problems described by Mr. Hooper, but by the positive achievements his program has achieved under adverse circumstances. Day in and day out, Mr. Hooper is insisting that good quality services be provided at home to people who might otherwise be institutionalized or neglected. He is providing a viable option that should be nurtured, not thwarted.

"ALTERNATIVES TO INSTITUTIONS"

It was with Mr. Hooper's situation very much in mind that I decided to call hearings that could explore home health services in some detail. Today and tomorrow, therefore, we will hear primarily from witnesses familiar with the problems and the promise of what are often called in-home services. This week's hearing will mark what I referred to as a new phase in our inquiry: An analysis of what are so often called "alternatives to institutions."

On this matter of "alternatives," I hope to confess that I have some misgivings about regarding home health care or day care centers or outpatient services of one kind or another as strictly a standin for institutions. As I have already said, there is no substitute for institutional care when institutional care is needed. But neither can there be any substitute for those services which, when made readily available even before illness becomes acute, can enable a person to live at home, calling the shots of his daily existence.

What I am saying is that the high cost of hospitalization and nursing homes may have driven us to think longingly but unrealistically about less-costly alternatives. We should, however, avoid the temptation to think that alternatives should only reduce the cost of institutionalization. They should have their own worthwhileness; they should exist because they make life better for the people they serve. And finally, they should be an integral part of a rational health care delivery system, not an appendage to our present, institutionally oriented system.

Good "alternatives" should change present habits. Instead of a system in which a patient is sent to a hospital or nursing home almost as a matter of the first resort, we should have a system in which institutionalization plays a proper role, not a dominant role.

Wishful thinking won't establish such alternatives. Fanciful thinking will not make them sound. What is needed is a realistic appraisal of the role that home health care—and other noninstitutional resources—can and should play.

*See part 3 of the hearings: *Barriers to Health Care for Older Americans*, Livermore Falls, Maine, April 23, 1973, appendix 1, item 3, p. 269.

I am, therefore, hopeful that the witnesses today and tomorrow will help give the answers to questions that are well worth congressional—and national—attention.

I'd like to know more about Federal policies which confound and discourage directors of home health care services. Why, for example, do less than 1 percent of Medicare payments go to home health care?

I'd like to know what in-home services should be covered by Medicare. How big a list of services should be provided? How should the so-called nonmedical services, such as needed housekeeping chores which are provided without question in an institution, be worked into the total mix?

ADMINISTRATION PLAN REQUESTED

I'd like to have more information about the actual cost-savings attributed to home health care. Several studies have very definitely indicated that high quality in-home services can be provided to some patients at significant savings over institutional care. Why, then, in this cost-conscious era is it not utilized more? Is there something else we need to know about cost-effectiveness?

In this regard, I'd like to hear the administration describe its own plans for the development of home health care services, including its utilization of these services in cutting the costs of health care for the aged. For that reason I am glad that the Department of Health, Education, and Welfare will be represented tomorrow by the Assistant Secretary for Health, Dr. Charles Edwards.

Finally, I'd very much like to know what Congress should do to encourage the development or support of home health care where it is most desperately needed. The last thing that is needed in our health care system is another level of care with loosely defined responsibility, standards, and mission. If new legislation is enacted, it definitely should not be of the type which encourages the expenditure of Federal dollars for services which are in short supply, substandard, or even unneeded.

For these reasons, in the course of my questioning, I will refer to legislation now under consideration by myself, our committee chairman, Senator Church, and other members of this committee. Our expert witnesses will certainly tell us whether we are on the right track.

I would also like, once again, to extend the thanks of the subcommittee to Brahma Trager, author of last year's report on Home Health Care in the United States. To help us in these deliberations, Miss Trager has prepared a new report* giving the latest information available on the state of home health care in the United States. One of her most alarming findings is that the number of provider agencies is continuing its decline. Miss Trager attributes this trend, not to mergers or healthy weeding out of unworthy programs, but to the intensive difficulties under which such units operate. Miss Trager also reports on a conference held last year largely because of her earlier report and the interest of the Senate Committee on Aging in home health care. The conference, held in Columbia, Md., resulted in major recommendations. I will ask the administration what followup has taken place as a result of the Columbia conference.

*Home Health Services in the United States: A Working Paper on Current Status, U.S. Senate, Special Committee on Aging, July 1973.

To begin, we will hear this morning from witnesses representing widely varying sections of the United States, each in his own way trying to extend the usefulness of home health care in this Nation.

Senator Fong.

STATEMENT BY SENATOR HIRAM L. FONG

Senator FONG. As the Subcommittee on Health of the Elderly continues its review of our Nation's responses to medical needs of older Americans, it is most appropriate that our attention turn to the very important matter of home health care service.

Our objectives for older Americans obviously must give high priority to adequacy of first class medical care for them. Concurrently important with this must be efforts to improve overall quality of life for all older persons regardless of their individual health levels and to increase choices available to them as individuals.

Adequate, dependable home health care services are extremely significant in achieving these objectives. This is especially so since the ability to remain in one's own home has such high priority among older persons.

Today's hearing reflects recognition by the Committee on Aging of values which home health care services can offer older Americans. Our subcommittee on health chairman, Senator Muskie, deserves commendation for initiatives on this key element in health care.

Expansion of opportunities for the elderly to remain in their own homes as much as possible has been a keynote of the administration's broad approach to needs of the aging—as repeatedly emphasized by Dr. Arthur S. Flemming in his responsibilities as the President's consultant on aging, chairman of the White House Conference on Aging, and now as U.S. Commissioner on Aging. I trust that this concern will be manifest in testimony tomorrow by Assistant Secretary for Health Charles C. Edwards when he appears on behalf of the Department of Health, Education, and Welfare.

No one with concern for the needs of older persons will challenge the desirability of vigorous promotion of home health care services as alternatives to care in institutional settings. To the extent that it is medically feasible—and efforts to expand that feasibility deserve high priority—it is obvious that home health care services can be an important factor in the socially desirable improvement of life-quality for many older persons.

I assume also that we will hear testimony during the next 2 days in support of the view that such programs can be an important positive health influence over and above actual delivery of medical service because of retention of the patient in the community.

Unquestionably we will hear of problems as well as successes in development of this relatively new approach to health care. And despite the fact that a few programs have been in existence in America since the 18th century, we must recognize that home health care is a new response to medical needs. As such it is inevitable that it face problems not found in other medical care delivery mechanisms. Answers to these problems must be developed as rapidly as possible.

I look forward to valuable suggestions and insights for such answers during these hearings.

Senator MUSKIE. Our first panel is represented by Mr. Hadley Hall, executive director, San Francisco Home Health Service; Mrs. Janet Starr, executive director, Coalition for Home Health Services in New York State; and Henry Smith, M.D., director of the Nebraska Department of Health.

STATEMENT OF HADLEY HALL, EXECUTIVE DIRECTOR, SAN FRANCISCO HOME HEALTH SERVICE

Mr. HALL. I am Hadley Hall, executive director of the San Francisco Home Health Service, a tax exempt, charitable agency which has been preventing, postponing, and reducing institutionalization of our ill and older citizens since 1957.

Many thoughtful and respected people believe that, in this country, there is what might be called a conspiracy to keep people in institutions because there are too many institutional beds. The documentation for this belief is contained in several documents I would like to submit for the record,* and the fact that less than 1 percent of the Medicare and Medicaid expenditures go to support home health services and even that small amount is decreasing daily.

Spokesmen for the Social Security Administration (SSA) and its Bureau of Health Insurance (BHI) are quick to deny and decry the "conspiracy theory" that requires keeping institutional beds as full as possible. These "defenders of the system" say they are not the villains: "* * * we are just interpreters of the law." The issue, as BHI sees it, hinges on the difference between home health aide care and homemaking or "home help" services such as maintaining a safe and hygienic environment, appropriate and nutritious food, clean bed linen, and simple personal care if a person is ill and can remain at home instead of being institutionalized. BHI spokesmen say:

But, darn it, home help services are not health care. And it strains logic to squeeze that kind of basic service into a program that is clearly focused on the provision of true health care services.

The Social Security regulations state:

* * * the home health aide may also perform certain household services which * * * prevent or postpone the patient's institutionalization. These services may include keeping a safe environment * * * changing the bed, light cleaning * * * laundering essential to * * * cleanliness * * * seeing to it that the nutritional needs (which may include the purchase of food and * * * assistance in the preparation of meals) of the patient are met, and washing utensils used in the course of the visit. If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimbursable. (Sec. 205.4.)

Can any reasonable person assume that doing necessary cleaning, shopping, cooking, and laundry because of health problems will be only "incidental" in terms of the time of any person? The reason home health aide services were included in the original Medicare legislation was so that our ill population could remain in their own homes rather than be institutionalized. This cannot happen if "maintenance services" are not covered in the regulations. We are not discussing maid service or housekeepers. It is home health services under a plan of care designed to prevent, postpone, and reduce institutional care that we are discussing.

* See appendix 1, item 1, p. 439.

SAFE AND HYGIENIC ENVIRONMENT

These same spokesmen from BHI will agree that no hospital can operate without clean bed linen, nutritious food, and a housekeeping staff to insure a safe and hygienic environment. BHI staff would quickly agree that hospital costs include the expense of the handyman who changes the lightbulbs, the janitorial staff that cleans the windows, and the gardener who mows the laws and cleans the flowerbeds. The questions are: "Is the person sick? Does the individual need his health care in an institutional setting?" If the person needs institutional care, then it logically follows that the institution must be reimbursed for the costs of maintaining the facility—costs are not rejected that relate to "maintenance."

At home, the same questions should determine what is "covered care"; that is, "Is the person sick? Does he need his health care in a home setting?" If he needs skilled care, if he is under a plan of treatment, and if he can remain at home with part-time and intermittent help as the law requires, then it seems to me that basic maintenance should be reimbursable if that is necessary to the health need. The American Medical Association (AMA) has asked: "So why was Medicare paying for home health services as late as mid-1970?" BHI spokesmen say that the law was never intended to cover these services, and it took from 1966 to 1971 to learn that the fiscal intermediaries were not following BHI's unwritten interpretations. One can fairly ask: "If the law was so clear, how could the fiscal intermediaries misread its intent so easily and why weren't fiscal intermediaries held responsible instead of small voluntary providers?" The fact is, the fiscal intermediaries and the providers did not misinterpret the law's intent.

So much for the history—the reality is that BHI has decided to reject claims for service unless a narrowly defined "skilled" service has been provided. This narrow definition will not keep people who are sick at home—it will create a need for hospital and nursing home beds, however. Realistically, home health service providers cannot continue to stand on principle by providing medically needed services on the basis of the person's health needs while BHI rejects the legitimate claims for reimbursement. More agencies will be forced to reduce services or go out of business.

HOME HEALTH SERVICES MUST BE DEFINED

Congress will have to resolve this dispute. Legislation is needed to define what the Congress means by "home health services"—surely the Congress does not intend that people with serious and chronic health problems will be able to remain at home without simple necessities. The average age of those getting home health services is nearly 75; three-fourths of these people live alone and the remainder usually live with someone equally old and often just as feeble. If we do not provide basic help, then I predict that we will need to build more unnecessary and expensive institutions just to warehouse our elderly who will need care. The question is, does Congress want to adopt a policy of institutionalizing our older citizens when illness strikes?

If Congress wants home health services to be used to prevent, postpone, or reduce institutional care as the current law states, then agen-

cies will have to be reimbursed for having basic services that maintain a safe and hygienic environment, provide nutritious food, clean bed linen, and the other necessities when they are needed and where they are needed because of health problems or health deficiencies. These tasks cannot be viewed as incidental.

Senator, there is a fundamental conflict between what is said to be public policy and what exists in reality. The conflict is between the institution and the home. There is no better example of the conflict than in the health insurance industry. Insurance companies have systematically retarded the growth and scope of home health services for reasons which seem to foster institutional services and custodial care. Insurance companies do not pay for health—they pay for illness.

All insurance companies, whether they are publicly supported—like Medicare and Medicaid—or private companies, agree that most of the costs of a stay in an institution are for “maintenance” and not for the “laying-on-of-hands” or “skilled” services. Why then do our public and private insurers provide only limited and severely restricted home care benefits? I wonder if it has something to do with a conspiracy to keep institutional beds full because we have them?

Mr. Chairman, for the record, I would like to submit several documents. The first is a speech dealing with cost effectiveness—what does it mean to a home health agency.* In addition, I would like to submit testimony by Philip L. Pillsbury, M.D., a member of the board of directors of my agency, to the department of social service of the city and county of San Francisco.** Finally, I would like to submit a document detailing the onerous reimbursement procedures under Medicaid which is titled “Steps to Bill and Receive Payment for Services under the Medi-Cal Program”***

Thank you very much.

Senator MUSKIE. Thank you very much, Mr. Hall. Those documents will be included in the record.

BUDGETARY QUESTION

I think I might ask a few questions at this point before other members of the panel testify. This seems such a commonsense argument that I am inclined to doubt that the issue is a substantive one. It seems to me that it is more a budgetary question than a substantive issue.

Do you have that feeling at all, Mr. Hall?

Mr. HALL. I cannot accept that argument, because we are spending so much money on insitutional care, and every bit of evidence that we have today indicates that care of people at home—

Senator MUSKIE. I did not mean “budgetary” from that point of view; it strikes me that this “budgetary” pressure may come from people who want to keep the Federal budget down, short term, this year.

Mr. HALL. I think that is true.

Senator MUSKIE. Clearly, if you tighten the definition of the law, it means that Federal expenditures for covered services are going to be

* See appendix 1, item 1, p. 439.

** See appendix 1, item 2, p. 443.

*** See appendix 1, item 3, p. 445.

less in this budget year. But on its merits alone, there is no answer to your argument that I can see. And it is hard to put questions to you that therefore explore the issue.

You have submitted for the record a step-by-step analysis of billing procedures under Medicaid. Is it not true that your agency has discontinued trying to get reimbursement under Medi-Cal?

Mr. HALL. That is true, Senator. It is so costly for us to try to bill the Medicaid program in California that we lose less money by providing the service free and forgetting about it, than going to the expense and paperwork of trying to collect the money.

Now, if they paid for the total cost, the cost of a nursing visit under Medicaid in California might reach even in a very responsible, efficient agency as much as \$100 because of all of the nonsense we must go through just to bill. The prior authorization, proof of eligibility, the processing, it is ridiculous.

Senator MUSKIE. Now, I notice that four agencies of the national organization—American Hospital Association, National Association of Home Health Agencies, National Council of Homemaker-Home Health Aide Services, and National League of Nursing—have agreed on a definition and position statement on home health services. Have the Federal agencies been asked to react to this definition? Have they taken a position with respect to it? Have they considered it as a basis for defining their responsibilities under the law?

INADEQUATE RESPONSE

Mr. HALL. I have a copy of that, and I have submitted it to various people in the administration, not as an official of any of the four organizations you mentioned. The response has been that is not what the law covers. There has been an inadequate response from the people I have submitted it to.

Senator MUSKIE. But do they go beyond their own narrow legal interpretation? After all, their responsibility is to the health of the people who need care. They may argue, according to your statement, that they are currently performing only as the law requires. But have they got any inclination to change the law? Or do they have a professional opinion on the adequacy of the law, or the justice of the law, or the rightness of the law? Has this definition of homemaker services been put to them in that context?

Mr. HALL. The spokesman for the Social Security Administration at the American Medical Association meeting in New York a couple of weeks ago stated he had no responsibility to do this, as a representative of the Social Security Administration, he was severely limited in what he could do in terms of advocating legislation. He was not interested in doing anything to help the situation.

Senator MUSKIE. Does that mean he had no professional interest in the issue that has been raised, an issue that has been described as important and critical to the four national organizations to which I have already referred?

Mr. HALL. The issue is, he is so trained and so brainwashed by the "insurance model" and the "institutional model," that people at BHI, and SSA simply cannot get out of that mold and start thinking about

"home" as a place to take care of people who are sick, yet whom they exclude—

Senator MUSKIE. I think you should have put a period after the word thinking.

Mr. HALL [continuing]. You may have been right.

Senator MUSKIE. I think that as we are talking about the law, Public Law 89-97, that it is important that we have it in the record before us.

Without objection, I will insert the appropriate reference in the record.

"Home Health Services"

"(m) The term 'home health services' means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

"(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

"(2) physical, occupational, or speech therapy;

"(3) medical social services under the direction of a physician;

"(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

"(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

"(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

"(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or extended care facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

"(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

"(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Senator MUSKIE. So now we can see the other half of the merry-go-round: The law says the regulations should determine the extent of the services, and now you are telling me the administrator says the law limits the extent to which the regulations can be made to provide the services.

INTERPRETING REGULATIONS

Mr. HALL. Yes, Senator, and we have that in writing 20 different ways. The fact is we keep pointing out the law does not say that, and the Social Security Administration keeps saying that it does, and so that is why I said in my testimony, that the Congress will have to resolve that argument.

Senator MUSKIE. That is a little difficult, because here the Congress undertook clearly to state its intent. But the effect of the administration's interpretation has been to pose the question of how do you find words clear enough to guide those who will not be guided.

Mr. HALL. I am sure you do not expect me to answer that.

Senator MUSKIE. Well, let us move on to other problems.

HEW has published in the Federal Register of July 2 of this year, proposed regulations which would impose premiums and enrollment fees under Medicaid and also deductibles and coinsurance, and this subcommittee held some hearings on those regulations. The regulations would require that vendor payments must be reduced by the amount of deductibles, coinsurance, whether or not it was actually collected by the vendor.

In your opinion, how does this affect the home health programs provided by the Medicaid in the various States?

Mr. HALL. In short, it will drive more home health agencies out of business, it will reduce the services that are provided by those that are left, and it will increase the cost of institutionalization.

Now, in California we have had a small amount of experience with this concept. It has not worked. It is, I think, designed as "an economy measure," that has no relationship to economy. What it is designed for in reality is to keep people from getting services, and I can find no merit in such a proposal.

In San Francisco, 75 percent of the people are already on public assistance and the reason for this is that they are already 75 years old, on the average, so that any savings, any resources that they have had, have already been spent in trying to stay well, trying to stay out of institutions, so that by the time they are 75, they do not have the money for this kind of thing.

REGULATION DESIGNED TO DENY SERVICE?

Now, even in California where we have "high" public assistance levels (that is, an old age assistance recipient can get as much as \$225 a month), to expect recipients to make a coinsurance and copayment is ridiculous. The cost of the sales tax is not even included in that \$225 theoretical allotment, so I think we have to recognize that this kind of regulation is designed to deny service, not to increase service.

Senator MUSKIE. Would you say the effect of this kind of regulation is the exact opposite of what is expressed?

Mr. HALL. Well, Senator, I started my statement by saying I thought there was conspiracy, or I thought that there were many people who thought there was a conspiracy, to keep people in institutional beds, and full; and I think this is more evidence of that conspiracy. It may not be accidental but the effect is the same.

Senator MUSKIE. Well, a conspiracy suggests some intelligent direction.

Mr. HALL. I think the conspiracy is by accident.

Senator MUSKIE. Well, that may be possible. That question is being explored in other parts at this time.

One final question, Mr. Hall, and then I will turn to the other panel members. Would you tell us more about the range of services offered through your agencies, and how much they cost?

Mr. HALL. Yes; we have a staff of about 150, including 17 professionals, nurses, social workers. We have arrangements for physical,

occupational, and speech therapy, and a large group of homemaker-home health aides. The average cost for a client for a month (average) is about \$158. This has held up for the last 2½ years, though our costs have increased.

One of the reasons for holding a line on the costs is that we have been able to add the Meals-on-Wheels program, so that instead of sending in a homemaker or a nurse, or somebody to do the shopping, and cleaning, and the food purchasing, cooking, that kind of thing, we send in Meals-on-Wheels, say 3 days a week, and professionally supervised staff the other part of the time. Now, this is good from several standpoints, because "7-days-a-week-airline-food" is not interesting for anybody, and so the Meals-on-Wheels program can be used to supplement the services. It is cheaper to send in the Meals-on-Wheels plate, even if it costs \$5, than it would cost to send somebody in to cook for one and shop for one, and clean up for one.

Now, you cannot keep anybody at home by just sending in a nurse, unless she is going to do all of the things your wife does for you when you are sick, change the bed, and see that you have your aspirin.

NONMEDICAL SERVICES INCLUDED IN COST

Senator MUSKIE. That is not a bad standard of service.

Let me ask you, in your cost figure of \$158, what proportion of that cost is for nonmedical services?

Mr. HALL. I consider it all medical, because we do not go in unless there is a medical need.

Senator MUSKIE. I mean the sense you discussed in your statement.

Mr. HALL. The cleaning, shopping, cooking, laundering?

Senator MUSKIE. Yes; all of that.

Mr. HALL. I would guess it is very close to the percent that is used in an institution, and some estimates, I have seen as high as 90 percent, but you cannot maintain anybody in an institution without the cooking, cleaning, shopping, laundering, anymore than you can maintain someone at home.

Senator MUSKIE. Has a suggestion been made to BHI to apply to home care services the same cost allocation required for similar services in an institution?

Mr. HALL. Yes.

Senator MUSKIE. Our distinguished ranking minority member, Senator Fong, is here. Did you have any question of this witness?

Senator FONG. Mr. Hall, I have one question.

Have you found any problem dealing with the delivery of cooked meals to low-income housing units, where some of your workers have been mugged?

Mr. HALL. We have never had anybody mugged in low-cost housing, though we have had sessions with the police department as a preventive thing, that is, what should the homemakers do, how should they handle themselves in these kinds of situations, and the fact is we do not go into many of these areas late in the day or after dark.

MEALS-ON-WHEELS PROGRAM

Now, the Meals-on-Wheels has not had any trouble, we have been using neighborhood people on the Meals-on-Wheels program, so that

the people in, for instance, a ghetto area are ghetto people themselves delivering the meals, they are known.

The Meals-on-Wheels program is organized by neighborhoods, so that in San Francisco, the Mission (the Spanish-speaking community) has Spanish-speaking people who deliver. In the Sunset (a bedroom, middle-class community), the local churches deliver meals. In Chinatown, Chinese deliver meals.

Senator FONG. As far as you know, is the problem prevalent elsewhere?

Mr. HALL. I have heard it is. I do not have any firsthand experience.

Senator FONG. It does not happen in San Francisco?

Mr. HALL. Not that I am aware of. That does not mean I have all of the information.

Senator MUSKIE. How many people do you serve?

Mr. HALL. Our agency averages 650, plus 125 that we are serving daily with meals. Those that are on Meals-on-Wheels would vary any day. The same person does not get Meals-on-Wheels every single day, so that caseload amounts to about 250, so we are talking about 900 people currently.

Senator MUSKIE. What is the basis of eligibility for Meals-on-Wheels?

Mr. HALL. A referral by a responsible person indicating they are sick, and they need their service.

We do not go into an expensive or elaborate billing, or accounting process, or eligibility clearance, and we find that excluding the administrative cost, \$1.50 a day will actually cover the cost of the food.

Senator MUSKIE. That matches our experience in my State.

Senator FONG. Do you have a central place where they can come for meals?

Mr. HALL. Yes, there are congregate feeding places, but we do not operate that out of the San Francisco home health service. It is operated out of another agency, and they have neighborhood groups; however, Meals-on-Wheels is working on a program of delivery to the homes in two neighborhoods in conjunction with "congregate feeding"; that is, we are coordinating those two things so we are not duplicating, and we try to get the people as they get rehabilitated, or able, from the home to the congregate setting, so that we get them out and get them socialized in that kind of setting.

Senator MUSKIE. Thank you, Mr. Hall.

We will now hear from Mrs. Janet Starr, executive director of the Coalition for Home Health Services in New York State.

Welcome to the subcommittee, Mrs. Starr.

STATEMENT OF MRS. JAMES H. (JANET) STARR, EXECUTIVE DIRECTOR OF THE COALITION FOR HOME HEALTH SERVICES IN NEW YORK STATE

Mrs. STARR. Thank you, Mr. Chairman.

I am Mrs. James H. (Janet) Starr, executive director of the Coalition for Home Health Services in New York State, a cooperative and intensive effort on the part of organizations and individuals to stimulate and strengthen the development of comprehensive programs of home health care throughout New York State. The coalition office is located at 700 East Water Street, Syracuse, N.Y. 13210.

I am accompanied by Edward G. Lindsey of Buffalo, consultant to the coalition, who is director of health services for the State Communities Aid Association, a century-old nonprofit health and welfare organization under whose aegis the coalition was formed.

The coalition was formally organized by representatives of 29 organizations in February 1973. Founding organizations include those whose main concern is nursing, medicine, supportive services, health planning, the therapies, insurance, hospitals, nursing homes, specific disease entities, and four departments of State government (health, social services, mental hygiene, and insurance, plus the State Office for Aging). Among its founding members are the State Association of Home Health Agencies, the State Nurses Association of Homemaker-Home Health Aide Services. We are working to broaden the base of the coalition to include participation of consumer, union, business, and industrial groups.

The coalition's purpose is to make an organized effort to define and develop comprehensive programs of home health services throughout New York State, make home health care accessible to all persons who would benefit by its proper use, insure that home health care is recognized as a proven alternative to institutional care and assumes its proper place in the health care system, and assign home health care higher priority in the allocation of health care resources.

Task forces of the coalition are already at work on two important problems confronting the development of adequate home health services: (1) Financing, and (2) the scope and organization of the services needed. I shall report today on initial progress and on some developments in New York State that show promise.

The excellent report of the Special Committee on Aging, "Home Health Services in the United States," published in April 1972, shows a keen understanding of the potential strength and current weakness of home health service delivery in the country today. I can report from the perspective of the State level that generally these same conditions and circumstances exist in New York State.

THWARTED BY FINANCES

As the committee's report makes so clear, the development of home health services is particularly thwarted by financial restrictions. In essence they are: (1) That most of the third-party financing available, both governmental and private, is for short-term, intensive care, most often coupled to a requirement for prior hospitalization; the majority of the persons needing home health services, however, are the elderly, who are prey to chronic and long-term illnesses and find themselves in circumstances requiring supportive as well as medical treatment services; (2) that at both the State and national levels there is a dearth of data, credible to funding sources, to prove the cost effectiveness of home health care and justify the need for additional financing.

New York has a new law,* the result of legislation sponsored by Senator Tarky Lombardi, Jr., chairman of the New York Senate Health Committee, that requires companies writing health insurance for in-hospital care to make coverage available for home health care

* See appendix 1, item 4, p. 447.

if requested by the policyholder. The coverage specified is limited to short-term care following hospital discharge, but it is an important breakthrough that could lead to broader coverage as the health insurance industry gains experience with it. I believe that Arizona, where disability policies must include home care benefits in lieu of hospitalization, is the only other State having a similar law.

A second significant feature of the New York law is that it moves home care into the mainstream for the first time by putting it under the section of the public health law that governs the planning, establishment, and regulation of hospitals, nursing homes, and other parts of the health care system throughout the State.

Promising as this new law is, it does not fully recognize the needs of the disabled, the handicapped, and the chronically ill. Such individuals may need a lesser concentration of services over a longer period of time and their primary need may be for services of a supportive nature. If their need is dictated by a health problem, they deserve the safeguards of health supervision and observation, plus access to more intensive services when needed.

Another recent New York law does, however, recognize this. It extends Medicaid coverage to include homemaker and housekeeping services when prescribed by a physician as part of a plan of treatment. This law is the result of a request from the New York State Department of Social Services following clearance by the Federal Government. It was signed by Gov. Nelson A. Rockefeller last month and became effective immediately, but regulations for its implementation are still being formulated. Experience with this law should yield some data on the effectiveness of these two supportive services in preventing, postponing, or shortening institutional care.

EFFORTS TO EXTEND COVERAGE

The coalition's task force on financing, chaired by David W. Stewart, managing director of Rochester Hospital Service Corp. (Blue Cross), will make an intensive effort to encourage employer and employee groups to negotiate home care benefits, thus extending available coverage to as many persons as possible. At the same time it will try to determine the facts and costs that must be isolated to demonstrate the cost effectiveness of comprehensive home health care, recognizing that human values defy cost analysis.

The coalition recognized at the start that before comprehensive programs of home health services could be planned and developed, the necessary components and how they are to relate to each other must be clearly defined and agreed upon. The Coalition's task force on scope of home care services is at work on this assignment under the chairmanship of Richard H. Schlesinger, executive vice president of the area-wide comprehensive health planning agency in central New York.

This task force has grouped services in a new way that makes it possible to focus on the home health needs of individuals and how home health agencies can realistically meet these needs directly or by arrangement. It has occurred to the coalition that the plan it is developing may have potential for revision of financing patterns and this will be investigated. I want to share with you this very preliminary and exciting thinking.

Three categories of home health services have been defined by the task force. They are: (1) Core health services—those health services required by a majority of patients in the program; (2) specialized health services—those health services just as important, but needed by fewer persons in the program; and (3) general services—those services used by the whole community for which home health agencies may need to extend special effort, or make special arrangements, on behalf of patients. A list of the services assigned to each category by the task force is attached to this statement.* It should be borne in mind that the needs of the patient will determine which services are most important for him and will make it possible for him to be cared for at home.

The new grouping of services does not force a patient into a "level of care," with certain services assigned to each level. Instead, it recognizes that the most urgent need for one patient may be for a supportive service. For another, a single, highly specialized service may be the most urgent need.

A basic promise of this way of looking at home health services lies in making needed services available to the elderly with stabilized or chronic health problems. Medicare, for example, might pay for the kinds of home health services now covered whenever one or more of them is needed to postpone or prevent costly institutional care. Partnerships with other funding sources could provide the necessary living support services.

HOSPITAL OVERUSE DOCUMENTED IN NEW YORK

Clinical team studies in three New York State metropolitan areas have documented hospital overuse at 15 percent to as high as 25 percent of medical-surgical patients and nursing home patient misplacement at an average of 20 percent. Many of these inappropriately placed patients could be cared for at home. At the same time we know that less than 1 percent of the 1970 Federal expenditures for Medicare and Medicaid went to payment for home care services. Government is therefore paying for a sizable amount of institutional care that is not necessary. Diversion of a larger portion of Medicare and Medicaid funds into reimbursement for those services designed to keep individuals out of institutions would, in our estimation, give us more health care for the dollar and is certainly worthy of trial. We urge this committee to direct its attention toward this end.

The surge of support for our coalition effort from all parts of New York State, the caliber of those accepting positions of leadership, and the determination of our members are all convincing evidence of the need to solve the problems blocking development of home health services. The interest of the Subcommittee on Health for the Elderly and the opportunity to appear before it today are deeply appreciated.

Senator MUSKIE. Thank you very much. On the question of cost, or cost effectiveness, if, for example, the 15 to 25 percent of misplaced medical service patients, 20 percent misplaced nursing home patients, could be transferred to home care, would the impact on the institutions involved be a cost savings which should be taken into account?

Mrs. STARR. Yes, it should be taken into account. I should point out not all of the 15 to 25 percent of the patients who are misplaced could

* See appendix 1, item 5, p. 467.

appropriately have been cared for at home, but a sizable portion of them could be. Some of them perhaps should be in other institutional facilities, but they were not properly placed in hospitals.

Senator MUSKIE. How can we get a question measuring the impact on the institutions of a decline in the use of their beds?

Mrs. STARR. How can you get a measure?

Senator MUSKIE. Yes, how do we get a measurement in order to get a picture of the cost savings that might be achieved by greater use of home care?

Mrs. STARR. I cannot quite answer that, but I can point to what has happened in Rochester, N. Y., where home care has been covered by Blue Cross for the last 12 years, and in that community, although what is covered is very intensive level of home care, with a definite termination point, the building of hospital beds has been cut down and held back. They have not built additional hospital beds, and the total cost of health care in the community has been contained.

Senator MUSKIE. So the implication is whatever the problem is, it will be washed out as the legitimate demand for hospital beds grow?

Mrs. STARR. Yes.

Senator MUSKIE. In your statement you say that legislation moved home health care into the mainstream by putting it in a powerful section of the public health law. Do you think we need similar action at the Federal level?

Mrs. STARR. I am not that familiar with the various articles of Federal legislation. I think the same thing should be attempted if it does not now exist. Home care is a part of health care, and I think this is the important fact. I cannot answer your question because I am not familiar with Federal statutes.

Senator MUSKIE. Well, applying your comment to the present Federal law, I would guess that the Congress needs to define clearly what it means by home health care service, and what it intends to support.

Mrs. STARR. And I think it also should make very clear, legislatively if necessary, that home care is a part of health care, and that if people can appropriately be cared for at home, provision should be made for this, just as it now is made for institutional care.

"POSTPONE OR PREVENT" INSTITUTIONAL CARE

Senator MUSKIE. I was interested in something you said in your statement, which also seems to offer some guidance. You say that Medicare, for example, might pay for the kinds of home health services now covered whenever they are needed to "postpone or prevent."

Now, as I understand it, these services listed in the Medicare law are not now available to "postpone or prevent" institutional care?

Mrs. STARR. To my knowledge, Medicare services are now available as long as there is a need for skilled nursing or therapy services and until the patient's condition is stabilized. Then Medicare does not cover.

Senator MUSKIE. Can the conditions be met in a way that would postpone or prevent institutional care?

Mrs. STARR. I think in many cases it could. I think, for instance, that only skilled nursing care may be necessary, or home health aide service supervised by a nurse.

Let us look at an elderly person with a stroke. His condition may be stabilized so he is not going to become any better, he is not going to be restored to full functioning and independent living. Medicare will not cover services to this individual when this point of stabilization has been reached. This is very clearly stated in interpretations of the law.

It seems to me if we are concerned with health care for the elderly and wish to care for them most appropriately, we will provide the services now covered by Medicare whenever use of these services makes it possible for a person to remain at home and relatively independent. Home health personnel would detect changes in the patient's condition so he could be moved back to more intensive home care or institutional care quickly when it is necessary. The net effect would be to cut the total cost. I think what is happening is that many elderly people are being forced into institutional care earlier than is necessary, because of the lack of the supportive kind of home health services. I think especially of homemaker-home health aide services, Meals-on-Wheels, this kind of thing.

Senator MUSKIE. So that even though Medicare might cover some of these services, postpone or prevent institutional care, the restrictions are such that it minimizes that possibility?

ELDERLY FORCED INTO INSTITUTIONAL CARE

Mrs. STARR. Yes. In our State, Medicaid does pay for some of these services for some people, but there are many elderly people who fall between the cracks of programs and cannot afford such services for themselves, and yet are not qualified for Medicaid, because of various restrictions of that program. The net effect, from my own personal observation, is that the resources of those people of limited income are depleted while their health condition is worsening, and they are forced into institutional care. Then it becomes a charge to the tax dollar eventually.

Senator MUSKIE. Now, the principal effect of the Lombardi law would seem to be moving in the direction of supporting home health care. Do you need a positive shot to get the Government more actively and positively involved in home health services?

Mrs. STARR. I think this would be very helpful. Thank you.

Senator MUSKIE. Thank you, Mrs. Starr.

Senator FONG. Mrs. Starr, the coalition was founded, organized, in the earlier part of this year, February 1973, and you say that already they are working on the problem of financing of this type of home care. How far has it gone?

Mrs. STARR. Well, we have started with the task force on financing to look at what is available, and to make sure that the best use is being made of what is available. The task force will concentrate on trying to get people who can be covered by the Lombardi law to take advantage of it. The health insurance coverage is made available, it is not mandatory. It has to be requested, and this involves a job of educating, not only business and industry, and consumers, but also many of the insurance carriers because they are not too well informed on the home care benefits. We will try to increase the use of covered services, make home care more known, and this will help develop the whole comprehensive home health care picture.

Senator FONG. The coalition is looking at it from the standpoint of the Lombardi law?

Mrs. STARR. Pardon me.

Senator FONG. The coalition is looking at it from the standpoint of the Lombardi law; is it also looking at it from the standpoint of Medicare?

Mrs. STARR. It certainly is.

Senator FONG. Medicare does not take care of these services which you are now talking about, does it?

Mrs. STARR. The Lombardi law covers health insurance for any person, such as your Blue Cross coverage, or my Blue Cross coverage, for any case in which home care is needed following hospitalization. It does not apply as much to the elderly because it excludes coverage similar to Medicare for those covered by Medicare.

Senator FONG. Medicare does not take care of it?

Mrs. STARR. Pardon me.

Senator FONG. Medicare does not take care of the services which you are now mentioning?

Mrs. STARR. The services covered by the Lombardi law are very similar to services covered by Medicare, but they apply to people under 65.

Senator FONG. I see. Now, Medicare does not take care of these home services which you are now talking about?

Mrs. STARR. That our coalition is now talking about?

Senator FONG. Yes.

Mrs. STARR. No, it covers some of them, but not all of them. We are talking about putting together the kinds of services that are needed to care for people in their homes. It is a broader range of services than the range of services now covered by Medicare.

Senator FONG. Is the coalition looking at Medicare with the view that it should be expanded to take care of these programs, or is it looking from the standpoint of changing the Lombardi law, and having programs financed privately?

Mrs. STARR. It is looking toward using every available resource to the best advantage for the benefit of people who need home health services. I think it is going to take both kinds of development, Senator.

Senator FONG. You have not come to a larger conclusion as to what to do yet?

Mrs. STARR. No, as for specific proposals, we do not have them yet.

Senator FONG. Thank you.

Senator MUSKIE. Thank you, Senator Fong.

Senator MUSKIE. Our next witness is Dr. Henry Smith, director of the Nebraska Department of Health.

STATEMENT OF HENRY SMITH, M.D., DIRECTOR, NEBRASKA DEPARTMENT OF HEALTH

Dr. SMITH. Thank you, Mr. Chairman.

My name is Henry Smith. I am the director of the Nebraska State Department of Health.

Over the past year and a half, my counterparts in Missouri, Iowa, and Kansas and I have been studying home health care in our region.

We have been impressed with the similarity of pattern of coverage and problems common to our four States.

Our region contains over 1.36 million persons 65 years of age or older—12.1 percent of our combined populations.

This segment of our population is increasing at a much faster rate than any other age group in our region.

One might question emphasis being placed on home health services in view of the many fine health institutions and other facilities available to provide care.

It is axiomatic that almost all persons prefer to live and function in their own home surroundings.

The quality of their lives, as well as the quality of their contributions to their communities, will be immeasurably more meaningful if people are maintaining themselves in their own homes.

Supportive services, especially nursing services, furnished as needed periodically can enable many older individuals with temporary, intermittent, or chronic disabilities to continue to live in their own homes.

Home health services represent a logical, feasible, economical means to maintain quality of life and conversely, forestall or shorten institutional care with its potential for diminishing an individual's capacities and will to exist independently.

An analogy would be the long and arduous process in rebuilding the function of an extremity immobilized in a cast for a lengthy period of time.

The construction and operating costs of hospitals and nursing homes is additional incentive to develop supplementary community health services as alternatives to institutional care.

Reference is made to the editorial carried on page 4 of the American Medical News for January 8, 1973.*

It succinctly summarizes the values of home health care services in a population that is increasing in age with a corresponding increase in chronic disorders. These demand sustained attention to avert acute episodes and crises.

In our four-State region certified home health care services are available in only about one-third of the 411 counties.

One-third of our population lives in counties without these services, and 40 percent of our persons over 65 are residents of counties without certified home health agencies.

These comparisons illustrate the higher proportion of older people in our rural counties.

Several of our out-State Nebraska counties have over 20 percent of their residents 65 years and older, and the majority exceed 15 percent. Fourteen of these counties in out-State Nebraska have no resident physicians.

In our region over 97 percent of the population over 65 is enrolled in Medicare for part B coverage. This includes eligibility for home health care services.

Only a small portion of the overall Medicare expenditures have gone for providing home health services.

Nationally, in 1971, the total was \$71 million out of a total Medicare expenditure of \$7.4 billion—less than 1 percent.

* See appendix 1, Item 6, p. 467.

We have felt that the restricted definition of skilled nursing care stressed in Social Security intermediary letter No. 395,* issued in August 1969, fails to recognize for reimbursement many valuable preventive, supportive, and counseling services to the elderly.

The intent seems to focus on provision of technical nursing procedures involved in acute care or sequential thereunto.

This is fine, and a valuable service, as far as it goes.

ELDERLY SUBJECT TO CHRONIC DISORDERS

However, the elderly are particularly subject to chronic disorders and are in need of preventive and supportive services which give motivation and guidance in avoiding health crises necessitating more costly institutional care.

Reference is made to the included material from Sarpy County and Tabitha Home** showing favorable effect of home health care services in a fast-growing suburban county and in Lincoln, Nebr.

Sarpy County has established home health services in a very interesting manner.

By contract, they are purchasing these services from the Omaha Douglas County Visiting Nursing Association, and they kept track in their first year of operation, and on what the alternatives would be in needs of the patient if the services for home health care were not furnished, and by their calculation, they felt the institutional care in Sarpy County would have cost \$170,600 more than the services that were furnished at a total cost of \$34,000 over that period of time.

Similarly in the city of Lincoln,*** the home health agency, utilizing the somewhat same method of figuring, felt over a 6-month period of time that they had saved in cost of alternative services—such things as preventing nursing home admission, preventing hospitalization, and enabling earlier discharges—almost \$178,000 at a cost of about \$17,000.

I think that—

Senator FONG. Would you give us information as to how they figured that out?

Dr. SMITH. As they accepted a patient, they figured what would have to be done with the patient if he had not been given home health care services, the type of care he would have had to have, either at a nursing home or in a hospital.

Senator FONG. Have you got the figures reduced down to the day?

Dr. SMITH. I did give the material to your committee, the way they did the itemization of it, yes.

Senator FONG. Will you give us an idea of how much you saved per day per patient?

Dr. SMITH. Yes, here is an example on a study, this is an individual who had an ear infection, he was hospitalized for 4 days at a cost of \$380, and the reason for continuing hospitalization was a need for antibiotic injections three times a day, and the patient was transferred to home health services and at the total cost for a similar period of time of \$60.50 for essentially the same type of treatment.

* See appendix 1, item 7, p. 468.

** See appendix 1, item 8, p. 471.

*** See appendix 1, item 9, p. 472.

Senator MUSKIE. Those materials will be included in the record.*

Dr. SMITH. Actually in our four-State area we have been concerned because we feel that there is a very definite problem, and we would like to offer recommendations.

FOUR-STATE RECOMMENDATIONS

No. 1, I think, as has been pointed out previously, a more affirmative attitude would be very helpful in the workings of the way Medicare deals with home health care services. For example, in the matter of reviewing hospitalization, if the utilization review committee would emphasize consideration of home health care, I think it is possible an earlier discharge could be brought about in many instances. The attending physician knows the status of his patient, and could benefit, I believe, from this type of review by utilization review committees.

I would like parenthetically to mention there have been alterations in Medicare provisions; for example, in 1970 the recertification date for a physician recertifying the need of continuing hospitalization was moved from the 14th to the 12th day with almost a direct line saving of, I believe, 1.6 days in the length of hospitalization of those patients. Also with preadmission diagnostic studies authorization, where initially people had to be hospitalized, there could be an appreciable savings, and I believe, in this spirit, more emphasis on home health services would be very worthy of exploration.

Two, I think, also, as has been pointed out here, very early consideration should be given to redefinition of skilled nursing care under Medicare to give unqualified recognition to the values of preventive and supporting nursing services.

If there is concern about possible abuse of nursing care services, a process similar to utilization review at the local level could be established utilizing practicing physicians, nurses affiliated with home health care services, representatives of the official agency providing community health services.

Certainly preventive and supportive services are capable of curtailing hospital and nursing home admission in many instances.

I think a double standard exists in that it is much easier to justify (in terms of reimbursement for your services) institutionalizing somebody than it is furnishing alternative care under Medicare reimbursement procedures.

There is precedence in the concept of furnishing maintenance services under the amendments of Public Law 92-603. The portion dealing with adding renal dialysis under Medicare is very definitely predominantly a maintenance type of program.

USE OF VOLUNTEERS STRESSED

Three, I would reiterate what the other witnesses have said, that ways whereby ambulatory services can be potentiated in private as well as public health insurance certainly are needed; and, incentives for those providing for institutional care should be equalled in planning treatment regimens, in ambulatory or home services. Home health

* See appendix 1, item 10, p. 474.

services can be potentiated through provisions such as the legislation dealing with the aged as in the Meals-on-Wheels program, and transportation. Many other ways of facilitating the use of volunteers and nonprofessional workers are possible to potentiate home health care services. This is something that could be stressed.

I would summarize by saying that our data and experience show home health care services have not been effectively developed throughout our region.

In addition to local and State efforts, strong Federal support is essential to bring about establishment of these vital services into areas where the elderly are in great abundance and economically disadvantaged, particularly the nonurban, low-population density counties.

Thank you for the opportunity.

Senator MUSKIE. Thank you.

How did your four States happen to get together on the question of health?

Dr. SMITH. Senator, we were just meeting actually for another purpose, and I guess from conversation, somebody mentioned the problem, and we rapidly established that this was a problem in all of our States. Despite the seeming differences of States like Missouri and Nebraska, this is a problem that can be almost superimposed.

Senator MUSKIE. So you are in agreement that home health care is an option that is being neglected, that is not being explored as fully as it should be.

What is the biggest obstacle?

Dr. SMITH. Well, I think the thing brought out here, namely it seems to furnish institutional care is much more easily carried about, and I think the matter that you mentioned, and you revert to the interpretation of it, to somehow or other clear this matter up, that the means whereby we are trying to help people are consistent with the ends that we are trying to achieve.

Senator MUSKIE. Does it come down to, putting it very simply, a need to have Government legitimize for you home health care, as a health service? Is that what this is all about?

Dr. SMITH. I think so, and I would also say, my impression is that this does not require expenditures of additional funds.

It is a matter of redistribution and realining the way in which we do conduct our business.

Senator MUSKIE. The bureaucrats seem to be still afraid of it as a legitimate option. It may be abused; they are afraid it may not work. Is that what lies behind the reluctance of the agencies to give it support?

Dr. SMITH. There is something there, Senator.

Senator MUSKIE. Well, we will try to get that out of them before these hearings are over so we can identify the reasons for the resistance—the clear resistance as you describe it—to using home health care more fully and more adequately and more humanely.

That is clearly the picture.

Is it a particular problem in rural areas?

Dr. SMITH. The rural areas I think have a big problem, that is peculiar onto themselves, with their scattered population, their higher percentage of elderly, their general lack of the elements that make up

for health care. In terms of economic feasibility, it takes a lot more effort to get something going in that type of area. In the concentrated populations in metropolitan areas, it is much easier.

Senator MUSKIE. Your rural counties in Nebraska are much like ours in Maine, and I suspect are populated by many people that came from our area.

Dr. SMITH. I think so.

Senator MUSKIE. Senator Fong.

Senator FONG. Is there sufficient personnel to take care of the home health service program in any community?

Dr. SMITH. Senator, I think that we do have communities where there are not sufficient personnel, and this is just a reason for organizing something like home health care, you can spread out the services, say of a physician in outreach so to speak, by having this type of mechanism available.

DROP IN PHYSICIANS "NOT SERIOUS"

I just happened to notice, Saturday, I had an invitation to go to McCook, Nebr., to help honor Dr. Earl Leininger, who is completing 50 years of practice. He was commenting on the fact when he started a practice in 1923 in McCook, in his county, there were 26 physicians, whereas now there are 9. He said that that is not as serious as it may seem, because they are now, through the modality of working through organizations, in effect able to do three times what one could do in 1923. But, I think, it is a matter of having the structure available to do so.

Senator FONG. Do you really think the present financing will do the job, just as a matter of redistribution?

Dr. SMITH. I personally believe that, yes.

I think that this means that it must be carefully defined as to what we are doing.

Under section 222 of Public Law 92-603, I think there is the provision for working into projects of this nature, called, I believe, on an experimental basis.

I believe the provision exists under that legislation.

Senator FONG. This would primarily consist of the physician or a nurse going into the home, is that correct?

Dr. SMITH. Primarily a nursing service.

Senator FONG. Primarily nurses?

Dr. SMITH. Yes, and the adjunctives to nursing, and in some instances, home aides also.

Senator FONG. In the old days, I do remember that nurses did visit the homes when I was a child. Is that so now?

Dr. SMITH. Yes.

Senator FONG. I think I had the impression they did visit the homes.

Has that been carried on in many of the communities, where there are nursing services going into various homes because people are sick?

Dr. SMITH. There is this provision, Senator.

I think the thrust of our testimony has been that it is insufficient, and also in dealing particularly with the group of people over age 65,

who have coverage under Medicare, that there is very restrictive definition of the nursing services that are allowed under this program.

Senator FONG. You do believe that this type of service will save money as an alternative to having these people institutionalized?

Dr. SMITH. I believe that it will do so. Yes, I believe it will be as economical, if not more so, than institutionalizing them. That is my belief.

Senator FONG. Has your region been experimenting on that? In these four States which you said you have tried these services, have you gone into that in depth?

ADDITIONAL SERVICES ESTABLISHED

Dr. SMITH. We are trying to extend these services. In my own State, we have in the past year been able to establish five additional services coverage for eight counties and portions of two others, and I think the other States are doing the same thing.

It is just that we do not possess the means to just blanket in everything that is not covered just immediately.

Senator FONG. Have you expanded the service in eight counties?

Dr. SMITH. Yes, we have.

Senator FONG. And what success have you had?

Dr. SMITH. I pointed out, we believe we are reducing the impact of hospitalization.

Senator FONG. Are you reaching almost everyone that needs care in that community?

Dr. SMITH. That is our hope. I do not know that we get everybody. We hope we have.

Senator FONG. You believe that you are reaching all of those that need care?

Dr. SMITH. I think that we have extended it to a large number of people that do need care, yes.

Senator FONG. Thank you.

Senator MUSKIE. Senator Stafford.

Senator STAFFORD. Thank you, Mr. Chairman.

I apologize that other commitments kept me from being here to hear the statement that you delivered, Dr. Smith, but I read most of it. Let me ask you this: Is our effort to supply home health services handicapped by a shortage of personnel, or by a maldistribution of doctors in your part of the country?

Dr. SMITH. We do have an affinity toward urban concentration, or a concentration in communities that are growing, and we view the home health agency as a means for extending, I think that we just are not going to see sparsely populated and somewhat declining economically disadvantaged counties attracting doctors, and I think this is the means whereby we can extend needed services.

I know it is the hope of every little town to have a doctor, but I do not think they are.

Senator STAFFORD. Let me ask you the same question with respect to nurses.

I gather your one-word answer to the first question would be "Yes," that the maldistribution of doctors contributes.

I know it does in my State which is also rural, like when you visit Senator Muskie's State, and like parts of yours, it is the same, but is the same situation true of nurses?

Dr. SMITH. Not to the same extent. There is, of course, a higher percentage in urban areas, but they gain by number and by other reasons are much more widely distributed than physicians in availability.

HAPPIER AT HOME?

Senator STAFFORD. I gather basically that not only is home health care a means of saving some money which is desirable, but more fundamentally that people, elderly people who can be cared for at home are much happier and more content with their lives than they are when they have to be institutionalized, am I correct on that?

Dr. SMITH. In almost all instances, that would be a very true statement.

Senator STAFFORD. Thank you, Mr. Chairman.

Senator MUSKIE. Thank you very much, Mr. Hall, Mrs. Starr, Dr. Smith, for your testimony.

Our next panel is a group of national organizations: The American Hospital Association, represented by Andrew Jessiman, M.D., assistant director of professional services, Peter Bent Brigham Hospital, Boston, Mass.; the National Association of Home Health Agencies, represented by Mr. Donald D. Trautman, chairman, NAHHA legislative committee, and director, NAHHA region X, Portland, Oreg.; the National Council for Homemaker-Home Health Aide Services, Inc., represented by Dr. Ellen Winston, Ph. D.; and the National League for Nursing, represented by Mrs. Maxine Thomas.

We will hear first from Dr. Andrew Jessiman.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION, PRESENTED BY ANDREW JESSIMAN, M.D., ASSOCIATE DIRECTOR OF PROFESSIONAL SERVICES, PETER BENT BRIGHAM HOSPITAL, BOSTON, MASS.

Dr. JESSIMAN. Mr. Chairman, I am Andrew Gaston Jessiman, M.D., associate director of professional services, Peter Bent Brigham Hospital, Boston, Mass. I appear before your subcommittee as spokesman for the American Hospital Association which represents some 7,000 hospitals and other health care institutions located in all parts of the country. The association is pleased to participate in this hearing on home care services for the elderly and problems connected with the provision of such services, as you requested. With me is Alice Gonnerman, a member of the staff of the association's bureau of professional services; and John E. Campbell, assistant for legislation in the Washington service bureau of the association.

First, I wish to note briefly some of the AHA's efforts in the field of home health care. Modern day involvement of hospitals in the provision of home health care services began in the late 1940's. There was very limited insurance coverage for such services then and funds for home health care came principally from operating income, philanthropy, and a few grants.

For several years, since the mid 1950's, the American Hospital Association has worked cooperatively with the U.S. Department of:

HEW, the American Medical Association, the Blue Cross Association, and the National Association of Blue Shield plans, to encourage development of home care programs together with adequate medical insurance coverage for such services.

POLICY STATEMENT ISSUED

The board of trustees of the AHA issued an official policy statement on the role and responsibilities of hospitals in home care in 1964, and the statement was revised in 1972. A copy of this statement is included in the supplemental materials we are providing.* When the association developed its "Policy Statement on Provisions of Health Services," home care was included as an important element of the continuum of health services which a health care corporation must assure its registrants. A copy of this 1971 policy statement is provided with our supplemental materials. H.R. 1, the National Health Care Services Reorganization and Financing Act, introduced at the beginning of this session of Congress by Representative Al Ullman of Oregon, incorporates the philosophy and much of the details set forth in the AHA policy statement on provision of health services. It specifically includes home care benefits in the basic health benefits package and we believe that any national health insurance legislation which Congress may eventually enact should include home care benefits.

Through the years the AHA has prepared publications related to home care services and two of these are included as supplements to this statement. They are a booklet entitled "The Hospital and the Home Care Program"*** and a leaflet "Taking Hospital Care to Your Home."** Both of these were distributed to our membership in 1972.

Educational programs have also been conducted by the association to assist its members in developing home care services to be administered by the hospital or by a community agency. The association maintains an assembly of ambulatory and home care services and home care agencies that are not hospital administered are eligible to join the association and the assembly that is specifically geared to their interests.

The association, as I noted earlier, works cooperatively with other national organizations that have an interest in home care services, and in our supplemental materials is a definition and statement of support of home care which was developed jointly by the AHA, the National League for Nursing, The National Association of Home Health Agencies, and the National Council of Homemaker-Home Health Aide Services, Inc. Each of these four organizations has endorsed the definition and statement and a copy of the June 25, 1973, announcement by AHA president John Alexander McMahon concerning the statement is also in our supplemental materials.***

APPROPRIATE USE OF INPATIENT BEDS

The AHA's support for home care services is predicated on the following: First, and foremost, the benefits to the patient who receives home care services and to his family; second, the economic value to the community, which comes from freeing acute hospital beds and thus

*See appendix 1, item 11, p. 475.

**Retained in committee files.

***See appendix 1, item 12, p. 477.

helping to some extent to alleviate the crisis that hospitals are facing in trying to keep up with their capital replacement and expansion needs; third, the hospital itself benefits from involvement in home care programs which extends its services into the community. Such programs help the hospital assume its proper responsibility of insuring a continuum of preventive, acute, rehabilitative, and long term care to the patient. They are of assistance to hospital utilization review committees and discharge coordinators. They make possible more appropriate use of inpatient beds, thus providing relief from overcrowding and too high occupancy rates.

At the 1973 Home Health Care Conference held in New York City just last month in conjunction with the annual meeting of the American Medical Association, the chairman of the AHA's board of trustees, John W. Kauffman, emphasized in his presentation that the most important of all the values of home health care is the benefit to the patient.

The association's support of home care programs is not limited to those that are hospital based. We support and have encouraged the development of home care programs to be administered by community agencies, such as visiting nurse associations and local health departments, as well as those to be administered by hospitals. In May of 1970 the AHA conducted a survey in order to learn more about the involvement of hospitals in home care programs and to identify the basic features of hospital administered programs. The results of the survey were published in the May 1, 1972, issue of *Hospitals*, the journal of the AHA, and a copy of that article is included in our supplemental materials.* We will be glad to furnish your committee the results of similar 1972 and 1973 surveys of hospital involvement in home care programs as soon as analyses and reports of them are completed.

One of the things our latest survey shows is that the number of hospital-administered home care programs has declined in recent months. This, we believe, may be due to restrictive State legislation in some eastern States. We are concerned about this trend for we believe the home care movement is strengthened by having hospitals actively involved, along with community agencies, in the administration of home care programs.

It is gratifying to note that a growing number of Blue Cross plans are showing increased interest in providing home care benefits to their subscribers. The Illinois and Connecticut Blue Cross plans are good examples, and the educational efforts directed at consumers by the Illinois Blue Cross plan include excellent TV announcements and full page newspaper advertisements. One of these newspaper advertisements is included in our supplemental materials.** We believe that home care ought to be in the basic medical insurance benefit package, and that it should not be offered to subscribers as an exchange for inpatient benefits, available only when home care serves to shorten a hospital stay. A Kaiser-Permanente study in Portland, Oreg., although it did not show that home care services reduce the length of hospital stays, did demonstrate the value of such services to the enrolled population (both the patient and his family), and home care was added to that organization's basic benefit package.

*See appendix 1, item 13, p. 479.

**See appendix 1, p. 478.

UNDERUTILIZATION OF HOME CARE SERVICES

Unfortunately, the promise of Medicare for home care has not been realized. A General Accounting Office study shows there has been a marked underutilization of home care services and less than 1 percent of Medicare expenditures is going for such services.

Underfinancing has been a hindrance to development and expansion of new home care programs and also threatens the survival of some existing agencies and programs. Home care agencies and programs have been burdened with added administrative and overhead costs in order to comply with Medicare requirements and have had to meet higher and higher personnel costs in order to retain competent staff in a competitive market where shortages of trained health care personnel are common. And no home care program can be innovative or expand its services when survival of the program is in jeopardy.

Among major problem areas connected with the provision of home care services for the elderly are:

(1) An artificial dichotomy has developed between the health needs and the social needs of homebound patients. Health services alone can mean little to a patient who also needs someone to keep his environment clean, prepare food, and do shopping and laundry.

We provide such services in hospitals and they must be provided at home if we are to help maintain our elderly in their homes. We can learn much from England's experience with "home helps" and also from the Tufts-Delta OEO project in Mound Bayou, Miss., where the pharmacy, having found that pills were not the answer, dispensed food to patients who were malnourished. We certainly need to become more rational about the way we fund human services as they relate to health programs.

(2) There has been confusion about the intent of Congress in regard to home care benefits under the Medicare program. As now administered, it consists mainly of nursing services in the home rather than fulfilling the concept we have endorsed—a coordinated multidisciplinary service provided to patients in their homes. Interpretations of the benefit in regulations promulgated by the Social Security Administration have had the effect of so severely restricting the benefit that few patients appear to qualify. Also, as with certain other Medicare benefits, there is a lack of uniformity in the interpretation of the definition of home health care as a covered service among intermediaries and even among the regional offices of the Bureau of Health Insurance. Retroactive denials of payments and restrictive rulings on coverage of home care services have had adverse effects on the development and maintenance of home care programs, as well as on physician referrals of patients for home care. There is also a lack of consumer understanding of and belief in the reality of this benefit.

Apparently, concern over opening the door too wide has kept the door so tightly shut that very little light and air could get in and few home care services could get out!

HOME CARE NOT REQUIRED UNDER MEDICAID

(3) Home care has never been one of the services that States are required to include in their Medicaid plans under title XIX of the

Social Security Act. Requiring States to provide institutional services for Medicaid beneficiaries without also requiring they be provided appropriate home care services tends to encourage overutilization of institutional care at the expense of home care.

Knowing that your committee is interested in finding solutions to problems, we wish to offer the following suggestions for your consideration:

(1) Elimination of the 3-day hospital stay requirement for home care benefits under part A of Medicare, so that home care can be used to prevent or delay institutionalization.

(2) Acceptance of the concept of different levels of home care, as is true in regard to institutional care, with the personal care level that is sometimes called the basic or minimum level being considered as important as the intensive home care level.

(3) The addition of occupational therapy, medical social work, and inhalation therapy as primary services along with physical therapy, skilled nursing, and speech therapy, the need for any one of which would entitle a Medicare beneficiary to receive home care services.

(4) The addition as covered home care benefits under Medicare of meal services and transportation necessary to obtain outpatient health services which cannot be provided in the home.

(5) Extension of home care benefits beyond the currently covered 200 per year visits under parts A and B of Medicare, and experimentation with other than the "per visit" basis for charging and reimbursement for home care services. I understand the association's home care consultant, Helen Rawlinson of Philadelphia, furnished your committee last year a proposal for a "per diem" charging method. She would, I feel sure, be pleased to provide any additional information needed to update the proposal in the light of enactment of Public Law 92-603, the Social Security Amendments of 1972.

(6) The provision of support for experiments in home care program staffing so that the use of multipurpose health workers, nurse practitioners and physician's assistants can be evaluated.

(7) A restudy and broadening of the definition of "skilled nursing services" as a home care benefit under Medicare, with the active participation of public health nurses in such study and review.

(8) The encouraging or requiring of fiscal intermediaries to make use of professional personnel having knowledge of home health care services in reviewing and processing claims for reimbursement for such services.

EFFECTIVE IMPLEMENTATION NEEDED

(9) Establishment of an advisory group of providers of home care services to assist and work with the Bureau of Health Insurance and the Social Security Administration for more effective implementation and improvement of the Medicare law as it relates to home care.

(10) Encouraging or requiring the States to provide appropriate home care services to beneficiaries under their Medicaid programs.

Thank you, Mr. Chairman, for the opportunity to present these comments. We shall be glad to respond to any questions and to provide any additional information we can to assist your committee.

Senator MUSKIE. Thank you very much, Dr. Jessiman.

I might say at this point that I think there is a vote on the Senate floor at 12:30, and it will probably prohibit the committee members from asking many questions, and I do not want you to infer from that any lack of interest in pursuing the issues you have raised.

I am thankful for the suggestions you have put at the conclusion of your statement, and some are included in legislation which Senator Church and I plan to introduce. We will examine them thoroughly, especially the new ones.

Dr. Jessiman, you are connected in your everyday medical duties with a hospital. Could you tell us something about the relationship in your hospital of home health care to institutional care?

Dr. JESSIMAN. Perhaps I can just speak from my own personal experience and that of the hospital where I work. I want you to understand that this hospital is a teaching hospital in an urban center, that it borders on a ghetto area in Boston. I was a surgeon there for many years, and for personal reasons I had to give up surgery, and found myself in the position of an administrator. I looked back on my experience, and recognized that while we provided superb care for the acutely ill in the hospital, when we discharged that patient, we tended to take them to the front door of the hospital, hand them a white card which said come back in 3 weeks, and when they came back in 3 weeks, we were amazed to find they were worse than when we sent them out. When I looked at why this was, it became obvious to me there was inadequate support in the community for that patient when he went home.

It happened the Medicare law was about to come into being, and I saw this was a source of funding, and I felt this was an opportunity for me to take a leadership role trying to move our institution to put together a home care program that would provide care to these patients, that we were sending out into their homes, and into the community.

I was able to sell to our trustees the concept that home care for these patients would be funded, and in a sense it would not cost the hospital anything. That was my first mistake. We put the program together, and it was a good program, and we recognized that there would be funding under Medicare for certain services for the elderly. I also went to our Medicaid people in the State, and got them to give me a "per diem," an arrangement so that for every day a patient on Medicaid was on our program, a sum of money would be paid to our program. I made the mistake of underestimating the cost of our program, but the plan worked relatively well.

RESTRICTIVE REGULATIONS

In the early days of Medicare, the understanding of the regulations of the Social Security Administration for the running of the program was that this service would be available for rehabilitation of patients needing rehabilitative care following hospitalization. The definition of that rehabilitation was more or less left to us, the people running the program, and funding seems to be fairly strong. Steadily these regulations were made more and more restrictive until even people, even some people who had a coronary heart attack, or who had a fractured hip were excluded from this type of care. This meant of course

that we had to either keep them in the hospital, or put them in some form of extended care facility. Perhaps they got good care from both places, but at a greatly increased cost, I believe, and at a human sacrifice to themselves, when they could have been at home.

So I am identifying that there was a major funding problem that became obvious to us after perhaps a year or two. We found with this funding problem, that it related to something I referred to in my testimony, the question of skilled nursing care. To be eligible for home care services under Medicare, there had to be skilled nursing care.

Already, you heard that someone like a person who has a stroke, may need much nursing care, but that care does not necessarily have to be skilled. The patient will need to be turned, they will need to be put on bedpans, they will need to have their back rubbed, but not necessarily skilled nursing care, as defined by the Social Security Administration, but certainly care that will keep that patient from returning to an institution, or keep them out of a nursing home. So we began to find that the official definition of the term "skilled nursing needs" was a disadvantage, was a restriction on our program. We found that it was almost impossible to provide personal care services, the cleaning of the house, the laundry, and so on. We found that the per visit funding was all too little, and we asked for a per diem type funding, an arrangement where we could be paid perhaps for a period of illness, for the type of care provided that is very highly skilled home care, or intermediate home care, and be paid on a per diem basis, irrespective of how many visits were made to the patient.

Under the present system, you can only bill if someone goes into the home. A hospital-based program has many administrative overhead costs that are necessary, such as a coordinator to run the program, a dietitian who will talk with the patient before he leaves the hospital and provide reasonable orders to be followed by the patient in the community. All of these overheads had to be tacked on top of the visit charge, and we found that the visit charges became catastrophically high. If we were paid on a "per diem" basis, this problem would be resolved. Our Medicaid funding was thus adjusted, but when I went back to ask the Medicaid authorities whether they would accept this method of per diem reimbursement, I found that they would not do this. They were not receptive, so let me say, Senator, that after 5 years of running what we believe is a fine program, with approximately 45 patients on it at any one time being cared for in their homes, and in low income areas, we had to discontinue our program.

"SWEEPED OUT OF BUSINESS"

The deficit that our hospital was incurring was about \$60,000 a year, and I did not feel this was an appropriate deficit that I could urge our trustees to continue with. Let me say we did from that moment on negotiate a contract with the Visiting Nursing Association of Boston, which is a health agency. They in a sense are picking up the deficit. We continue to see that our patients are cared for, but are no longer a home health service agency. We have been swept out of business by the lack of adequate funding.

Senator MUSKIE. Is it your impression that these increasingly restrictive definitions and policies are the product of a developing concept of health care or a product of conservative funding?

Dr. JESSIMAN: It is not the development of the concept of care. I think it is the bureaucratic process trying to conserve funding. It is not working in the interest of the elderly, or the sick elderly.

Senator MUSKIE. Your experience seems to have led to the conclusion that the hospital itself benefits from involvement in home care programs, and of extended services in the community. It strikes me there is great merit in that suggestion from the perspective of total community health need as well, and the management of health care resources. Is the hospital utilization, the authorization, the best organization approach to that objective?

Dr. JESSIMAN. As I just said, it is something on a personal basis again. I had never stepped out of the hospital in the 8 years I was surgeon, never gone into a patient's home in Roxbury, or out into our community around us, and I am ashamed of that. But I would say that applies to the bulk of physicians working in the major institutions in urban centers. The fact that I had to go out into patients' homes to set up the program and the fact that I got involved with major programs of nursing homes, took me out into the community, and taught me—this was about 6 years ago—that our hospital must have a new and important role to play, a role that it should have been playing in the past in the community. And as a result, we have, I believe, a very fine community hospital relationship. We have three neighborhood health centers. The spinoff of starting a home health care program was great, as far as changing the role of the university teaching hospital. The basic conception that the hospital had was to teach, and we learned we ought to do something else out there in the community with community programs. The fact that we had a home care program, and now an ability for a home care program, is a tremendous adjunct to our utilization. It is another resource that we can suggest to the physician that should be used, so that the patient can be moved out and into the home care.

Senator MUSKIE. One other question, and then I think I have to move to the other witnesses.

With respect to the definition of your home care, has any effort been made to get acceptance of this definition by appropriate Government agencies, and if so, what has been the response?

Dr. JESSIMAN. I would have to bow to the staff's knowledge of this. May I ask them to respond to this now?

Ms. GONNERMAN. It is so recently approved by our board of trustees, that we have not had a chance to carry it forward.

Senator MUSKIE. We will try to help carry the ball when the appropriate witness appears before the committee. One of the responses for the question this morning is that they may be forewarned.

Our next witness is Mr. Donald D. Trautman of the National Association of Home Health Agencies.

STATEMENT OF DONALD D. TRAUTMAN OF THE NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Mr. TRAUTMAN. Thank you, Senator. I will summarize our complete statement, and ask that it be submitted for the record, in order to devote our time to what we feel are the critical areas of specific interest to you and your committee.

My name is Don Trautman. I appear before you today as chairman of the legislative committee of the National Association of Home Health Agencies and as an administrator of a Medicare certified home health agency in Portland, Oreg.

With me is Mr. Neal Colby, president of the Missouri Association of Home Health Agencies, board member of NAHHA, and administrator of Catholic Family and Community Services' home health care department, Kansas City, Mo.

Our national association was founded in October of 1970. Our voting membership is made up of all types of certified home health agencies from throughout the United States. The major objectives and purposes of this association are—

(a) To foster high standards of patient care by home health agencies,

(b) To inform the public, health, professional, and governmental bodies of the physical, emotional, and economic advantages of appropriately delivered home health services,

(c) To promote methods of financing home health care and encourage the development of adequate services throughout the Nation, and

(d) To provide an organized and unified voice for home health agencies.

The Special Committee on Aging's report entitled, "Home Health Services in the United States," is an excellent report that identifies the problems of home health services.

ROADBLOCKS TO SURVIVAL

Such problems as narrowing of coverage, reducing duration of coverage, complexities of administration, and reimbursement which the report cited as serious roadblocks to the development of home health services have become so serious that they are roadblocks to survival.

Today, home health agencies are facing a financial crisis and are being forced to curtail services, or in some cases terminate operation.

The impact of the home services according to research we have reviewed indicates that if current Medicare expenditures are at the \$100 million level for home health services, that the estimated additional cost to replace home health services would be around \$250 million.

The human cost is another factor. Your committee report states it rather well, that if home care were not available, the older person would be faced with two choices, "helpless isolation at home or the sterility of an institution."

There are three basic problems. We will address ourselves to the underlying causes of those problems, rather than discuss the technical details, since we feel you have adequate input on this. They are:

(1) The patient's receiving home health services under Medicare are deprived of certain covered Medicare services;

(2) That there is a fragmentation in the covered home health services under Medicare; and

(3) That home health agencies do have some unique processing problems which is causing their current financial crisis.

The Medicare patient is deprived of certain services just because he is at home.

The following excerpts from the Medicare regulations I think will demonstrate this point.

"Drugs and biologicals are covered as inpatient hospital or extended care facilities"—NOT home health services.

"Diagnostic or therapeutic items or services may be covered under part A even when they are furnished off the hospital premises"—NOT as home health services.

"Psychologists diagnostic services are covered on a reasonable cost basis, if the billing is handled by the hospital"—but NOT by a home health agency.

"Diagnostic services furnished to an inpatient by an independent clinical laboratory are reimbursable under part A"—but NOT as home health services.

"Drugs and biologicals which cannot be self-administered are covered part B services when furnished in a physician's office"—but NOT as a home health service.

"Inhalation therapy services are covered as a hospital inpatient or outpatient service"—but NOT as a home health service.

"When a hospital sends hospital personnel and hospital equipment to a patient's home to furnish a diagnostic service, the service is covered as if the patient had received the service in the hospital-outpatient department"—but NOT as a home health service.

That really is quite detrimental to the patient. He is really penalized when he receives home care services.

Senator MUSKIE. I think that is a very useful recitation as a comparison.

IMPACT OF STATUTORY LANGUAGE

Mr. TRAUTMAN. Fragmentation follows and we feel one of the basic causes of this is because of the way the statutory language is written. For example we submit for your consideration a comparison between the wording of a hospital benefit language under Medicare and home health language, and rather than to read it, I will just point out what we feel is the impact.

We feel that like hospital inpatient hospital services, any benefit for home care should be written in similar language. It should pay only for the services provided by the agency that were needed by the patient. We have found that listing specific detail does not prevent administrators from determining, based on their balance sheet, which services can or cannot be covered at a given point in time.

This seems to be one of the underlying causes of a lot of the problems we face when we try to correlate the needs of these patients, and the services they receive, with adequate funding.

The third and most critical is the financial crisis that we face today, and this is caused by a lack of coordination between Government agencies and the unique processing problems of home health agencies.

More specifically this is caused by a combination of the Cost of Living Council regulations, rescinding current financing by the Bureau of Health Insurance and the lesser charge or cost provision under the 1972 Medicare amendments.

This is devastating at this point. We have explained our problem to the various administrative agencies, and experienced nothing but frustration since, I would say, December.

Frustrating because we have submitted documents, and have received response but no action.*

In addition to lack of coordination, we have the uniqueness of home health agencies. For example under Medicare, the time it takes agencies to prepare and submit claims to the intermediary and the intermediary to approve the claims, the combined time for this activity is considerably more than for hospital claims.

According to one Social Security Administration report, it is 28 days longer. That is almost twice as long for a home care claim than it is for a hospital claim to be processed from first service until approval for payment is made.

Senator MUSKIE. That is pretty mean treatment.

Mr. TRAUTMAN. We feel so.

By comparing the 1969 and 1973 budgets on a percentage basis we find that in 1969, 91 percent of the total budget was expended for hospital services and in 1973, the estimated expenditures will equal 96.3 percent. That is a substantial increase. During this same period we have seen a decrease percentagewise for home care. We feel that part of this increase is due to a lack of utilization of home health services.

ALTERNATIVE APPROACHES SUGGESTED

It is not just an inflationary increase in costs, but the funding again dictating the level of services being provided, not the beneficiaries needs.

For example, on this current financing issue, we have suggested alternative approaches that would help agencies to sustain their cash flow. The response we have received from the various parties in HEW is that they have to base their formula on the impact it will have on the fiscal 1974 budget.

It is not a question of whether or not the money is due to the provider, it is just that they have to keep it within their guideline. Therefore, they have to extend the payment lag to compensate for this, and that is as it relates to one specific issue, timely reimbursement.

Senator MUSKIE. You mean they have expressly made and stated that as the basis for the policy?

Mr. TRAUTMAN. They are saying this is part of their consideration.

I have supplemental information for the record including our statement which we presented to Acting Commissioner Hess,** and a detailed statement on the Cost of Living Council problem. We need your help. Our problems are your problems because they affect many Medicare beneficiaries. Any solutions that you could generate from this committee would be very much appreciated by the entire industry.

Thank you.

Senator MUSKIE. Thank you very much.

I think I will proceed to the statements of the other two witnesses to be sure we get them in while we have time, and then use the time that is left for questioning.

*See appendix 1, Items 14-15, p. 484.

**See appendix 1, Item 16, p. 489.

Your prepared statement will be made a part of the record.

PREPARED STATEMENT OF DONALD D. TRAUTMAN

My name is Don Trautman. I appear before you today as chairman of the legislative committee of the National Association of Home Health Agencies and as an administrator of a Medicare certified home health agency in Portland, Oreg.

With me is Mr. Neal Colby, president of the Missouri Association of Home Health Agencies, board member of NAFHA and administrator of Catholic Family and Community Services' home health care department, Kansas City, Mo.

PURPOSE OF NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Our national association was founded in October of 1970. Our voting membership is made up of all types of certified home health agencies from throughout the United States. The major objectives and purposes of this association are:

- (a) To foster high standards of patient care by home health agencies.
- (b) To inform the public, health, professional, and governmental bodies of the physical, emotional, and economic advantages of appropriately delivered home health services.
- (c) To promote methods of financing home health care and encourage the development of adequate services throughout the nation.

- (d) To provide an organized and unified voice for home health agencies.

Our board of directors is made up of 19 members. Four are the elected officers—president, vice president, secretary, and treasurer. Ten are elected as regional directors by the voting membership from each of the ten HEW regions. Five are elected as directors at large by the total voting membership. As you can see by the attached list,¹ the board of directors is not only multidisciplinary but has representation from all types of home health agencies.

DECREASE OF HOME HEALTH SERVICES

The Special Committee on Aging's report entitled "Home Health Services in the United States" is an excellent report that identifies the problems of home health services. Such problems as narrowing of coverage, reducing duration of coverage, complexities of administration and reimbursement which the report cited as serious roadblocks to the development of home health services have become so serious that they are roadblocks to survival. Today home health agencies are facing a financial crisis and are being forced to curtail services, or—in some cases—terminate operation.

IMPACT

If a substantial portion of home health agencies are forced to discontinue operation, there will be no recourse but to keep patients in institutions. Our research reveals that the cost of health care in such settings is at least two and one-half times more expensive than the same service delivered in the home. If current Medicare expenditures for home health services were \$100 million, elimination of home health services would cost the program an additional \$250 million.

It would be the ultimate irony if such a situation came into being through the implementation of rules and regulations aimed at reducing cost and encouraging the development of alternatives to institutionalization.

The human cost is difficult to measure because without home health services, the aged in the United States would be deprived of maintaining a decent life at home. The disabled and chronically ill aged persons will be faced with, as Brahna Trager stated, "one or two choices, helpless isolation 'at home' or the sterility of an institution."

THREE BASIC PROBLEMS

The basic problems with coverage of home health services under Medicare cause:

Patients receiving home health services to be deprived of certain covered Medicare services.

Fragmentation in covered home health services.

Unique processing problems for home health agencies.

¹ Retained in committee files.

Under Medicare the home care patient is deprived of certain "covered services" just because he is at home and not because he may or may not need the service. The following excerpts from the Medicare regulations will demonstrate this point.

"Drugs and biologicals are covered as inpatient hospital or extended care facilities"—*Not home health services.*

"Diagnostic or therapeutic items or services may be covered under part A even when they are furnished off the hospital premises"—*Not as home health services.*

"Psychologists diagnostic services are covered on a reasonable cost basis, if the billing is handled by the hospital"—*but Not by a home health agency.*

"Diagnostic services furnished to an inpatient by an independent clinical laboratory are reimbursable under part A"—*but Not as home health services.*

"Drugs and biologicals which cannot be self-administered are covered under part B services when furnished in a physician's office"—*but Not as a home health service.*

"Inhalation therapy services are covered as a hospital inpatient or outpatient service" *but Not as a home health service.*

"When a hospital sends hospital personnel and hospital equipment to a patient's home to furnish a diagnostic service, the service is covered as if the patient had received the service in the hospital outpatient department"—*but Not as a home health service.*

Under Medicare fragmentation in delivery of covered home health services exists because statutory language causes fragmentation. The attached exhibit A² compares the inpatient hospital services benefit (1861-b) with the home health services benefit (1861-m). For example the language for nursing service under the home health service benefit reads, "Part time or intermittent nursing care provided by or under the supervision of a registered professional nurse; to the extent covered in the regulations, part time or intermittent services of a home health aide." The language for nursing service under the inpatient hospital benefit reads, "Such nursing services . . . as are ordinarily furnished by the hospital for the care and treatment of inpatients." Home health agencies by this language serve the program instead of what is needed for the care and treatment of each home care patient. Home health services provided under such restrictive language will never become a viable alternative to institutionalization. An unfounded fear or skepticism appears if a service is not contained within four walls, even though the same services are provided.

The financial crisis in home health services is the result of the lack of coordination between Government agencies and the unique processing problems of home health agencies. We have received letters from the Bureau of Health Insurance, Office of Budget and Management, the Cost of Living Council, and HEW, responding to questions we have raised, which stated that it was not their intent to cause home health agencies financial hardship.³ The problem is that nothing has been done to correct the problem except to continue to produce more letters saying that what they are doing is not intended to effect home health agencies the way they are.

The following comparison of Medicare statistics demonstrates some of the unique processing problems with home health services.

The fifth annual report of Medicare to Congress states on page 3, "Part A intermediary processing time consistently showed improvement." "Table I—Part A Bills" on page 3 states that "Contractor processing time (mean days)" was 18.6 for fiscal 1969 and 11.9 for fiscal 1971. What this fails to say is that the part A processing for home health claims for the quarter ending June 1971 was 16 mean days, while the part A processing for hospital claims during the same period was only 7.3 mean days. Neither did they state that the "combined provider and intermediary" processing times were 38.5 mean days for hospital claims and 66.5 mean days for home health service claims. This is a *difference of 28.0 mean days*. Why does it take the intermediary more than twice as long to process home health agency claims?

Expenditures by principal provider of service for Medicare part A actuarial note DHEW, SSA No. 87, published December 1972, revealed that the percentage of hospital payments has increased from 91.0 percent in 1969 (fiscal) to an esti-

² Retained in committee files.

³ See appendix 1, item 15, p. 489.

mated 96.3 percent of the total part A expenditures for 1973. According to the same report expenditures for home health services has decreased from 1.1 percent in 1969 to an estimated 0.7 percent of total part A expenditures in 1973. How much of that increase was due to rising costs and how much was due to reduced utilization of home health services?

It appears from the above that the Medicare program continues to provide incentives for institutionalization by penalizing patients that use home health services.

SUMMARY

We have identified and presented factual information on three basic barriers to health care for older Americans. Older Americans that are under Medicare and eligible to receive home health services. The critical financial problems currently facing home health agencies are your problems because we provide an important and vital health service that helps disabled and chronically ill older Americans maintain their independence in their own home. These problems are reaching crisis proportion and cannot be solved by taking no action.

Since we have discussed the solutions to these problems with respective agencies, exhausting all the administrative possibilities we are forced to seek your help. We need immediate action. Will you, the members of this committee, both individually and as a committee, help us to survive the current crisis?

Senator MUSKIE. We will now hear from Dr. Ellen Winston of the National Council for Homemaker-Home Health Aide Services, Inc.

STATEMENT OF DR. ELLEN WINSTON OF THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

Dr. WINSTON. My name is Ellen Winston. I am presenting this testimony in my capacity as president of the National Council for Homemaker-Home Health Aide Services, Inc., which is a national, nonprofit, tax-exempt 501(c) (3) membership organization with offices at 67 Irving Place, New York, N.Y. 10003.

I am accompanied by Mrs. Florence Moore, executive director of the national council.

I should like to request that my entire testimony be filed in the record, together with a number of attachments which include, among others, our official statement with regard to legislative objectives, known as the "whereas statement,"* and a tentative draft of possible Federal legislation.** Then I would like to pick up on my testimony at several points and to make a few additional comments, because so much has already been covered, in the interest of time.

There have been a good many references to the joint statement on home health services.

I would like to add for the record a very simple definition of homemaker-home health services as follows:

Homemaker-home health aide services help individuals and families remain in their own homes when a health and/or a social problem strikes or help individuals return to their homes after specialized care.

The homemaker-home health aide, a member of the health and/or welfare team providing service in the home, carries out assigned task in the individual's or family's place of residence, working under the supervision of a professional person who also assesses individually the need for the service and has responsibility for implementing the plan of care.

An older person or family's need for help in times of crisis or overwhelming stress does not always fall neatly into what might be called "health" or "social" areas.

*See appendix 1, item 17, p. 491.

**See appendix 1, item 18, p. 491.

To the contrary, very frequently the situation involves problems in both the health and social spheres.

PARAPROFESSIONAL ASSISTANCE

And, when the solution to the older person or family's problem, in whole or in part, is assistance by paraprofessional personnel known as homemaker-home health aides, commonsense indicates that one person rather than two should carry out all the tasks appropriate to this member of the helping team.

An important aspect of this service is that the homemaker-home health aides must be trained and supervised by an appropriate professional person or persons.

In most instances this will be a nurse or a social worker; on occasion it will be a physical therapist or other professional person. At times the knowledge and guidance of more than one professional person will be needed by the older person or family concerned, and by the homemaker-home health aide.

A homemaker-home health aide was assigned to care for a frail, worn mother, 79, crippled with arthritis, and her daughter, 56, terminally ill with cancer.

In the 2 days a week the aide was with them she helped with meals, did the laundry, shopped, and helped both women with hair care and bathing.

In addition, she helped the daughter change dressings on the area afflicted with cancer.

These latter activities were done under the supervision of the visiting nurse. Besides preventing the institutionalization of both women, the lightening of the physical burdens meant an easing of emotional tension between the mother and daughter.

Equally important, according to the social worker, was the tremendous mental lift the aide gave the family.

One trained supervised aide was able to perform all the paraprofessional tasks with which this family needed help to remain at home.

You have already had a detailed discussion of what the homemaker-home health aide does, when she goes into the home situation.

We are often asked how many homemaker-home health aides we need. We need some measure with regard to the adequacy of provision for this type of service. We have now been saying on the basis of European experience and on the basis of some of our own better agencies that, adequately, to serve persons 65 or older, we need one homemaker or home-health aide for every 100 persons who fall into this age group.

We recognize the fact that homemaker-home health aides can operate under a great variety of auspices.

I do not believe that this has been covered. In some instances, we have public agencies which may be either health or social welfare oriented, and about half of our current agencies fall within public agency categories.

Services may be provided by nonprofit volunteer agencies, again, under either health or social welfare auspices, and many of the early

agencies providing the service came out of the private voluntary field.

We are increasingly seeing service being provided by proprietary agencies.

In many instances, we advocate and are providing through some of our agencies additional supportive services. Mr. Hall talked about his meals program which might take care of the days that the homemaker-home health aide did not go in.

AGENCIES USE TELEPHONE PROGRAM

Many of our agencies are developing a telephone program, because we need to know what is happening to our cases on the days when the homemaker-home health aide does not go in.

In one particular agency, where they have about 150 cases, by using a telephone program on the off days, they are picking up about three emergency situations a week.

This indicates that we must be thinking in terms of clusters of service, with the homemaker-home health aide service serving as the core around which these other services are developed.

You asked a question a little earlier about providing services in rural areas. Some 20 years ago I had the opportunity, through some project funds, to test out how one could provide services to older people in rural areas.

We found no real problems. After all, the case workers, the public health workers, and others were going about their business in their automobiles, and so did the homemaker or home health aides.

In some instances, it was to their advantage because they could carry equipment they might need when they got into the home, which is more difficult when you are using buslike transportation.

There has been a great deal of reference this morning to the problems and the barriers that are created with regard to implementation of title XVIII of the Social Security Act.

We had high hopes at one time that this legislation would make it possible for us to meet the home health needs of the aged, but the definitions as pointed out again and again have been increasingly more narrow.

I think that we should also emphasize more than perhaps we have up to this point the companion legislation with regard to the social services.

As you are well aware, the Senate Finance Committee has recently had hearings in this general area, because the new regulations which have been sent out by the Department of Health, Education, and Welfare, even as revised, so greatly restrict what can be done with respect to services under the provisions of title XVI of the Social Security Act.

This has been especially traumatic for those of us who are particularly concerned with the approach to home care through the social services channel. Under former regulations, homemaker service was mandated for the aged who needed that service. We had broad definitions of former and potential recipients who would be eligible for homemaker services.

We had a requirement that agencies providing the service by a given date must meet approved national standards. All of these requirements have been literally washed out as a result of the proposed new regulations. We are only hopeful that with a deferment in the actual implementation of the service regulations there can be effective changes. You have to have not just one source of funding, but sources of funding which can complement and supplement each other. I would hope that in your inquiry, you also take account of what can be done in so many instances through the social services channel to make possible the kind of homemaker services that older people need.

There has been a good deal of talk this morning about institutionalization. We would like to make the point that from our approach, home health services should constitute the basic, or the first, method of health care for the aging and other persons, with institutionalization recognized as an alternative form of care.

Instead, currently because of services limitations, one often looks first to institutional care, and then comes up with some kind of in-home care as an alternative. We believe that the balance should be changed as we evaluate the need for these various types of services.

A NEED FOR NATIONAL STANDARDS

The final point I would like to make at this point is really our most important point of all—and that there is need for a vigorous concerted effort to see that homemaker-home health aide services meet basic national standards.

Without such attention to standards, homemaker-home health aide services delivered in the unstructured setting of the home could bring further hardship to the very population at risk that they are intended to serve. This field could find itself in a similar or even worse situation than that plaguing standards for nursing homes.

Current attempts at the Federal level to eliminate all reference to basic national standards for homemaker-home health aide services except for those included in the Medicare program must be rejected as they represent a serious backward step.

Alternatively, references to basic national standards for homemaker-home health aide service at the Federal level should be strengthened and further buttressed by having specific reference made to them in State plans in both the health and welfare areas.

The National Council's approval (accreditation) program which was implemented in 1972 and is available to homemaker-home health aide services under all auspices, voluntary nonprofit, commercial, and governmental, has already had a significant impact on upgrading standards in this field and in assuring safe, effective, and efficient service.

This kind of voluntary self-regulating program in the standards area needs to be strongly supported by continuing reference to it in Federal regulations promulgated in the Federal Register and through all other means at the disposal of this committee and other concerned organizations.

I think you will be interested to know that under our initiative, over 80 homemaker programs have applied for approval. We have com-

pleted the review process and have certified 31 of those agencies. We are happy to tell you that three of them are in Maine, two of them through the Catholic Social Services, which is under the direction of Tom Hagerty, and one in connection with your mental health program.

In Maine, yours is the first mental health program in which we have been asked to approve the homemaker-home health aide component.

EVIDENCE ON COSTS

We have a good bit of evidence with regard to costs of care. We have been especially interested in the fact that we now have data from two communities which indicate that case costs, the total costs of the case, are less when an agency meets our approval standards, than when an agency cannot meet those standards.

This is because there is a regularized proper assessment of the need; there is adequate supervision; the needed service is provided, but only for as long as it is required by the individual or the family situation. In our judgment, it is important that we look at the total case cost, and not rely solely on the per hour cost of care. Sometimes the care that costs more per hour has the cheaper case cost, the more efficient cost, the more effective cost, because only care which is necessary is given.

In summary, given the availability of adequate funding for comprehensive service and provided they meet basic criteria in terms of quality, homemaker-home health aide services could rapidly fulfill their potential as a major health and welfare service to help thousands of people remain in or return to their own homes.

No group is in greater need of this service and other home health services than the aging population. We urge that it be given priority attention by the Subcommittee on Health of the Elderly, as well as by the Special Committee on Aging of the U.S. Senate.

Senator MUSKIE. Thank you very much, doctor, for your testimony. Your prepared statement will be made a part of the record. I think the vote is coming in about 2 minutes, and it does not make much sense to start on the next witness' testimony at this time. So I think we will recess for 10 or 15 minutes, and I hope you will be back. We will take Mrs. Maxine Thomas next, and then Dr. Charles Weller.

Thank you very much.

[The prepared statement of Dr. Ellen Winston follows:]

PREPARED STATEMENT OF DR. ELLEN WINSTON

INTRODUCTION

My name is Ellen Winston. I am presenting this testimony in my capacity as President of the National Council for Homemaker-Home Health Aide Services, Inc., which is a national, nonprofit, tax-exempt 501 (c) (3) membership organization with offices at 67 Irving Place, New York, N.Y. 10003. I am accompanied by Mrs. Florence Moore, executive director of the National Council.

The National Council regards the hearings being held by this committee as an important step in helping the country come to grips with the need many older persons (and many others as well) have for home health services. The hearings follow an earlier significant development, the publication in 1972, of "Home Health Services in the United States," a report to the Special Committee on Aging of the U.S. Senate. The size and nature of the problems which many older

people face who wish to live in their own homes has been well documented in this publication in a section entitled, "The Population at Risk," found on pages 2 through 4. It is in relation to this picture of need that the National Council discusses homemaker-home health aide service, a basic component in home health services and a significant part of the solution to problems plaguing many elderly persons.

We have been asked to focus our testimony on how homemaker-home health aide services are provided to the elderly and particularly the fact that this service spans both the health and welfare fields. These are especially appropriate subjects for the Council to address, and particularly the latter, since it goes directly to a basic concept underlying this flexible in-home service. It also relates directly to the reason for and the way in which the National Council itself was founded at the request of over 30 national voluntary health and welfare organizations and bureaus of the Department of Health, Education, and Welfare to promote quality homemaker-home health aide services throughout the country.

DEFINITION OF HOMEMAKER-HOME HEALTH AIDE SERVICES

Homemaker-home health aide services help individuals and families remain in their own homes when a health and/or a social problem strikes or help individuals return to their homes after specialized care. The homemaker-home health aide, a member of the health and/or welfare team providing service in the home, *carries out assigned tasks in the individual or family's place of residence, working under the supervision of a professional person who also assesses individually the need for the service and has responsibility for implementing the plan of care.*

HOMEMAKER-HOME HEALTH AIDE SERVICE

An older person or family's need for help in times of crisis or overwhelming stress does not always fall neatly into what might be called "health" or "social" areas. To the contrary, very frequently the situation involves problems in both the health and social spheres. And, when the solution to the older person or family's problem, in whole or in part, is assistance by paraprofessional personnel known as homemaker-home health aides, common sense indicates that one person rather than two should carry out all the tasks appropriate to this member of the helping team. An important aspect of this service is that the homemaker-home health aides must be trained and supervised by an appropriate professional person or persons. In most instances this will be a nurse or a social worker; on occasion it will be a physical therapist or other professional person. At times the knowledge and guidance of more than one professional person will be needed by the older person or family concerned, and by the homemaker-home health aide.

Homemaker-home health aides must be able to function adequately in a wide spectrum of care situations, and perform tasks in the following areas, as well as many others, in-home health services for the elderly: Bathing, hair care, dressing, moving the person from the bed to a chair or to a wheelchair, toileting needs, being certain the right medication is taken as prescribed, preparation of meals including special foods for those on diets, light housekeeping, laundry, changing the bed, shopping, and assisting with therapy routines established by the professional therapists. For aides to undertake these numerous essential tasks safely and effectively they must undergo an initial basic training program. Training courses must include the whole range of personal care tasks, household management, and (because we are speaking of a comprehensive homemaker-home health aide) child care skills. Also, knowledge about human needs at various ages and the many variations in life styles of individuals and families must be communicated to the aides. Opportunity for in-service training is equally necessary especially in those areas where the aide may in fact be concentrating, such as in care of the aging, personal care, child care, psychiatric care, care of the blind, disabled or others.

Homemaker-home health aides must be carefully selected to be certain that they are emotionally mature, healthy persons who have the capacity to adjust to a wide variety of situations and relate to individuals and families of very different backgrounds. They must be able to work as a member of a helping team, be observant of and report conditions requiring changes in treatment, additional treatment or other attention. They must conduct themselves at all times in a

manner which helps to strengthen the immediate and long range coping abilities of the individuals and families with whom they work. Because they spend more time in the home than any other member of the team, they can bring valuable information to the professional person(s) whose role it is to establish and reassess the plan of care.

Homemaker-home health aide service is all the help that is needed in some situations and in others, particularly in home health service, it frequently facilitates the delivery of urgently needed remedial, palliative, and treatment services.

The presence of an aide in the home several hours each day or a few days each week can help to unify service delivery when a number of specialties are involved. An important aspect of an aide's role, where it is possible and appropriate, is to assist in training family members so that outside help is no longer necessary. As we all know, however, a number of older people live alone and when problems occur, without supportive outside help, many would not be able to stay at home or return home after specialized care. Some brief case illustrations may help to bring the usefulness of this service into sharper focus. Since we are concentrating here on home help services for the aging, illustrations will be drawn from this area.

HOMEMAKER-HOME HEALTH AIDE SERVICE PREVENTS INSTITUTIONALIZATION

A homemaker-home health aide was assigned to care for a frail, worn mother, 79, crippled with arthritis, and her daughter, 56, terminally ill with cancer. In the 2 days a week the aide was with them she helped with meals, did the laundry, shopped and helped both women with hair care and bathing. In addition, she helped the daughter change dressings on the area afflicted with cancer. These latter activities were done under the supervision of the visiting nurse. Besides preventing the institutionalization of both women the lightening of the physical burdens meant an easing of emotional tension between the mother and daughter. Equally important, according to the social worker, was the tremendous mental lift the aide gave the family. One trained supervised aide was able to perform all the paraprofessional tasks with which this family needed to help to remain at home.

HOMEMAKER-HOME HEALTH AIDE SERVICE ENABLES AGING PERSONS TO RETURN HOME

Mrs. S, 79, went to a nursing home on the advice of her physician, but was extremely unhappy and returned to her own home. She was referred to the home health agency by the doctor and maintained at home under an appropriate plan through a homemaker-home health aide assisting with the care of her person, shopping, meal preparation and light housekeeping on a 4-hour, 3-day a week basis.

In another situation, when a husband, 80, visited his wife of the same age in the hospital, and heard that she was to be discharged, he went to the floor nurse with tears in his eyes and said, "What am I going to do? I am not able to take care of her." His wife was completely bedridden as the result of a fractured hip. The nurse referred them to the Visiting Nurse Association coordinator and homemaker-home health aide service was planned. After several months, the aide was no longer needed as the wife was able to move about and manage her own personal care. A niece was recruited to help with some of the housework.

FORMATION OF THE NATIONAL COUNCIL FOR HOMEMAKER SERVICES

I turn briefly now to discuss the formation of the National Council as it is pertinent to the subject of this testimony.

During the National Conference on Homemaker Services held in 1959, a resolution was passed requesting "The National Health Council and National Social Welfare Assembly to bring into being a new independent national organization with a board broadly representative of health and welfare interests . . ." The purpose of the new organization was stated as follows: "The promotion of homemaker services of high quality in public and private nonprofit organizations under various auspices, such promotion to include standard setting, consultation and research."

The National Health Council and National Social Welfare Assembly agreed to sponsor formation of this new national agency, and it was incorporated late in 1962.

A 10-year report entitled, "Focus on the Future," just published by the National Council, documents the heartening growth of this service from 158 administrative units in 1958 to approximately 3,000 in 1972. The number of aides has grown from under 4,000 in 1963 to 30,000 today. However, the need for the service continues to far exceed the available service since it is estimated that 300,000 homemaker-home health aides are required if the service is to be available when and where it is needed across the land. This figure is based on one aide per 1,000 persons in the general population and one aide for each 100 people over 65 years of age.

The 10-year report lists some of the ways the National Council has carried out its responsibilities in the homemaker-home health aide field, especially fulfilling its charge in relation to standards and consultation for the service. Following the adoption of a written code of standards for the service, an approval program (accreditation) was developed and put into effect. It is interesting to note that the auspices of the first 31 agencies whose homemaker-home health aide services have achieved approved status under the National Council approval program, include health and welfare, voluntary and governmental, and free standing homemaker-home health aide agencies and multiservice agencies where homemaker-home health aide service is one among many. The large majority of the approved agencies are providing homemaker-home health aide service in both the health and welfare fields, bearing out the high hopes for comprehensive homemaker-home health aide service of those attending the 1959 Conference on Homemaker Services. It will be of special interest to this committee that much of the work of these approved agencies is with the aging.

BARRIERS SLOWING DEVELOPMENT OF HOMEMAKER-HOME HEALTH AIDE SERVICES

Some of the barriers preventing the much more rapid acceleration of homemaker-home health aide services include the following areas.

Passage of title XVIII of the Social Security Act, brought with it high hopes that at last the home health needs of the aged would receive the attention they so urgently require. However, because the definitions in regard to home health services have been so narrowly interpreted, Medicare has only reached a few of those who need help.

This same title officially introduced the term "home health aide" to describe the tasks, largely of a personal care nature, which could be funded under Medicare. So long as major funding mechanisms such as Medicare are task oriented rather than need oriented, homemaker-home health aide service will be delivered all too frequently in a fragmented fashion including in some situations, two paraprofessionals going into the same home at the same time, one providing personal care and the other home management type service.

This issue of fragmentation of the service was addressed as follows in *Addenda to Standards for Homemaker-Home Health Aide Services*, published by the Council in 1969, "the homemaker-home health aide is one and the same person. The term 'home health aide' may be required for certain funding or legislative purposes; it should not, however, influence the service rendered by the homemaker in the home." Also, in 1971, members of the National Council for Homemaker Services changed the name of the organization to National Council for Homemaker-Home Health Aide Services, Inc., so that it would clearly symbolize the comprehensive nature of the service and of the Council's work.

All who see the urgent need for this basic service must help to speed the day when third party payers, whether governmental, nonprofit or commercial insurance companies, or others, will pay for comprehensive homemaker-home health aide service, necessary to help many older persons and families remain in their own homes or be returned sooner from institutional or other out-of-home care.

Home health services should constitute the basic or first method of health care for the aging and other persons, with institutionalization recognized as the alternative form of care. Instead, currently, there is an excessive emphasis on institutional care. One need look no further than the Medicare figures for documentation since less than one percent of all monies expended under this program are spent on health services in the home, including homemaker-home health aide service.

The dollar savings which can accrue from home health services have been documented many times on a case-by-case basis and through studies carried out by direct service agencies. There is a dearth of such information nationally

however, because most fiscal and statistical reporting systems at the local level are sufficiently different to prevent compilation on a broad scale nationally. This lack of national data is especially true in regard to homemaker-home health aide services. Ways and means must be found to develop a system for keeping data at the direct service level which can be compiled nationally. Finding funds to undertake this task in the homemaker-home health aide field is a priority item with the National Council.

Even without additional data, however, the sheer size and projected growth in the number of older people with ever extending life spans will surely persuade those in positions of responsibility on this continent to learn from many other countries' experience and recognize that basic services which adequately maintain individuals in their own homes over long periods of time, are a "must" service. As some of the Special Committee on Aging's own publications document, when one adds the number of younger chronically ill or disabled to the number of older people who need some help to remain in their homes, it is readily apparent that it is not only humane, but also fiscally sound to provide a preventive service which assists people to remain independent and in their own homes and communities for as long as possible. Many can avoid expensive institutional care altogether. As our case illustrations indicate, intermittent care for a short period of time is all that is needed by many to remain self dependent and at home. We know from the William G. Bell study in Hillsborough County, Fla., and from other studies that the majority of older people desire to remain in their own homes for as long as possible. We know, too, from "outcome" studies of home health services, such as that conducted at the Benjamin Rose Institute in Cleveland, Ohio and the study of congestive heart failure patients by Farag and Mazer in California, that people cared for in their own homes are more content, have fewer placements in the hospital for acute illnesses, and stayed fewer days when hospitalization or other institutional care became necessary.

In light of the need for and soundness of the service, the current thrust at the Federal level in regard to this and other health and welfare services, is a serious barrier to the delivery and extension of home health services to the elderly. We refer to imposition of a closed end appropriation for social services, much too restrictive regulations in a number of areas, removal of the mandate for services for the aged including homemaker-home health aide services, lack of appropriation of authorized funds and similar activities.

A final point—but the most important one of all—is the need for a vigorous concerted effort to see that homemaker-home health aide services meet basic standards. Without such attention to standards, homemaker-home health aide services delivered in the unstructured setting of the home could bring further hardship to the very population at risk that it is intended to serve, and this field could find itself in a similar or even worse situation than that plaguing standards of nursing homes. Current attempts at the Federal level to eliminate all reference to basic national standards for homemaker-home health aide services except for those included in the Medicare program must be rejected as they represent a serious backward step. Alternatively, references to basic national standards for this service at the Federal level should be strengthened and further buttressed by having specific reference made to them in state plans in both the health and welfare areas.

The National Council's approval (accreditation) program which was implemented in 1972 and is available to homemaker-home health aide services under all auspices, voluntary non-profit, commercial, and governmental, has already had a significant impact on upgrading standards in this field and in assuring safe, effective and efficient service. This kind of voluntary self-regulating program in the standards area needs to be strongly supported by continuing reference to it in Federal regulations promulgated in the Federal Register and through all other means at the disposal of this committee and other concerned organizations.

In summary, given the availability of adequate funding for comprehensive service and provided they meet basic criteria in terms of quality, homemaker-home health aide services could rapidly fulfill their potential as a major health and welfare service to help thousands of people remain in or return to their own homes. No group is in greater need of this and other home health services than the aging population. We urge that it be given priority attention by the Subcommittee on Health of the Elderly, as well as by the Special Committee on Aging of the U.S. Senate.

AFTER RECESS

Senator MUSKIE. We are still operating under time pressures, as there may be another vote within 30 minutes, so let's see if we can complete our business in 30 minutes if possible.

Mrs. Thomas, would you proceed with your statement in any way that you like.

Whatever you do not read will be included in the record as is the case with the other statements, and we will try to have some time for questions.

**STATEMENT OF MAXINE THOMAS OF THE NATIONAL LEAGUE
FOR NURSING**

Mrs. THOMAS. Mr. Chairman and members of the committee, my name is Maxine Thomas, and I am executive director of the Salt Lake Community Nursing Service, Salt Lake City, Utah, an accredited community health service agency.

I appear before you today representing the Council of Home Health Agencies and Community Health Services of the National League for Nursing, of which my agency is a longtime member.

The council is the national spokesman for over 1,350 official, voluntary, and other home and community health agencies throughout the country and includes in its membership the majority of the large community health agencies.

These agencies utilize the services of nurses, physical therapists, occupational therapists, physicians, social workers, nutritionists, home health aides, and speech and hearing therapists.

I am accompanied by Jane Keeler, president of the council and Rebah Kellog, executive director of the council.

As requested, I have selected case histories of two patients recently served by our agency to demonstrate our care of sick services.

Council agencies also provide health care services in schools, ambulatory health centers, and in other community settings such as senior citizen centers, housing projects, and neighborhood health centers.

Since my statement will be made a part of the record, Mr. Chairman, I will not read the case histories.*

I have been asked to testify regarding two barriers, created by Federal legislation, to the delivery of health care services to the elderly:

(1) Problems related to the requirement for "skilled" nursing care under Medicare home health provisions, and

(2) Fiscal dilemma created by the combination of Public Law 92-603, and the economic stabilization program mandates.

"SKILLED" NURSING DESIGNATION

The major component of service needed and provided in home health agencies is nursing. With the enactment of Medicare legislation the designation "skilled" was unfortunately attached to nursing as a reimbursable service provided by home health agencies.

*See p. 428.

The practice of nursing is an art, a science, and a skill as is practice of medicine, physical therapy, or occupational therapy.

Fortunately, these later disciplines escaped the "skilled" label and Medicare regulations do not refer to skilled medical care, skilled physical therapy, or skilled social worker, as a requirement for reimbursement.

The attachment of the label of "skilled" to nursing has become a major barrier to the delivery of care to the aged. The definition has resulted in great variance in interpretation.

In limited instance where nurses with community health background staff the fiscal intermediary offices administering reimbursement for nursing in home health agencies, the problem has been greatly reduced.

In many States, however, and with great variance still from State to State, restrictive technical definitions have been applied without recognition of nursing care or patient needs.

Attempts to interpret the definition have in many instances been smothered by technically prepared, task-oriented staff working in fiscal intermediary offices who are unfamiliar with community health nursing practice and nursing and other therapeutic needs of people in their homes.

Greatly needed care has been withheld; patients, families, nurses, and SSA/BHI personnel have suffered immeasurable pain, frustration, expense, and wasted effort at horrendous cost without return to taxpayers.

We recommend that future legislation refer concisely to "nursing" and that all disciplines function as appropriate in such levels of care, reflecting intensity of service needed, as are described in this committee's April 1972 report on "Home Health Services in the United States."

As exemplified in case 2, care given to maintain a patient's maximum degree of recovery or care provided to promote wellness or to prevent regression of mental or physical well-being, is not currently deemed to be a Medicare-reimbursable service.

As one nurse director expressed it, "Prevention and health maintenance are words which will immediately prohibit payment for our service."

This shortsighted approach frequently leads to necessity for costly institutional care except in those limited instances where United Way or other funds make service delivery possible.

REEXAMINATION OF SERVICES NEEDED

The situation is worsening as Medicaid programs in many States and private insurance programs are inexorably moving to adopt these Medicare standards. This movement adds urgency to the need for re-examination of types and levels of services which are to be Medicare reimbursable.

We strongly concur with the statement in your committee's 1972 report on "Home Health Services in the United States" that, "Home health planning must be based primarily on the professional judgment of those familiar with consumer needs rather than the remote decision-makers far removed from the problem."

The council recommends that the established NLN-APHA community health agency accreditation criteria be used for determining agency standards and practice.

We further urge that the utilization review process be required in home health agencies.

The council has published helpful guidelines and continually provides counsel to agencies in developing utilization review techniques and skills.

We have provided to the staff of your committee eloquent testimony from agencies throughout our country* of denial of needed health services to the elderly in their homes because these services:

- (1) Do not meet erroneously applied inappropriate standards, or
- (2) Were deemed to be preventing illness and disability or maintaining an individual's regained (often at great institutional care expense) health.

An important concurrent phenomenon is the decreasing accessibility of physicians to care for people in their homes, especially in inner-cities and in rural communities.

Our agencies report that nurses, in an evolving role, are assuming ever increasing responsibility for primary care services to people in their places of residence.

Future legislation must reflect this development.

The second barrier, another fiscal dilemma, I will report briefly.

In Public Law 92-603, section 233 mandates that as of January 1, 1973 (or whenever fiscal year begins after January 1, 1973) home health agencies will be paid "cost" or "charge" whichever is less for services provided to Medicare recipients (whereas in the past agencies were reimbursed at "reasonable cost" without regard to their charge to the public).

Unfortunately, many home health agencies, of which 57 percent are public and 24 percent voluntary, nonprofit, have not, in the past, charged full cost of their services to the public.

REGULATIONS PREVENT ESTABLISHMENT OF POLICY

Efforts to establish such a business-like policy have been stymied since 1971 by economic stabilization program regulations.

Many agencies are forced to go through the costly "application for exception" proceedings in order to raise their charges to actual cost—a process now prohibited by the ESP freeze.

The dilemma is further complicated in the section 233 with the stipulation that "public providers" (57 percent of home health agencies) will be reimbursed at "reasonable cost" if they are now charging only "nominal fees" (assumed to mean "less than 50 percent of actual cost").

Thus, in a health department where the cost of a home visit is \$20 and the charge to the public is \$15, the agency is contemplating lowering charge to \$9 (nominal fee) in order to collect full cost for all visits to Medicare recipients, the majority of their caseload.

This will result in regressive business practices; and inability to collect actual cost for services provided to those patients under 65 years of age and will increase local taxes to cover these irretrievable losses.

*Retained in committee files.

This section of the law is highly discriminatory and will have adverse effects on the fiscal well-being of private, voluntary agencies.

Mr. Chairman, despite these repressive burdens the home and community health service agencies have established many programs to specifically meet the health care needs of the elderly.

Correspondence documenting these innovative services together with ways agencies have found to reduce costs of home health services have been provided to your staff.

Thank you for the opportunity to provide this testimony.

The Council of Home Health Agencies and Community Health Services wishes to support and be of assistance to this committee in removing the barriers we have listed and in expanding services to meet the health care needs of the elderly in their homes and communities.

Senator MUSKIE. I must say we are doing our best to destroy this whole concept.

Mrs. Thomas, just one question, because I want to get to our last witness.

You speak of the increasing role of the nurse in the home.

Will this role be filled by registered nurses, practical nurses, or by some other group that has been trained in some nursing skills?

Mrs. THOMAS. The prepared community nurse is a qualified nurse.

She has working with her licensed practical nurses and home health aides, and we work through agencies.

PROFESSIONAL NURSE RESPONSIBILITIES

The professional nurse is responsible, of course, for more than "washing and ironing" the patient and placing him between sheets and carrying out those few tasks that have been deemed "skilled."

In addition to carrying out the medical orders and providing the direct nursing care treatment, she must make the total assessment of the patient's total needs, and must evaluate the family and home situation to see that home care is adequate.

She is responsible for observations in relations to the disease process and all of the body systems.

The professional nurse develops the nursing care plan to meet the individual patient's needs.

She teaches and instructs the patient, the family, and auxiliary personnel.

She also supervises the auxiliary personnel, and in addition organizes the total care plan and utilizes other disciplines and services to see that the goals for this patient are accomplished.

Senator MUSKIE. Are we going to be able to get enough of this kind of person?

Mrs. THOMAS. I can speak for back in Utah. We have them.

Senator MUSKIE. Dr. Winston suggested we have 1 for every 100 persons served by these programs.

Mrs. THOMAS. That is home health aide and homemaker.

Senator MUSKIE. Are those people going to be available?

Mrs. THOMAS. We hope so.

Senator MUSKIE. You see no problems?

Mrs. THOMAS. We have problems in Salt Lake City, because our homemaker services have been funded with Model Cities money which has been matched with money wherever it could be found.

Senator MUSKIE. Do you find so long as Government legitimizes the concept, you can get the people to provide the services?

Mrs. THOMAS. The money has been withdrawn, so the services are going to go.

Our homemaker services were placed in our division of family services, and now we have moved it around and started it somewhere else.

Now it will be available only to the division of family service clients.

Senator MUSKIE. One question of you, Dr. Winston, and I am going to release this panel. In your statement you seem to suggest that Federal programs have contributed to what may be described as a diluting of high standards for the services offered to many patients by your organization. Is that a correct interpretation?

Dr. WINSTON. Yes, sir.

We have been vastly concerned over the development of standards. We welcomed the fact that under earlier Federal regulations there was a requirement that agencies providing homemaker service through Federal funds under the Social Security Act would have to meet national standards, such as those of the National Council for Home-maker-Home Health Aide Services, Inc. Now under the new regulations which were issued by HEW this spring, there is no longer such a requirement. There is some sort of generalized statement, but it does not give us the basic support that we need of a requirement that these vulnerable older people who need this in-home service will receive a service that meets accepted national standards.

Senator MUSKIE. What is the consistency in those two policies, one a policy of narrowing and restricting eligibility for Medicare support, and another policy which is undermining or diluting the standards which would fit into those restrictive guidelines?

Where is the consistency?

Dr. WINSTON. We both have difficulty when we try to find consistency among all Federal policies that relate to a given area.

Senator MUSKIE. The consistency is, I suppose, that both approaches aim toward lesser Federal financial obligation. I guess that is the consistency.

Thank you all very much for your testimony. I wish we had more time. We could learn a great deal, I know, but we have one more witness, and I want to get him in before we close out.

Thank you very much.

[The two cases reported by Mrs. Thomas follow:]

CASE ONE

Mrs. N. was transferred from a hospital in Phoenix to her daughter's home in Salt Lake City. Her diagnosis was stroke with paralysis and congestive heart failure. The local physician accepted a "terminal" prognosis forwarded from Phoenix and ordered "general nursing care."

After careful assessment of Mrs. N's condition, our nurse determined the following positive action plan:

Close supervision of medications and medical regime.

Physical therapy evaluation and rehabilitation measures.

Institute bowel and bladder training.

Nutrition instruction.

Teach family exercises and other rehabilitative techniques.

The physician reluctantly agreed to order these measures, "Oh, well, if you want to, but it won't do any good."

Within 5 weeks, this 90-year-old lady was up walking with the use of a cane, had regained bowel and bladder control and was approaching maximum rehabilitation. Mrs. N's determination, an intelligent, involved family—daughter, son-in-law and three grandchildren—together with care provided in 29 visits by our agency team—nurse, physical therapist, and nutritionist—led to this successful conclusion: A happy rehabilitated 90-year-old-lady who can remember when Grover Cleveland was President.

*Service summary and comparison with institutional (room charge only) costs—
services provided by community nursing service*

Visits:	
Nurse -----	15
Physical therapist -----	14
	349.13
Total cost of service -----	\$349.13
Payment for service:	
Medicare -----	279.32
Medicaid -----	69.81
Institutional care costs for comparable period of service (per diem rate only—35 days):	
Hospital -----	2,695.00
Nursing Home -----	875.00

CASE TWO

Mr. and Mrs. T., a 87-year-old couple, lived alone in the home they have owned for 62 years. Mrs. T. was totally blind and Mr. T., legally blind.

Mrs. T. suffered her first stroke in January 1969. She was not hospitalized and no one referred her for home nursing care. The husband secured a wheelchair for Mrs. T. and they managed fairly well to maintain their household until December 1972, when Mrs. T. had a second stroke which left her totally paralyzed and aphasic. The family physician called our agency, asking us to provide needed home care as Mr. T. did not wish to have Mrs. T. hospitalized. Our staff organized a nursing care plan to teach the husband bed exercises and proper positioning to prevent skin pressure areas and helped him to implement the medical orders, provide personal care and proper nutrition. Mr. T. cooked for and fed his wife, and with the support of two nursing visits and aide services weekly, Mrs. T. was maintained at home comfortably and without the emotional and financial expense of hospitalization until her death on June 11, 1973.

Our social worker assisted with planning for these services at an adjusted fee rate (\$1.50 per visit) since this couple were subsisting on Social Security income. She arranged for volunteer Friendly Visitor service to relieve Mr. T.'s 24-hour vigil. Of the 42 visits we provided for Mrs. T., only the last three were reimbursable by Medicare, meeting the current rigid SSA standards for "covered" home health services. All other services, no matter how necessary and complicated, were adjudged to be merely maintaining Mrs. T.'s present health status and since they were not contributing to her "rehabilitation" were therefore not deemed reimbursable.

*Service Cost Summary and Comparison With Institutional (Per diem only)
Charges—Services Provided by Community Nursing Service*

Visits:	
Home health aide -----	11
Nurse -----	28
Social worker -----	3
	399.00
(Total cost of service -----	\$399.00
Payment received:	
Patient -----	58.50
United Fund -----	306.00
Medicare -----	34.50
Institutional care costs for comparable period of service (per diem rate only 160 days):	
Hospital -----	12,320
Nursing home -----	4,000

Senator MUSKIE. Our final witness is Dr. Charles Weller of the American Medical Association and a member of the committee on community health care.

STATEMENT OF DR. CHARLES WELLER OF THE AMERICAN MEDICAL ASSOCIATION

Dr. WELLER. Thank you very much.

I hope being the last witness does not mean the AMA is wagging the dog.

Mr. Chairman, the American Medical Association is pleased to have this opportunity to express its views on the importance of home health care services in the overall health care delivery system.

I am Dr. Charles Weller from Larchmont, N. Y., an internist in the private practice of medicine and a member of the association's committee on community health care. With me is Mr. Charles W. Pahl, assistant director of the association's legislative department.

The committee on community health care has primary responsibility for studying and recommending to the association policies regarding home health care programs. The AMA's committee on aging also is concerned with these programs as they affect our older citizens.

Mr. Chairman, in deference to the time, we are late, and I believe we all have low blood sugars and maybe have to go out and feed our stomachs pretty soon, so with your permission, I would just like to quote a few salient remarks from the presentation that was submitted to you for the record.

Senator MUSKIE. That will be fine, and the whole statement will be included, of course.

Dr. WELLER. Of course, we heard a lot about financing, and I will not go into this at this time.

The factor of cost is very important, and the factor of efficiency in utilizing scarce resources of manpower and facilities must also be considered.

Effective home health care programs can reduce or eliminate the need for both initial and continued institutional care for many patients.

PATIENTS PREFER HOME

Physicians generally agree that a majority of their patients are likely to prefer being in their own homes, and that improvement in their convalescence is likely to be more complete and rapid.

This report contains the association's definition of home health care which is: Any arrangement for providing, under medical supervision, needed health care and supportive services to a sick or a disabled person in his home surroundings. The provision of nursing care, social work, therapies (such as diet, occupational, physical, psychological, and speech), vocational and social services, and homemaker-home health aide services may be included as basic components of home health care.

Senator MUSKIE. That definition seems to be fully consistent of the definition of the four agencies I read earlier today; would you agree with that?

Dr. WELLER. Yes, sir.

One of the continuing difficulties in the successful development and operation of these programs is the financing of home health care services.

From the standpoint of coverage and reimbursement, home health services have been largely ignored by third party payors in the past.

In recent years, however, home care coverage is becoming increasingly available as a result of patient and provider satisfaction and the recognition by all parties of the potential cost savings.

The AMA believes that home health services should be an integral part of any health insurance program.

Physicians believe that current and future governmentally financed programs should also contain practical realistic provisions for reimbursing effective home health care agencies and programs.

We have supported the concept that patients should receive needed care in the most appropriate location for their specific conditions and needs.

This may be in health care institutions, in physicians' offices, or in their own home. It is extremely regrettable if there is a good home health program available that is not being used because of financing restrictions in either the private or public sector.

As the professional association representing this Nation's physicians, the AMA is particularly concerned with its responsibilities in home health care programs.

The AMA has offered five suggestions for physicians:

(1) Physicians should be aware of the home care services available in the community and the various methods by which they can be developed or improved.

(2) Physicians should assist in initiating innovative ways in the community that encourage the delivery of more efficient, more economical, and more appropriate care in the natural home setting of the patient.

(3) Physicians should become familiar with the various financing alternatives that can be used in paying for home health services.

(4) When referring patients for home care, physicians should establish a plan of treatment for each patient and should periodically review this plan and the patient's progress with the home health personnel providing the care.

(5) The physician should insure that he receives regular reports, observations, and progress notes from the health personnel or home care program providing the services.

MEDICAL SOCIETIES CONCERNED

We know that local medical societies are also concerned with the availability and adequacy of health care services for the population in their areas.

The medical society, therefore, should stimulate physician interest in, and acceptance of, home care as an integral part of the overall continuum of care.

Along with this, the society should provide community leadership in both improving the coordination of existing home care services and stimulating the development of new services where they are needed.

We recognize that a home care program without any limitations could get out of bounds. We believe, however, the physicians and other professional personnel who want the best possible care for their patients must be allowed to order and provide preventive, supportive, and rehabilitative services at home as they presently do at other sites.

We believe that the range of home services covered by Government programs needs reexamination.

We urge that the experience of physicians who are participating in home health care programs should be utilized in the process of such a reexamination.

I believe one further point should be made regarding the provision of home health services.

The American Medical Association believes that home health services are an important component of any national health insurance proposal, and it has included home health services in its Medicare bill.

In summary, the AMA actively supports the development and expansion of sound home care programs. We will continue to urge that they be covered under both private and public programs.

We believe they can aid selected patients, reduce costs, reduce institutionalization and provide valuable assistance to physicians whose patients participate in them.

More education is needed about the benefits of home care programs, and physicians will continue their efforts in this field.

This concludes our statement, Mr. Chairman. We appreciate having this opportunity of presenting our views on home health services programs.

I will now be happy to try to answer any questions which the committee may ask.

Senator MUSKIE. Thank you very much, Dr. Weller.

You have attached a publication of the AMA on home health care.

I understand it is a very positive statement, and we will be happy to include that in the record as well.*

Dr. WELLER. That will be fine.

Senator MUSKIE. With respect to the points you make in your statement concerning the involvement of the physicians in the home health care program, I put that beside the suggestion of Dr. Jessiman earlier, that hospitals also get involved in their hospitalization review programs, and in the consideration of the total health resources of the community.

I am not sure to what extent hospitals and doctors are receptive to this kind of advice or lecturing.

In all frankness, are not doctors focusing on the utility of the home care program mainly in the sense that the AMA itself is emphasizing their importance, but have we got a selling job to do?

EDUCATIONAL PROGRAMS STARTED

Dr. WELLER. Yes, sir, we do have a selling job to do with physicians, and the AMA is embarking on educational programs with physicians.

As an example, the county medical societies have become active in the formation of their local home health care community hospital

*See appendix, p. 498.

based and community based committees to coordinate their total effort and bring it into the mainstream of medical care.

There is no doubt there is some physician apathy in the country. This is gradually being overcome, and we anticipate in the future, that there will be a lot more utilization.

Senator MUSKIE. I suppose one of the great frustrations of patients everywhere, including this one, is the difficulty of getting physicians to make home calls.

I understand the difficulties that stand in their way, but it seems to me the positive attitude toward this kind of program will tend to offset some of the PR problems which that may create.

Dr. WELLER. That is true. Of course the house call problem is a real one. We feel that there is much time that simply is wasted by a physician going to the home, and making a house call, whereas with an acute illness, where he belongs in a hospital, he is needed, and, second, there are a lot of things that can be done by home health agencies that really do not need a physician to make home calls.

MONITORING CARE

Senator MUSKIE. Should there be an ongoing monitoring or supervision of home health care programs by physicians?

Dr. WELLER. Yes, sir, I think there is no doubt that there is a need for monitoring the quality of care, and it is a question of how this should be done, who should do this, and so forth. As you know, right now, we are embroiled in developing PSRO legislation, and I think if one looks at the monitoring of quality care as outlined in PSRO's, mainly in hospitals and nursing homes, in the Medicare and Medicaid patients, if one can envision this as a flow of patients, from hospital, extended care, nursing home, and out into the home, if you are to keep that pipeline of services flowing, one must develop adequate home health care services at the end of this pipeline in order to make the effective flow from the beginning, from hospital, and so forth, all the way out.

We have had a lot of difficulty in some of the cases as to extended care units, because it is difficult to get the patients back into their own homes, because of many problems of lack of proper service, so we feel this is a very important thing, as far as developing standards, and monitoring the process. If and when PSRO's become effective, maybe this is one area in which this can be brought into the total plan of a hospital or nursing home and home health care in monitoring.

Senator MUSKIE. Would the providing of increased services of home care enhance the choices available to patients in terminal cases?

Dr. WELLER. Yes, I think it certainly does enhance the alternatives to care. Most such patients would prefer to remain in their own home, and we certainly encourage this all the way, but there is need for development of all of the total services in home health care to answer this need.

Senator MUSKIE. Doctor, a nonmedical question: it has been my observation in 13 years here that the AMA has considerable political clout.

Dr. WELLER. Thank you, sir.

Senator MUSKIE. And I simply wanted to raise the possibility of making use of that to solve some of the problems that have been raised

here this morning in connection with the Social Security Administration, BHI, the Cost of Living Council, and I think we could add one or two to that list.

There seems to be some very real problems here, so simply without asking for any comment, I would request that you enlist your services in achieving some of these breakthroughs.

Dr. WELLER. Thank you very much, Senator. I agree with you, and I certainly will put it in the hopper and hope something will come out of it.

Senator MUSKIE. Well, I thank you very much, doctor.

Your prepared statement along with the attached document* will be made a part of the record.

[The statement follows:]

PREPARED STATEMENT OF CHARLES WELLER, M.D.

Mr. Chairman and members of the subcommittee:

The American Medical Association is pleased to have this opportunity to express its views on the importance of home health care services in the overall health care delivery system. I am Dr. Charles Weller from Larchmont, N.Y., an internist in the private practice of medicine and a member of the Association's committee on community health care. With me is Mr. Charles W. Pahl, assistant director of the association's legislative department. The committee on community health care has primary responsibility for studying and recommending to the Association policies regarding home health care programs. The AMA's committee on aging also is concerned with these programs as they affect our older citizens.

I am sure you are aware of the increased incidence of chronic illness in our population, which is composed of a constantly growing number of older people. In many cases, these chronic conditions are not continuously disabling or are only partially disabling. However, diabetes, hypertensive and arteriosclerotic heart disease, cerebrovascular disease, arthritis in its many forms, neurological disorders, and other long-term illnesses often create disabilities severe enough for patients to require noninstitutional health services that are more readily available, appropriate and accessible than those provided in more formal health care facilities.

Also to be considered are the patients of all ages who are temporarily disabled during convalescence from acute illness, surgery, and accidents. It is generally recognized, at the present time, that patients in both these categories frequently occupy acute care hospital beds when they no longer need the sophisticated, constant care for which these facilities are designed. Others are in skilled nursing facilities or in other types of nursing homes which, while less expensive than hospitals, are staffed and equipped to provide more skilled services than that required by many of these patients. Again, higher than necessary costs result.

The factor of cost is not our most important concern. The factor of patient satisfaction is very important, and the factor of efficiency in utilizing scarce resources of manpower and facilities must also be considered. Effective home health care programs can reduce or eliminate the need for both initial and continued institutional care for many patients. Physicians generally agree that a majority of their patients are likely to prefer being in their own homes, and that improvement in their convalescence is likely to be more complete and rapid.

The American Medical Association supports the appropriate use of home health care programs. In 1960, it recommended "that physicians be urged to participate in organized home care programs for any patient who can profit from the program and to promote such programs in their communities." In 1962 it called for additional study and evaluation of existing coordinated home care programs, their proper role in the whole field of medical care, and their proper support by medical care insurance, "with a view toward stimulating development and extension of such programs."

*See appendix, p. 498.

More recently, at the AMA Clinical Convention in 1972, a report, *Statement on Home Health Care*, was adopted. (That statement, in pamphlet form is appended to this statement.*)

This report contains the Association's definition of home health care which is: "Any arrangement for providing, under medical supervision, needed health care and supportive services to a sick or a disabled person in his home surroundings. The provision of nursing care, social work, therapies (such as diet, occupational, physical, psychological, and speech), vocational and social services, and homemaker-home health aid services may be included as basic components of home health care."

Home care has been generally considered to be categorized into three component levels: (1) concentrated or intensive care; (2) intermediate service; and (3) basic services. Research is currently going on to evaluate proper categorization of services according to patient needs and demands.

The most concentrated or intensive service is for patients who might otherwise require admission to inpatient institutions. Some patients require complex professional services on a coordinated and continuing basis for brief periods of time. They do not require full-time resources and can benefit from intensive home health care services.

Intermediate services are those needed on a less intensive basis. Patients requiring intermediate services may have long-term problems or may have been recently discharged from an acute care facility.

Basic services are those that provide an effective level of health care for an individual within that person's home. Basic service should be sufficient to sustain patients adequately so that they can remain relatively independent. Assuming they have stabilized physical conditions, they do not have to return to an inpatient facility for more intensive care.

Whatever the organizational mechanism, home care services at any of the described levels should be viewed as an alternative to hospital, nursing home, or other institutional care and as a part of a total medical care plan. As such, home care can enable the patient to remain in, or return to, a home environment that may be psychologically therapeutic as well as result in a cost saving.

Training of the patient in self-care and instruction of family members are of prime importance in achieving maximum effective utilization of available professional health personnel. For example, institutional efforts devoted to careful instruction of a diabetic or a post-coronary patient and his family before the patient goes home provide for continuity of care and a reinforcement of the educational process in the setting of the patient's home. Home care is enhanced by having instructions start in the hospital because they will then be reinforced in the home.

A special aspect of the coordinated home care programs are the homemaker-home health services program component. Services are provided by homemaker-home health aides who are mature and specially trained persons with skills in both homemaker and personal care. They help maintain and preserve a family environment that is threatened with disruption by illness, death, ignorance, social maladjustment, and other problems. They can assume full or partial responsibility for child or adult care, for household management, and for maintaining a wholesome atmosphere in the home. Their activities are performed under the general supervision of a nurse, social worker, or other appropriate health professional.

Homemaker-home health aides can perform a number of routine duties: light housekeeping, light laundry, preparation and serving of meals, shopping, simple errands, teaching of household routine and skills to well members of the family, and general supervision of the children of the patient. There is a need for the expansion and extension of this service in new and imaginative ways.

One of the continuing difficulties in the successful development and operation of these programs is the financing of home health care services. From the standpoint of coverage and reimbursement, home health services have been largely ignored by third party payors in the past. In recent years, however, home care coverage is becoming increasingly available as a result of patient and provider satisfaction and the recognition by all parties of the potential cost savings. The AMA believes that home health services should be an integral part of any health insurance program.

*See appendix 1, p. 498.

Physicians believe that current and future governmentally financed programs should also contain practical, realistic provisions for reimbursing effective home health care agencies and programs. We have supported the concept that patients should receive needed care in the most appropriate location for their specific conditions and needs. This may be in health care institutions, in physicians' offices, or in their own home. It is extremely regrettable if there is a good home health program available that is not being used because of financing restrictions in either the private or public sector.

Private insurance companies and Blue Cross-Blue Shield are recognizing that proper utilization of home health care services potentially can result in significant cost savings. As a result, a greater number of health insurance policies are beginning to include coverage of home health care services. Insured home care programs in two areas—Philadelphia, Pa., and Rochester, N.Y., have been in operation for several years and have reported significant cost savings.

In the greater Philadelphia area, some Blue Cross subscribers were provided a broader range of benefits. The patients who have made use of the home care have been released from hospitals an average of 13 days earlier than they would have been without the availability of the coordinated home care service. Expressed in the value of inpatient days saved on 3,940 home care cases, this amounted to a gross savings of approximately \$2.5 million. Net savings amounted to approximately \$1.3 million, or \$330 per case after deducting the cost of providing home care services and the related program administrative costs.

The Rochester (N.Y.) Home Care Association program is underwritten through the Rochester Blue Cross program. This program grew from a total of 141 referrals in 1961 to over 1,500 referrals in 1970. The national inpatient per diem cost rose from \$36 in 1961 to \$92 in 1971. In 1961, the Rochester home care cost per day was about \$8 and in 1971 it was \$16, and it offered a saving of approximately \$76 per day compared to charges for a patient day in the hospital. The average hospital length of stay for the type of patient served by the program was about 40 days. However, through utilization of home care services a savings of 21 inpatient days per case was realized. For the calendar year 1970, the Rochester home care program achieved a net savings of over \$1 million.

Both of these programs illustrate that effective programs of home care services can reduce costly inpatient stays and achieve significant savings.

Some Federal programs now provide for reimbursement of home health services, but there are generally deductibles and some restrictions. You are aware, I am sure, of the reimbursable home health benefits under Medicare. Coverage under part A of title XVIII is available only if the patient has been hospitalized for three days or has been in an extended care facility. In addition, part B provides for an additional 100 visits during a calendar year. In 1971, home health services accounted for less than 20 percent of the number of claims and less than 1 percent of the dollars paid out under Medicare.

About 80 percent of the individual state Medicaid programs have included home health services either for the categorically indigent or the medically indigent. As of July 1, 1970, all States were required to provide home health services for eligible individuals entitled to skilled nursing home services. In the overall Medicaid program, home health expenditures again are a small part, totaling less than a half of one percent of the dollars paid out.

Other Federal programs in which home health services may be provided include the civilian health and medical program for the uniformed services (CHAMPUS) and the Federal employees health benefits program (FEHB).

As the professional association representing this Nation's physicians, the AMA is particularly concerned with its responsibilities in home health care programs. The AMA has offered five suggestions for physicians: (1) Physicians should be aware of the home care services available in the community and the various methods by which they can be developed or improved. (2) Physicians should assist in initiating innovative ways in the community that encourage the delivery of more efficient, more economical, and more appropriate care in the natural home setting of the patient. (3) Physicians should become familiar with the various financing alternatives that can be used in paying for home health services. (4) When referring patients for home care, physicians should establish a plan of treatment for each patient and should periodically review this plan and the patient's progress with the home health personnel providing the care. (5) The physician should insure that he receives regular reports, observations, and progress notes from the health personnel or home care program providing the services.

We know that local medical societies are also concerned with the availability and adequacy of health care services for the population in their areas. The medical society, therefore, should stimulate physician interest in, and acceptance of, home care as an integral part of the overall continuum of care. Along with this, the society should provide community leadership in both improving the coordination of existing home care services and stimulating the development of new services where they are needed.

The May 14, 1973 issue of *American Medical News* featured an article called, "Home Care Curbs Stir Dispute." The article points out the difficulties home care agencies have experienced as a result of the Social Security Administration's administration of the program. At present preventive, supportive, and counseling services are not reimbursable.

We recognize that a home care program without any limitations could get out of bounds. We believe, however, the physicians and other professional personnel who want the best possible care for their patients must be allowed to order and provide preventive, supportive, and rehabilitative services at home as they presently do at other sites. We believe that the range of home services covered by Government programs needs reexamination. We urge that the experience of physicians who are participating in home health care programs should be utilized in the process of such a reexamination.

I believe one further point should be made regarding the provision of home health services. The American Medical Association believes that home health services are an important component of any national health insurance proposal and it has included home health services in its Medicare bill.

In summary, the AMA actively supports the development and expansion of sound home care programs. We will continue to urge that they be covered under both private and public programs. We believe they can aid selected patients, reduce costs, reduce institutionalization, and provide valuable assistance to physicians who patients participate in them. More education is needed about the benefits of home care programs, and physicians will continue their efforts in this field.

This concludes our statement, Mr. Chairman. We appreciate having this opportunity of presenting our views on home health services programs. I will now be happy to try to answer any questions which the committee may ask.

Senator MUSKIE. I want to thank everyone of you for your testimony.

We will be in recess until tomorrow morning at 10 o'clock.
[Whereupon, the subcommittee was recessed at 1:15 p.m.]

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. COST EFFECTIVENESS—WHAT DOES IT MEAN TO A HOME HEALTH AGENCY; BY HADLEY DALE HALL, EXECUTIVE DIRECTOR, SAN FRANCISCO HOME HEALTH SERVICE

In the past few years, 59 home health agencies have gone out of business in California because of problems in collecting for their costs from Medicare. In Texas, I understand hundreds of home health agencies have gone bankrupt—WHY?

Since 1969, one home health agency provided 3 percent yearly increments or salary adjustments for its employees, yet the cost for a professional visit increased 110 percent. In one California home health agency, the cost for an hour of Homemaker/home health aide time, for a Medicare patient, increased from \$4.50 to \$8.61 or 91 percent—WHY?

President Nixon has said that our nursing homes are inadequate and that patients are not being served adequately at home. Congressman Wilbur Mills, from Arkansas, is publicly concerned because there has been no expansion of covered benefits under the home health provision of Medicare; yet costs for the Medicare program continue to increase dramatically—WHY?

Nearly all home health agencies show a marked decline in Medicare services to people. The income of agencies from Medicare has steadily declined. There has been a decrease in the number of home health agencies participating in the Medicare insurance system and according to a Senate Committee on Aging report, payments for home health services were less than 1 percent of the Medicare and Medicaid expenditures and even that small portion is rapidly declining. Payments were nearly cut in half between 1969 and 1971, while at the same time, there was a dramatic increase in the expenditures for institutional care—WHY?

Did "cost effectiveness" bring about this situation? The answer is, YES, but it has been the wrong kind of cost effectiveness! It has been based upon a fundamental conflict between what is said to be public policy and what actually exists in the "nonsystem" of health delivery. The fundamental conflict is between the "institution" and the "home."

A discussion of "cost effectiveness" as it has been applied to home health services, and the conflict between the institution and the home may shed some light on the issues and problems before us.

In discussing cost effectiveness, let me first define the terms:

- I. What are the *goals* of cost effectiveness;
- II. What are the *barriers* to cost effectiveness;
- III. What measure should be taken to *eliminate the barriers* or reduce their impact upon cost and effective delivery of service, and finally;
- IV. What can be done to *achieve our goal* in a rational and economic manner.

I. GOALS OF COST EFFECTIVENESS

The primary goal of cost effectiveness must be that the people in need of services are "getting their money's worth." Accountability for this goal must be primarily to the user—the consumer of needed services—that is, the patient. We have allowed cost effectiveness to mean that the providers receive money and the

fiscal intermediaries obtain their costs while the Bureau of Health Insurance obtains a larger staff and the auditing firms expand their profits. While this has been occurring, patients (and services to people in need of them) have been decreasing in scope and volume.

II. BARRIERS TO COST EFFECTIVENESS

Services of the best quality in the maximum quantity and supplied by methods which are efficient and economical are basic to cost effectiveness. There is no place in this concept for the idea that services should include the support of a large administrative superstructure as a part of the goals of cost effectiveness. What, then are the barriers to good cost effectiveness?

The most critical barrier is the use of "middlemen" which has added to a costly administrative superstructure. No one would deny that auditing firms have expanded their staff and profits to review agencies—often in a piecemeal manner. The Bureau of Health Insurance has expended its staff in order to "supervise" the administration of the home health benefit. Fiscal intermediaries have been building huge warehouses and office buildings. All of us at the provider level can give detailed testimony about the increased costs of service caused by additional administrative overhead. Each addition to administration increases the cost of service and each increase helps to create an even larger administrative superstructure. How has this been accomplished?

(A) "Middlemen" at every level have imposed costly and complicated "paper" routines on "service" agencies.

The record demonstrates a costly, complicated paper routine imposed on providers which deny services to the people in need of them. An agency is certified and in California also licensed. Each process requires a lot of paper work. Each patient is under the care of a licensed physician who prescribes his plan of care in writing. Each agency must employ qualified and licensed people who plan and review, in writing, the status of each patient at stated intervals. Each agency has a utilization review committee to examine the work of the staff, in writing, and to review the patient's plan of care as established by the licensed physician for each patient—all of it on paper. County medical societies have committees to review agencies and physicians—and they document their findings in writing. But that is not enough!

The Bureau of Health Insurance and their fiscal intermediaries also have "medical review." But their physicians do not make home visits or see patients. These "medical reviews" have been arbitrary, hospital oriented—without consultation with home health professionals and they have been done retroactively—without regard to law, logic or the people it affects, sometimes by nonmedical personnel.

In short, the performance of all of us as middlemen has added costly and complicated paper routines to our service.

(B) We, as "middlemen," have failed to use modern business methods and we have failed to make use of modern techniques of checking for efficient and effective service delivery.

For instance:

(1) *Auditing*: No modern method of cost control which is effective or efficient would allow "audits" to take place years after the fact. The word "audit" is placed in quotes because the auditors only do reviews and reports—there have been no audits in the true sense of the word. When reviews of financial records take place so long after the fact, records must be maintained. This requires file space and an endless clerical staff to keep files in order, relocate documents, and maintain records.

Though such examinations or "audits" are in order, the practical effect of such examinations has resulted in inefficiencies and increased costs. For example, the same year or years may be examined by different accounting firms—one for Medicare and another for Medi-Cal. As we add other programs such as home-maker services and Meals-on-Wheels, will we have additional audits? Much of the statistical work and documentation of the provider is not examined at all. The accounting firm accepts, as fact, the statistics developed by the fiscal intermediary or, in California, the department of health care services. Even after the examination has been completed and "exit" conferences held by personnel from the accounting firm, the fiscal intermediary, and the provider, the issues in dispute often remain unresolved leaving the providers and their patients

uncertain as to the end result. This does not apply the basic principles of cost effectiveness and accountability. It creates a bureaucratic quagmire—and that quagmire is an expensive thicket, at best, or an exercise in bad business practice at least.

(2) *Shifting authority and staff*: No effective method of accountability allows for a constant shifting of authority within the fiscal intermediary staff or the staff of the Bureau of Health Insurance, or the firms engaged for audit purposes. One agency executive told me: “. . . twelve different, charming, well-scrubbed gentlemen representing three auditing firms were necessary to complete audits on Medicare and Medi-Cal in an 18-month period.” Some accountants earn as much as \$75 an hour and more, but home health agency staff must explain the “ins” and “outs” of Medicare; the differences between parts A and B of title 18 of the Social Security Act; Medicaid; and other terms and concepts necessary to review a home health agency. Costs simply increase when there is constant shifting of staff and authority in the Bureau of Health Insurance; with the fiscal intermediaries and their auditing firms.

(3) *Secret guidelines or regulations*: The Bureau of Health Insurance has secret criteria used by fiscal intermediaries to help the intermediaries determine whether services are reimbursable. Some secret criteria are included in regulations contained in fiscal intermediary manuals which are not available to providers of service or recipients of service. The effect of this situation is that you have two sets of guidelines: one public and open, the other private and secret. Naturally, this gives rise to inevitable contradictions and effectively eliminates a meeting of the minds. The result is, of course, an additional administrative superstructure which quickly begins to feed upon itself.

A fiscal intermediary manual or an auditor's manual that is not available to a provider is like playing a football game with referees who are paid for their services by only one of the teams and the other team does not know the rules of the game—it may be a lot of fun but the score will be lopsided and you will not be able to tell very much about capacity, ability, or how a team (presumably a home health team) functions. Besides, it is costly and unfair—though it may not be illegal, it is certainly immoral.

For example, we, the California Association of Home Health Agencies, have repeatedly complained about the Bureau of Health Insurance sending fiscal intermediaries one set of instructions and providers another set of instructions. The most recent example is Revision No. 36. Before this revision was issued, as in most other situations, we were not consulted. The collective pronoun *we* means home health professional groups such as the California Association of Home Health Agencies, the National Council of Homemaker-Home Health Aide Service, the National Association of Home Health Agencies and the National League for Nursing. In some situations, providers receive the revisions weeks and months after they become effective and in the case of Revision No. 36, some providers still do not have the document.

How costly and confusing for our patients in need of services! But, my friends, there is more! Fiscal intermediaries are then allowed to “interpret” the revisions and even review cases—applying new principles to services given before the “new rules” become effective. How does this affect the person in need? We know what happened to 59 providers serving people in California.

(C) “Middlemen” have insisted upon the inefficient and expensive device of reviewing individual claims:

The device of reviewing individual claims inevitably leads to a lack of standardization in the application of regulations. This device also leads to confusion on the part of all principals and there is the added process of costly paper work.

No bureaucracy can be created in government or in a middleman organization to review each claim fairly. Congress did not intend the Medicare program to do so.

The Medicare law certainly requires the Social Security Administration and its fiscal intermediaries to “. . . assist in the application of safeguards against unnecessary utilization of services . . .”, but the law places equal responsibility upon the fiscal intermediaries to: “. . . assist providers . . . in the development of procedures relating to utilization practices . . .”

In the process of individual claim review, there is inevitably confusion and delay of payments. Such a review must result in the “saving of money” or there would be no purpose in such a process. For example, reasons for denying reimbursement on specific claims are so vague as to constitute no reason at all.

"Excessive visits."—This hardly seems to be a logical reason for denying a claim. The logic is that the person was "excessively sick" to require so much attention.

"Skill is exhausted."—Skilled nursing was ordered by the physician but a clerk decides the skill is exhausted.

"Patient is custodial."—This implies that the patient needs to be in the "custody" of an expensive institution, yet, someone receiving part time and intermittent services can hardly be considered in "custody."

In the past few years, it has been documented repeatedly that more than one-half of the patients in nursing homes do not need 24-hour care.

"The care was for too long a duration."—Honest providers rarely exceed the 100 visit limits and have not exceeded these limits since organized care at home was started except in rare but justifiable circumstances.

"The care is beyond the generally accepted practice in the community."—This standard of "generally accepted practice" has never—and we repeat, NEVER—been identified or communicated. If such a standard were available and applied to home health services, we would greatly increase our patient load, not decrease it.

"The patient was not 'actively treated.'"—Treatment of the aged and homebound is often less "active" than treatment for "acute" medical problems. In any case, "active treatment" has never been defined.

"The potential for rehabilitation has been exhausted."—The statute states that one of the purposes of the home health service benefit is to prevent or postpone institutionalization. The statute recognizes the very logical and real limitations of the "target group"—those over 65—for they never get younger, their medical conditions are usually acute exacerbations of, or secondary to, chronic illnesses and the conditions nearly always get more complicated.

(D) "Middlemen" have been allowed—indeed, encouraged, to establish self-serving bureaucratic special interest groups which now have a vested interest in maintaining themselves.

Sometimes this process is referred to as "Parkinson's Law"—and there may be a bit of the "Peter Principle" thrown in. For example:

(1) *Auditing firms.*—Since "real audits" are not performed, differences of opinion and unresolved issues will confront us—what happens? There is further delay in reimbursement or cost settlements with more conferences, more meetings, more paper work, and "a more complete examination of the documents"—that is, more work for auditing firms.

(2) *Fiscal intermediaries.*—All fiscal intermediaries have added monuments to bricks and mortar (new buildings)—each more lavish than the last, to house an expanding army of claims processors, utilization reviewers, and provider relations staff. Appropriately, one might wonder if this army will ever go to war for or against the patients.

(3) *Government.*—One division of the Bureau of Health Insurance advertises benefits while an "integrity branch" of the same bureau expands its staff in an attempt to limit payments for services rendered.

III. SOLUTIONS

This is a dismal situation, what are the solutions?

(1) We must re-establish the true goal of cost effectiveness—are the people in need of services getting their money's worth?

(2) We must make a maximum investment in services and reduce the investment in middlemen.

(3) There must be a drastic simplification of all bureaucratic routines. An executive of a member agency of this association recently reported that a fiscal intermediary notified her that a patient had no Medicare coverage 6 years after the service had been provided and 5 years after the patient's death. Computers can simply do a better routine than that or there should be a statute of limitations. Mistakes are inevitable but the only person holding "the bag" is the provider—the home health agency.

(4) There must be acceptance of the fact that agency standards, in themselves, are the best safeguards for good care. Agency standards may, in fact, be the only safeguards available to us. No army of investigators can guarantee adequate standards as well as the knowledgeable people in this room. Violations can be determined by an *intermittent* review of claims rather than an individual examination of prescription services.

(5) We must reduce the number of single purpose or single focus agencies and we must increase the number of comprehensive service agencies—in other words, mergers of home health service agencies may be required.

(6) There must be examination and widespread publication of the costs of the middlemen. We must publish the costs of direct service as well as the costs of administrative overhead and we must examine and publish the costs for claims processing; that is, how do these costs add to or detract from cost effectiveness in terms of the user?

(7) Agencies must improve their current programs and develop new and innovative approaches to such centralized housekeeping services as purchasing, billing, statistics, standard forms, training, payroll, insurance, public education, and politics.

IV. TO ACHIEVE OUR GOAL

How can this be achieved? The barriers of cost effectiveness can be reduced and even eliminated. We can achieve our goal by an aggressive approach which combines efforts utilized by national agencies and groups for accrediting services and agencies. The National Council for Homemaker-Home Aide Services, the National Association of Home Health Agencies, the National League for Nursing and others have an interest in meaningful standards for services and true cost effectiveness. These groups must be encouraged and supported. Since providers are the poorest of the middlemen, the financial support will have to come also from the other middlemen—auditing firms, fiscal intermediaries, and the Bureau of Health Insurance.

Finally, at the outset I said there was a fundamental conflict between what is said to be public policy and what exists in reality. It was suggested that the conflict was between the institution and the home. There is no better example of this conflict than in the health insurance industry.

Many of my friends tell me that they and their insurance companies are in favor of home health care. I must point out to them that they ignore the fundamental conflict between what they believe as individuals and what their companies do in practice. Insurance companies have systematically retarded the growth and scope of home health services for irrational and emotional reasons which often seem selfish. Insurance companies do not pay for health—they pay for illness. The formula is simple; costly illnesses equals more premiums and reserves or dividends are too often a percent of premiums.

All insurance companies, whether they are publicly supported—like Medicare and Medicaid—or private companies, agree that most of the costs for a stay in an institution are for “maintenance” and not for the “laying-on-of-hands” or “skilled” services. Most of an institution’s expenses are caused by the costs of providing clean bed linen, a hygienic environment, nutritious food delivered on wheels to the bedside and some TLC. Why then do our public and private insurance companies provide only limited and severely restricted home care benefits? Does it have something to do with cost effectiveness?

If we apply appropriate procedures to assure the goal of cost effectiveness, it will require that we change some of our priorities and we will have to fund services that people need at home just as we underwrite the costs of care that we provide in institutional settings. When these priorities are established and financed, it will mean that people in need of services are “getting their money’s worth”. It will mean that 59 new agencies will have been established—not destroyed—and that existing agencies will have been expanded in their scope and quality of services. It will mean that unit costs and costs per patient will decrease and Senators will not have to ask “. . . will home health services become a major component in a rational and responsive health care system or will their shortcomings of today become even worse tomorrow in a health care system grown still more costly and less helpful to people in need of service, but not institutionalization?”

ITEM 2. TESTIMONY BY PHILIP L. PILLSBURY, M.D., MEMBER, BOARD OF DIRECTORS, SAN FRANCISCO HOME HEALTH SERVICE; BEFORE THE SOCIAL SERVICES COMMISSION, JUNE 8, 1972*

At the request of your department’s staff and based on the minutes of your April 1972 commission meeting, I am here to present some information about our agency and its programs related to our mutual clients. Essentially, I want to

*Submitted by Mr. Hadley Hall.

discuss our charges and the quality of our services. I am Philip L. Pillsbury, M.D., a physician in private practice. I have been a member of the medical advisory committee of this commission and department for many years. We are all aware that caring for people in their own homes instead of in institutions is good practice. We all understand the reasons for this and the tremendous benefits that are possible because of it. That is why the San Francisco Home Health Service was created in 1957. The Home Health Service is a tax-exempt, nonprofit community agency and I am a member of their board of directors. I receive no compensation or reimbursement of any kind.

In 1963, with the encouragement and assistance of the Department of Social Services, the San Francisco Home Health Service spearheaded a drive to help find ways to improve the program of "attendant care." Overall, the attendant care program was an attempt to help people who should stay at home and out of expensive institutions. It provided employment for people as "attendants," but this proved somewhat unsatisfactory. There was a change in Federal and State laws so that private, nonprofit agencies can obtain direct payment for "homemaker" services through contracts with local welfare departments. In February of 1971, you signed a contract with us for homemaker services—the first of its kind in California. The contract identifies the responsibilities of each of us and requires that our books, records and other documents be open to review, inspection and audit. We have submitted reports and have had outside independent certified public accountants provide you with audits, reports and other information. We will be happy to provide additional materials that you might need or require. Mr. Hadley Hall, our executive director, is with me today and can provide you with details related to costs, charges and service patterns. Before that, however, let me discuss a few of the issues that our board of directors has grappled with for some time. These issues need exposure and understanding.

1. "Hourly rate" is only one measure of cost. For example, if a client needs 2 hours of service and one agency charges \$7.50 per hour without a minimum number of hours, then the visit cost is \$15. However, if another provider has an arbitrary *minimum* of 4 hours and his rate is \$6 an hour, then the visit cost will be \$24 for that client even though the client needed only 2 hours of service.

In addition to "hourly rate" and "visit cost," one needs to know what the average "monthly cost" per client is. What does it cost to take care of someone, on the average, for a month? In our situation, during the first 3 months of our contract with the Department of Social Services (February, March, and April 1971) our average monthly cost per client was \$158.78. Our average monthly cost per client for the first 4 months of this year (January through April 1972) was \$156.56, a decrease of \$1.22 over the average for the first 3 months of the contract. Our average "visit cost" was less than \$19 during this time. This included training, supervision, evaluations and all other charges.

All of this is to say: It is easy to understand that costs per patient can be measured in several ways—by the hour, by the visit or by the month—but this does not tell us much about the people we care for.

I said earlier that the attendant care program was not entirely satisfactory. We do not get a fair return on our expenditure. We are now offering a trained and supervised service to keep people in their own homes and the costs are going to be greater than those incurred in a less satisfactory program. In other words, good care costs money.

2. What is included in the charge? Once one determines the relationships between hourly charge, visit cost and average cost per month per recipient, one must ask what is included in those figures. In our case, in addition to the more than 10,000 homemaker visits to the homes for as little as 15 minutes, there were over 1,400 visits made by professionals (nurses, social workers, nutritionists, field service workers, physical therapists, and other professional persons) employed by our agency. These visits were necessary or institutionalization or rehospitalization would have become necessary. In addition to this, 1,870 hours were used in individual conferences, inservice training and supervisory meetings with the homemaker staff. We provide this information to the department routinely so that we can be accountable to the people we serve, the community that supports us, and to fulfill appropriate requirements of our contract which asks us to place and supervise *trained* homemakers. We also provide the professional evaluations and periodic reevaluations for your department. These activities are necessary if we are to do the job of keeping people out of institutions.

3. What are the standards of service? There are several "standard setting" and "quality control" mechanisms available to measure our service. One is our general reputation—do people like to use the services of our agency? Another mechanism is to apply standards established by third parties such as the State Department of Social Welfare, the National Council of Homemaker-Home Health Aide Services, the Child Welfare League of America, and others. We meet all of those standards and we have been regularly commended for the leadership we have been asked to assume in assisting other agencies, including public and proprietary groups, to meet minimum standards of service.

4. Employment of recipients of the Department of Social Services. We, of course, give preference to the employment of recipients of the Department of Social Services. In one study, we found that 73 percent of our employees were former recipients of welfare. It is not enough, in our view, just to give preference in *beginning* employment. An agency must have an aggressive, positive and successful program for career development and mobility. We have such a program. As one example, a former AFDC recipient just graduated from the University of San Francisco. This lady began employment with our agency 12 years ago and has, with our help, managed to accomplish this feat without loss of salary during the entire period. Other upgrading and career possibilities are also available to our employees such as keypunching, billing, clerical and service activities.

5. Union membership. Though we have grave reservations about a public body requiring the unionization of employees of its contractors, we want to underscore our history with employee groups. We sought unionization of homemakers many years ago because we recognized the social value of doing so and we wanted to prevent the kinds of abuses that occur in registries, day work employment, and the attendant care program. A union does not guarantee appropriate working conditions and other employee benefits but it is one way of giving voice to defenseless and lowly paid personnel. Our agency was the first to sign a contract for unionization of employees of this type. Our contract is the prototype of the others but since we have been in business longer, our employees are at the top of pay scales and have earned increased wages and fringe benefits.

Finally, adequate homemaker services cannot be provided without trained personnel to monitor clients and employees. Quality controls are required to insure that there is appropriate supervision and followup of client and employee. A good program costs money but a poor and inadequate program costs even more and increases human misery. Without a good homemaker service program, people will need to be warehoused in increasingly expensive institutions.

ITEM 3. STEPS TO BILL AND RECEIVE PAYMENT FOR SERVICES UNDER THE MEDI-CAL PROGRAM; FROM THE SAN FRANCISCO HOME HEALTH SERVICE, SAN FRANCISCO, CALIF.*

I. If a patient requires a nursing visit and has been visited within the last 6 months, "prior authorization" must be obtained before the nurse can visit and the agency can expect reimbursement:

Activity:

(A) The nurse pulls the patient's file to check if a visit has been made within 6 months;

(B) If there has been a visit within the past 6 months, the nurse must:

(1) Phone the Medi-Cal consultant at Department of Health Care Services, San Francisco Ferry Building, to obtain prior authorization. Waits of 10-15 minutes are common or the nurse may be unable to reach the consultant—election day, for example.

(2) When the nurse is able to reach the Medi-Cal consultant, she must then "plead her case," i.e., justify the need for the visit, and explain to the consultant why the service cannot be billed to Medicare. (Generally, the Medi-Cal consultants are unaware of the Medicare regulations affecting this skilled service.)

(3) The Medi-Cal consultant may grant "prior authorization." If "prior authorization" is not granted, any possible reimbursement is prevented for this visit. If he does grant "prior authorization", the consultant gives the nurse an "authorization number" for that patient for that service.

*Submitted by Mr. Hadley Hall.

(4) The nurse must then pull the patient's record and write the treatment authorization request (called in government jargon a "TAR") in detail, with justifications and it must include the "authorization number" and the date and the consultant's name on another form (MC 161). *Total time involved 1 hour (equivalent to a chargeable visit)—total cost \$18.25.*

(C) A clerk or secretary must then :

(1) Type the treatment authorization request.

(2) Copy the medical orders.

(3) Enter the name and date the form is sent to the Ferry Building in a log so that follow up can be instituted if the form is not returned in 2 weeks.

(4) Obtain signature of director of nursing on the piece of paper.

(5) Address envelope and attach postage.

(6) Mail request.

(7) Return patient's file to the nurse.

Total clerical time involved one-half hour—total cost \$2.

Total director of nursing time involved to read and sign—10 minutes—cost \$1.50.

II. The nurse visits the patient: The nurse performs the service required and at that time must :

(A) Obtain "proof of eligibility" (a piece of paper or sticker 1¼ inches long and one-half inch wide) for the current month from the patient.

(B) Very often the "proof of eligibility" is lost or mislaid by the elderly and ill patient, is never received, or all of the stickers have been taken by the first provider of service to see the patient in that month (M.D., clinic, pharmacy, medical supply, etc.). Lack of this sticker will, of itself, cancel payment (despite the telephone "prior authorization" and the signed and returned treatment authorization request. Hence, the nurse may drop by the patient's home again when the card is received or located or may attempt, through phone calls and visits to pharmacies, physician's office, etc., to obtain it.) *Total time involved (equivalent of two chargeable visits) 2 to 3 hours—total cost \$36.50.*

(C) If a "proof of eligibility" label is available in the patient's home, the nurse attaches it to a Medi-Cal billing form and forwards this to the billing department. *Total time involved 1-1½ hours—total cost \$18.25.*

III. Unreturned requests for authorization are followed up by the director of nursing within the calendar month. This involves more phone calls to the Department of Health Care Services, each taking approximately 30 minutes—*total cost \$4.50.*

IV. Billing :

Assuming :

(A) "Prior authorization" is granted.

(B) The written treatment authorization request is returned and signed.

(C) The "proof of eligibility" label is obtained.

(D) Nothing is lost in the shuffle, the billing department compiles and types the bill on the required form, attaching all of the above material, and mails the claim to Blue Cross. *Total estimated time of preparing bill 1½ hours—total cost \$11.*

V. Total cost to agency of one Medi-Cal claim for one nursing visit before submission to the fiscal intermediary :

Minimum estimated time involved, 5 hours ; 0 minutes equal minimum estimated cost—\$55.50.

Maximum estimated time involved, 6 hours ; 40 minutes equal maximum estimated cost—\$73.75.

Average estimated time involved, 6 hours ; 10 minutes equal average estimated cost—\$64.63.

VI. If fiscal intermediary processes and pays claims promptly :

Minimum payment.....	\$12. 50
Maximum payment.....	18. 50
Average payment.....	15. 50

VII. Result :

Average estimated cost.....	64. 63
Average payment.....	15. 50

Or : Medi-Cal costs the agency over four times what the agency collects.

ITEM 4.

LAWS OF NEW YORK.—By Authority

CHAPTER 918

AN ACT to amend the public health law, in relation to providing for the establishment of home health agencies and repealing paragraph (l) of subdivision one of section two hundred six of such law, and to amend the insurance law, in relation to requiring reimbursement for home care in certain cases

Became a law June 8, 1972, with the approval of the Governor. Passed by a majority vote, three-fifths being present

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Paragraph (l) of subdivision one of section two hundred six of the public health law is hereby **repealed**.

§ 2. Section twenty-eight hundred one of such law is hereby amended by adding thereto a new subdivision, to be subdivision seven, to read as follows:

7. "*Home health agency*" means a public or voluntary non-profit organization primarily engaged in providing directly or through contract arrangement professional nursing services, home health aide services and other therapeutic and related services including, but not limited to, physical, speech and occupational therapy, nutritional and medical social services which may be of a preventative, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home.

§ 3. Such law is hereby amended by adding thereto a new section, to be section twenty-eight hundred one-c, to read as follows:

§ 2801-c. *Establishment of home health agencies.* 1. No home health agency, as defined in this article, shall be established except with the written approval of the public health council and pursuant to a certificate of approval issued by the commissioner.

2. An application for approval of the proposed home health agency shall be filed with the public health council together with such other forms and information as shall be prescribed by, or acceptable to, the public health council. Thereafter, the public health council shall forward a copy of the proposed application for establishment and accompanying documents, to the state hospital review and planning council and the regional hospital review and planning council having a geographical jurisdiction of the area where the proposed agency is to be located. The public health council shall act upon such application after the state and regional councils have had a reasonable time to submit their recommendations. The public health council shall not

EXPLANATION—Matter in italics is new; matter in brackets [] is old law to be omitted.

*Submitted by Mrs. James H. Starr.

take any action contrary to the advice of either until it affords to either an opportunity to request a public hearing and, if so requested, a public hearing shall be held. If the public health council proposes to disapprove the application it shall afford the applicant an opportunity to request a public hearing. The public health council may hold a public hearing on the application on its own motion. Any public hearing held pursuant to this subdivision may be conducted by the public health council or by any individual designated by the public health council.

The public health council shall not approve an application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the agency at the time and place and under the circumstances proposed; (b) the character, competence, and standing in the community, of the proposed incorporators, directors and sponsors; (c) the financial resources of the proposed agency and its sources of future revenues; and (d) such other matters as it shall deem pertinent.

§ 4. Subdivisions one and two of section twenty-eight hundred three of such law, subdivision one as amended by chapter eight hundred sixty-two of the laws of nineteen hundred sixty-eight, subdivision two as amended by chapter nine hundred fifty-seven of the laws of nineteen hundred sixty-nine, are hereby amended to read, respectively, as follows:

1. The commissioner shall have the power to inquire into the operation of hospitals and home health agencies and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care, hospital service, including health-related service, home health service, system of accounts, records, and the adequacy of financial resources and sources of future revenues.

2. The council, by a majority vote of its members, shall adopt and amend rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of this article, including, but not limited to (a) the establishment of requirements for a uniform statewide system of reports and audits relating to the quality of medical and physical care provided, hospital utilization and costs, (b) establishment by the department of schedules of rates, payments, reimbursements, grants and other charges for hospital [and], health-related services and home health services as provided in section two thousand eight hundred and seven, (c) standards and procedures relating to hospital operating certificates, and home health certificates of approval, and (d) the establishment of a system of accounts and cost finding to be used by hospitals, including a classification of such hospitals and the prescription of a system of accounts and cost finding for each class. The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

§ 5. Section twenty-eight hundred four of such law is hereby amended by adding thereto a new subdivision, to be subdivision three, to read as follows:

3. *The commissioner shall establish within the department a unit for home health services and agencies to assist him in carrying out the provisions of this article. He shall also appoint a home health council to advise on matters affecting home health services and agencies.*

§ 6. Such law is hereby amended by adding thereto a new section, to be section twenty-eight hundred four-a, to read as follows:

§ 2804-a. *No home health agency shall be operated unless it shall possess a valid certificate of approval issued by the commissioner pursuant to this article.*

§ 7. Such law is hereby amended by adding thereto a new section, to be section twenty-eight hundred six-a, to read as follows:

§ 2806-a. 1. *A home health agency certificate of approval may be revoked, suspended, limited or annulled by the commissioner on proof that the home health agency has failed to comply with the provisions of this article or rules and regulations promulgated thereunder.*

2. *No home health agency certificate of approval shall be revoked, suspended, limited or annulled without a hearing. However, a certificate may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the home health agency following a finding by the department that the public health or safety is in imminent danger.*

3. *The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered mail to the home health agency at least twenty-one days before the date fixed for the hearing. The home health agency shall file with the department not less than eight days prior to the hearing, a written answer to the charges.*

4. *All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered mail of a copy of the order or determination upon the applicant.*

§ 8. Section twenty-eight hundred seven of such law, as amended by chapter eight hundred sixty-two of the laws of nineteen hundred sixty-eight, subdivisions two and three as amended by chapter nine hundred fifty-seven of the laws of nineteen hundred sixty-nine, is hereby amended to read as follows:

§ 2807. Payments for hospital and health-related service. 1. *No government agency and no corporation organized and operating in accordance with article nine-c of the insurance law shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service, including home health service, unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service or in the case of a home health agency a valid certificate of approval.*

2. *Payments for hospital service and health-related service, including home health service, made by government agencies or cor-*

porations organized and operating in accordance with article nine-c of the insurance law shall be at rates approved by the state director of the budget in the case of government agencies and approved by the superintendent of insurance in the case of corporations organized and operating under article nine-c of the insurance law. Notwithstanding the foregoing, rates of payment for hospital and health-related service made by government agencies, approved by the state director of the budget and in effect March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine. Rates approved by the state director of the budget for the first time after March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine.

3. Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service, *including home health service*, are reasonably related to the costs of efficient production of such service. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital *or agency* is located, the rate of increase or decrease of the economy in the area in which the hospital *or agency* is located, costs of hospitals *or agencies* of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research, those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service *or home health service*, and allowances for costs which are not specifically identified.

§ 9. Subdivision (a) of section twenty-nine hundred four of such law, as amended by chapter six hundred twenty-one of the laws of nineteen hundred sixty-eight, is hereby amended to read as follows:

(a) There is hereby created within the state department of health a state hospital review and planning council comprised of thirty-one persons appointed by the governor by and with the advice and consent of the senate. In making such appointments the governor shall consider recommendations from agencies and organizations primarily concerned with hospital, nursing home and medical affairs. The council shall be representative of the public including persons having capacities identified with consumers of hospital and nursing home services. The council shall include at least one member nominated initially by each of the regional hospital planning councils named in paragraph (d) of this section and thereafter by each regional council recognized by the state council as hereinafter provided. At

least six members shall be persons engaged in hospital or nursing home work at the policymaking or administrative level. At least six members shall be duly licensed physicians. *On and after April first, nineteen hundred seventy-three, at least one member of the council shall be representative of home health agencies.* No more than fifteen members of the council shall be physicians, or persons engaged in full-time paid employment connected with hospitals or nursing homes. However, a change in the status or employment of a member of the council shall not require his resignation or a change in the composition* of the council until further appointments are made. The members of the council shall have fixed terms of three years except that ten of the initial appointments shall be for one year and ten shall be for two years. No person shall be a member of the council for more than six years in any period of twelve consecutive years. The council shall meet at least four times in each full calendar year.

§ 10. Nothing in the provisions of this act shall be construed to invalidate or affect in any respect the validity of any license or certificate of approval issued by the commissioner to a home health service or agency prior to the first day of April, nineteen hundred seventy-three.

§ 11. Section one hundred sixty-two of the insurance law is hereby amended by adding thereto a new subdivision, to be subdivision seven, to read as follows:

7. Every insurer issuing a group policy which provides coverage for inpatient hospital care must make available and if requested by the contract holder provide reimbursement for home care. No such policy need provide such home care coverage in any contract providing coverage complementary to medicare. Home care shall mean the continued care and treatment of a covered person who is under the care of a physician but only if (i) continued hospitalization would otherwise have been required if home care was not provided, (ii) only if the plan covering the home health service is established and approved by a physician within seven days following discharge by the hospital for the same or related condition for which the covered person was hospitalized, and (iii) the home care is commenced within seven days following discharge. Home care shall be provided only by a (i) hospital possessing a valid operating certificate, and certified to provide home health services or (ii) by a non-profit or public home health service or agency possessing a valid certificate of approval issued pursuant to section twenty-eight hundred one-c of the public health law and shall consist of one or more of the following: (i) part-time or intermittent home nursing care by or under the supervision of a professional nurse, (ii) home health aide services, (iii) physical, occupational or speech therapy if provided by the home health service or agency, and (iv) medical supplies, drugs and medications, and laboratory services by or on behalf of a hospital to the extent such items would have been provided under the contract if the covered person had remained in the hospital. For the purpose of determining the benefits for home care available to a covered person, each visit by a

* So in original. [Word misspelled.]

member of a home care team shall be considered as one home care visit; the contract may contain a limitation on the number of home care visits but not less than forty such visits in any calendar year; four hours of home health aide service shall be considered as one home care visit.

§ 12. Section one hundred sixty-four of such law is hereby amended by adding thereto a new subdivision, to be subdivision seven-f, to read as follows:

7-f. Every insurer issuing a policy of accident and sickness insurance must make available and, if requested by the insured, provide reimbursement for home care in a policy which provides coverage for inpatient hospital care. Home care shall mean the continued care and treatment of a covered person who is under the care of a physician but only if (i) continued hospitalization would otherwise have been required if home care was not provided, (ii) only if the plan covering the home health service is established and approved by a physician within seven days following discharge by the hospital for the same or related condition for which the covered person was hospitalized, and (iii) the home care is commenced within seven days following discharge. Home care shall be provided only by a (i) hospital possessing a valid operating certificate, and certified to provide home health services or (ii) by a non-profit or public home health service or agency possessing a valid certificate of approval issued pursuant to section twenty-eight hundred one-c of the public health law and shall consist of one or more of the following: (i) part-time or intermittent home nursing care by or under the supervision of a professional nurse, (ii) home health aide services, (iii) physical, occupational or speech therapy if provided by the home health service or agency, and (iv) medical supplies, drugs and medications, and laboratory services by or on behalf of a hospital to the extent such items would have been provided under the contract if the covered person had remained in the hospital. For the purpose of determining the benefits for home care available to a covered person, each visit by a member of a home care team shall be considered as one home care visit; the contract may contain a limitation on the number of home care visits but not less than forty such visits in any calendar year; four hours of home health aide service shall be considered as one home care visit. No such policy need provide such coverage in any contract providing coverage complementary to medicare.

§ 13. Subsection five of section two hundred twenty-one of such law is hereby amended by adding thereto a new paragraph, to be paragraph f, to read as follows:

f. Every insurer issuing a policy or contract of group accident, group health or group accident and health insurance must make available and if requested by the insured provide reimbursement for home care in a policy which provides coverage for in-patient hospital care. Home care shall mean the continued care and treatment of a covered person who is under the care of a physician but only if (i) continued hospitalization would otherwise have been required if home care was not provided, (ii) only if the plan covering the home health

service is established and approved by a physician within seven days following discharge by the hospital for the same or related condition for which the covered person was hospitalized, and (iii) the home care is commenced within seven days following discharge. Home care shall be provided only by a (i) hospital possessing a valid operating certificate, and certified to provide home health services or (ii) by a non-profit or public home health service or agency possessing a valid certificate of approval issued pursuant to section twenty-eight hundred one-c of the public health law and shall consist of one or more of the following: (i) part-time or intermittent home nursing care by or under the supervision of a professional nurse, (ii) home health aide services, (iii) physical, occupational or speech therapy if provided by the home health service or agency, and (iv) medical supplies, drugs and medications, and laboratory services by or on behalf of a hospital to the extent such items would have been provided under the contract if the covered person had remained in the hospital. For the purpose of determining the benefits for home care available to a covered person, each visit by a member of a home care team shall be considered as one home care visit; the contract may contain a limitation on the number of home care visits but not less than forty such visits in any calendar year; four hours of home health aide service shall be considered as one home care visit.

§ 14. The opening paragraph of subsection one of section two hundred fifty of such law, as separately amended by chapters nine hundred eighty-two and twelve hundred eleven of the laws of nineteen hundred seventy-one, is hereby amended to read as follows:

A membership corporation may be organized under the [membership corporations] *not-for-profit corporation* law, and a consumers' co-operative stock corporation may be organized under article two of the cooperative corporations law, for the purpose of furnishing medical expense indemnity, dental expense indemnity, hospital service, or health service or, upon compliance with the applicable provisions of paragraph (b) of subdivision four of this section, both medical expense indemnity and hospital service to persons who become subscribers under contracts with such corporations. Medical expense indemnity shall consist of reimbursement for medical care provided through duly licensed physicians, dental care provided through duly licensed dentists, optometric care provided through duly licensed optometrists, podiatric care provided through duly licensed podiatrists, chiropractic care provided through duly licensed chiropractors, psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in the contract of insurance, provided through physicians, psychiatrists or duly certified and registered psychologists, physical therapy care provided through duly licensed physical therapists upon the prescription of a physician, for nursing service and of furnishing necessary appliances, drugs, medicines and supplies and, in addition, may consist of reimbursement for bio-analytical or clinical laboratory examinations and reports thereof reported to a physician, osteopath, dentist, optometrist, podiatrist, chiropractor or physical therapist made by any privately operated bio-analytical or

clinical laboratory. It is not mandatory that a subscriber contract shall provide for and offer services as defined in section seventy-one hundred one of the education law, but if it does so provide, the subscribers shall have freedom of choice to select either a physician or an optometrist to render such services. It is not mandatory that a subscriber contract shall provide for and offer reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, but if it does so provide, the subscribers shall have the option to select either a physician, psychiatrist or a certified and registered psychologist with respect to psychiatric or psychological services or diagnosis and treatment when the services to be rendered are within the lawful scope of their practice. Unless such subscriber contract shall otherwise provide there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, and/or appurtenances thereto. Every such plan shall be open to the participation of duly licensed physicians, duly licensed podiatrists, duly licensed chiropractors, duly licensed optometrists, duly licensed physical therapists and duly licensed dentists, certified and registered psychologists without discrimination against schools of medical practice, podiatry practice, chiropractic practice, optometric practice, physical therapy practice, dental practice and psychological training as defined in the education law. Dental expense indemnity shall consist of reimbursement for dental care provided through duly licensed dentists and of furnishing necessary appliances, drugs, medicines, and supplies, prosthetic appliances, orthodontic appliances, precious metal and ceramic restorations. Hospital service shall consist of in-patient hospital care and out-patient hospital care (including, but not limited to, pre-admission procedures) when such hospital care is provided through a hospital which is maintained by the state or any of its political subdivisions, or maintained by a corporation organized for hospital purposes under the law* of this state, or such other hospitals as shall be designated by the state department of health, and hospitals of other states subject to the supervision of such other state, convalescent care provided by any convalescent institution, or nursing care provided by any nursing home. A hospital service corporation may also provide reimbursement for expenses incurred outside of the hospital, convalescent institution or nursing home, for nursing service, necessary appliances, drugs, medicines, supplies, and any other services which would have been available in the hospital, convalescent institution or nursing home (excluding physicians' services), whether or not provided through a hospital, convalescent institution or nursing home. A hospital service corporation may also furnish reimbursement for ambulance service expenses. *A hospital service corporation and a health service corporation must make available and, if requested by a subscriber holding a direct payment contract or by all subscribers in a group remittance group or by the contract holder in the case of group contracts issued pursuant to subsection six of this section, provide coverage for home care in all contracts which provide coverage for in-patient hospital care, except that no such corporation*

* So in original.

need provide such coverage in any contract providing coverage complementary to medicare. Home care shall mean the continued care and treatment of a covered person who is under the care of a physician but only if (i) continued hospitalization would otherwise have been required if home care was not provided, (ii) only if the plan covering the home health service is established and approved by a physician within seven days following discharge by the hospital for the same or related condition for which the covered person was hospitalized, and (iii) the home care is commenced within seven days following discharge. Home care shall be provided only by a (i) hospital possessing a valid operating certificate, and certified to provide home health services or (ii) by a non-profit or public home health service or agency possessing a valid certificate of approval issued pursuant to section twenty-eight hundred one-c of the public health law and shall consist of one or more of the following: (i) part-time or intermittent home nursing care by or under the supervision of a professional nurse, (ii) home health aide services, (iii) physical, occupational or speech therapy if provided by the home health service or agency, and (iv) medical supplies, drugs and medications, and laboratory services by or on behalf of a hospital to the extent such items would have been provided under the contract if the covered person had remained in the hospital. For the purpose of determining the benefits for home care available to a covered person, each visit by a member of a home care team shall be considered as one home care visit; the contract may contain a limitation on the number of home care visits but not less than forty such visits in any calendar year; four hours of home health aide service shall be considered as one home care visit.

The term health service, as used in this article, includes the types of services referred to in this paragraph which are hereafter authorized by appropriate amendment to its certificate of incorporation to provide the types of services described in this paragraph provided by a corporation heretofore and hereafter organized and governed by the provisions of article nine-c of this chapter. Such health service corporation engaged in providing medical care through medical groups to persons insured under contracts and policies issued by a corporation created pursuant to this article, to provide for hospital services as herein defined and the provision of dental care as defined herein, may include as a component of its rate a sum of five per centum of such rate to be used for the purchase or construction of facilities for the conduct of its business, and for the implementation of its program, or for making loans for the purposes of implementing the program of such health service corporation.

§ 15. This act shall take effect April first, nineteen hundred seventy-three and shall apply to policies written, renewed, modified or altered on or after such date.

STATE OF NEW YORK }
Department of State } ss:

I have compared the preceding with the original law on file in this office, and do hereby certify that the same is a correct transcript therefrom and of the whole of said original law.

JOHN P. LOMENZO
Secretary of State

STATE OF NEW YORK



Cal. No. 94

S. 907—A

1973-1974 Regular Sessions

IN SENATE

January 18, 1973

Introduced by Sen. LOMBARDI—(at request of the State Department of Insurance)—read twice and ordered printed, and when printed to be committed to the Committee on Insurance—reported favorably from said committee with amendments and ordered reprinted as amended and when reprinted to be committed to Committee of the Whole

AN ACT

To amend the insurance law, in relation to coverage of home care, and to repeal paragraph f of subsection five of section two hundred twenty-one of the insurance law in relation to coverage of home care

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

- 1 Section 1. Subdivision seven of section one hundred sixty-two
- 2 of the insurance law, as added by chapter nine hundred eighteen
- 3 of the laws of nineteen hundred seventy-two, is hereby amended
- 4 to read as follows:
- 5 7. Every insurer issuing a group policy *for delivery in this*
- 6 *state* which provides coverage for [inpatient] *in-patient* hospital

EXPLANATION — Matter in *italics* is new; matter in brackets [] is old law to be omitted.

1 care must make available and if requested by the contract holder
2 provide [reimbursement] coverage for home care to residents in
3 this state. Such home care coverage may be included at the incep-
4 tion of all new policies and added to all such policies and to policies
5 issued before April first, nineteen hundred seventy-three, at the
6 first annual anniversary date thereafter, without evidence of insur-
7 ability and at any subsequent annual anniversary date, subject
8 to evidence of insurability. Such coverage may be subject to an
9 annual deductible of not more than fifty dollars for each person
10 covered under the policy and may be subject to a coinsurance
11 provision which provides for coverage of not less than seventy-
12 five per cent of the reasonable charges for such services. No such
13 policy need provide such home care coverage [in any contract
14 providing coverage complementary] to persons eligible for medi-
15 care. Home care shall mean the continued care and treatment of
16 a covered person who is under the care of a physician but only if
17 (i) continued hospitalization would otherwise have been required
18 if home care was not provided, (ii) [only if] the plan covering
19 the home health service is established and approved in writing by
20 [a] such physician within seven days following discharge by the
21 hospital for the same or related condition for which the covered
22 person was hospitalized, and (iii) the home care is commenced
23 within seven days following discharge. Home care shall be pro-
24 vided [only] (i) by a [(i)] hospital possessing a valid operating
25 certificate, and certified to provide home health services or (ii) by
26 a non-profit or public home health service or agency possessing
27 a valid certificate of approval issued pursuant to section twenty-

1 eight hundred one-c of the public health law and shall consist
2 of one or more of the following: (i) part-time or intermittent
3 home nursing care by or under the supervision of a *registered*
4 professional nurse (*R.N.*), (ii) *part-time or intermittent* home
5 health aide services *which consist primarily of caring for the*
6 *patient*, (iii) physical, occupational or speech therapy if provided
7 by the home health service or agency, and (iv) medical supplies,
8 drugs and medications *prescribed by a physician*, and laboratory
9 services by or on behalf of a hospital to the extent such items
10 would have been [provided] *covered* under the contract if the
11 covered person had remained in the hospital. For the purpose
12 of determining the benefits for home care available to a covered
13 person, each visit by a member of a home care team shall be
14 considered as one home care visit; the contract may contain a
15 limitation on the number of home care visits, but not less than
16 forty such visits in any calendar year *or in any continuous period*
17 *of twelve months, for each person covered under the contract*;
18 four hours of home health aide service shall be considered as one
19 home care visit.

20 § 2. Subdivision seven-f of section one hundred sixty-four of
21 such law, as added by chapter nine hundred eighteen of the laws
22 of nineteen hundred seventy-two, is hereby amended to read as
23 follows:

24 7-f. Every insurer issuing a policy of accident and sickness
25 insurance *for delivery in this state which provides coverage for*
26 *in-patient hospital care* must make available and, if requested by
27 the insured, provide [reimbursement] *coverage* for home care [in

1 a policy which provides coverage for inpatient hospital care]
2 to residents in this state. Such home care coverage may be
3 included at the inception of all new policies and added to all
4 such policies and to policies issued before April first, nineteen
5 hundred seventy-three, at the first annual anniversary date there-
6 after, without evidence of insurability and at any subsequent
7 annual anniversary date, subject to evidence of insurability. Such
8 coverage may be subject to an annual deductible of not more than
9 fifty dollars for each person covered under the policy and may be
10 subject to a coinsurance provision which provides for coverage
11 of not less than seventy-five per cent of the reasonable charges for
12 such services. Home care shall mean the continued care and
13 treatment of a covered person who is under the care of a physician
14 but only if (i) continued hospitalization would otherwise have been
15 required if home care was not provided, (ii) [only if] the plan
16 covering the home health service is established and approved
17 in writing by [a] such physician within seven days following dis-
18 charge by the hospital for the same or related condition for which
19 the covered person was hospitalized, and (iii) the home care is
20 commenced within seven days following discharge. Home care
21 shall be provided [only] (i) by a [(i)] hospital possessing a
22 valid operating certificate, and certified to provide home health
23 services or (ii) by a non-profit or public home health service or
24 agency possessing a valid certificate of approval issued pursuant
25 to section twenty-eight hundred one-c of the public health law
26 and shall consist of one or more of the following: (i) part-time or
27 intermittent home nursing care by or under the supervision of a

1 *registered professional nurse (R.N.), (ii) part-time or intermittent*
2 *home health aide services which consist primarily of caring for the*
3 *patient, (iii) physical, occupational or speech therapy if provided*
4 *by the home health service or agency, and (iv) medical supplies,*
5 *drugs and medications prescribed by a physician, and laboratory*
6 *services by or on behalf of a hospital to the extent such items*
7 *would have been [provided] covered under the contract if the*
8 *covered person had remained in the hospital. For the purpose of*
9 *determining the benefits for home care available to a covered*
10 *person, each visit by a member of a home care team shall be con-*
11 *sidered as one home care visit; the contract may contain a limita-*
12 *tion on the number of home care visits, but not less than forty*
13 *such visits in any calendar year or in any continuous period of*
14 *twelve months for each person covered under the contract; four*
15 *hours of home health aide service shall be considered as one home*
16 *care visit. No such policy need provide such coverage [in any*
17 *contract providing coverage complementary] to persons eligible*
18 *for medicare.*

19 § 3. Paragraph f of subsection five of section two hundred
20 twenty-one of such law is hereby repealed.

21 § 4. The opening paragraph of subsection one of section two
22 hundred fifty of such law, as last amended by chapter nine hundred
23 eighteen of the laws of nineteen hundred seventy-two, is hereby
24 amended to read as follows:

25 A membership corporation may be organized under the not-for-
26 profit corporation law, and a consumers' co-operative stock corpora-
27 tion may be organized under article two of the cooperative corpora-

1 tions law, for the purpose of furnishing medical expense indemnity,
2 dental expense indemnity, hospital service, or health service or,
3 upon compliance with the applicable provisions of paragraph (b)
4 of subdivision four of this section, both medical expense indemnity
5 and hospital service to persons who become subscribers under con-
6 tracts with such corporations. Medical expense indemnity shall
7 consist of reimbursement for medical care provided through duly
8 licensed physicians, dental care provided through duly licensed
9 dentists, optometric care provided through duly licensed optome-
10 trists, podiatric care provided through duly licensed podiatrists,
11 chiropractic care provided through duly licensed chiropractors,
12 psychiatric or psychological services or for the diagnosis and
13 treatment of mental, nervous or emotional disorders and ailments,
14 however defined in the contract of insurance, provided through
15 physicians, psychiatrists or duly certified and registered psycholo-
16 gists, physical therapy care provided through duly licensed physi-
17 cal therapists upon the prescription of a physician, for nursing
18 service and of furnishing necessary appliances, drugs, medicines
19 and supplies and, in addition, may consist of reimbursement for
20 bio-analytical or clinical laboratory examinations and reports
21 thereof reported to a physician, osteopath, dentist, optometrist,
22 podiatrist, chiropractor or physical therapist made by any privately
23 operated bio-analytical or clinical laboratory. It is not mandatory
24 that a subscriber contract shall provide for and offer services
25 as defined in section seventy-one hundred one of the education
26 law, but if it does so provide, the subscribers shall have freedom
27 of choice to select either a physician or an optometrist to render

1 such services. It is not mandatory that a subscriber contract shall
2 provide for and offer reimbursement for psychiatric or psychologi-
3 cal services or for the diagnosis and treatment of mental, nervous
4 or emotional disorders and ailments, but if it does so provide, the
5 subscribers shall have the option to select either a physician,
6 psychiatrist or a certified and registered psychologist with respect
7 to psychiatric or psychological services or diagnosis and treat-
8 ment when the services to be rendered are within the lawful scope
9 of their practice. Unless such subscriber contract shall otherwise
10 provide there shall be no reimbursement for ophthalmic materials,
11 lenses, spectacles, eyeglasses, and/or appurtenances thereto. Every
12 such plan shall be open to the participation of duly licensed physi-
13 cians, duly licensed podiatrists, duly licensed chiropractors, duly
14 licensed optometrists, duly licensed physical therapists and duly
15 licensed dentists, certified and registered psychologists without dis-
16 crimination against schools of medical practice, podiatry practice,
17 chiropractic practice, optometric practice, physical therapy prac-
18 tice, dental practice and psychological training as defined in the
19 education law. Dental expense indemnity shall consist of reim-
20 bursement for dental care provided through duly licensed dentists
21 and of furnishing necessary appliances, drugs, medicines, and sup-
22 plies, prosthetic appliances, orthodontic appliances, precious metal
23 and ceramic restorations. Hospital service shall consist of in-patient
24 hospital care and out-patient hospital care (including, but not
25 limited to, pre-admission procedures) when such hospital care is
26 provided through a hospital which is maintained by the state or

1 any of its political subdivisions, or maintained by a corporation
2 organized for hospital purposes under the [law] laws of this state,
3 or such other hospitals as shall be designated by the state depart-
4 ment of health, and hospitals of other states subject to the super-
5 vision of such other state, convalescent care provided by any
6 convalescent institution, or nursing care provided by any nursing
7 home. A hospital service corporation may also provide reim-
8 bursement for expenses incurred outside of the hospital, conva-
9 lescent institution or nursing home, for nursing service, necessary
10 appliances, drugs, medicines, supplies, and any other services
11 which would have been available in the hospital, convalescent insti-
12 tution or nursing home (excluding physicians' services), whether
13 or not provided through a hospital, convalescent institution or
14 nursing home. A hospital service corporation may also furnish
15 reimbursement for ambulance service expenses. A hospital service
16 corporation and a health service corporation must make avail-
17 able and, if requested by a subscriber holding a direct payment
18 contract or by all subscribers in a group remittance group or
19 by the contract holder in the case of group contracts issued pur-
20 suant to subsection six of [this] section *two hundred fifty-three*,
21 provide coverage for home care *to residents in this state* in all con-
22 tracts which provide coverage for [inpatient] *in-patient* hospital
23 care[, except that no]. *Such home care coverage may be included*
24 *at the inception of all new contracts and added to all such contracts*
25 *and to contracts issued before April first nineteen hundred seventy-*
26 *three, at the first annual anniversary date thereafter, without evi-*

1 *dence of insurability and at any subsequent annual anniversary*
2 *date, subject to evidence of insurability. Such coverage may be sub-*
3 *ject to an annual deductible of not more than fifty dollars for*
4 *each covered person and may be subject to a coinsurance provi-*
5 *sion which provides for coverage of not less than seventy-five per*
6 *cent of the reasonable cost of services for which payment may*
7 *be made. No such corporation need provide such coverage [in*
8 *any contract providing coverage complementary] to persons eligi-*
9 *ble for medicare. Home care shall mean the continued care and*
10 *treatment of a covered person who is under the care of a physician*
11 *but only if (i) continued hospitalization would otherwise have*
12 *been required if home care was not provided, (ii) [only if] the plan*
13 *covering the home health service is established and approved in*
14 *writing by [a] such physician within seven days following discharge*
15 *by the hospital for the same or related condition for which the cov-*
16 *ered person was hospitalized, and (iii) the home care is com-*
17 *menced within seven days following discharge. Home care shall*
18 *be provided [only] by (i) a [(i)] hospital possessing a valid*
19 *operating certificate, and certified to provide home health services*
20 *or (ii) by a non-profit or public home health service or agency*
21 *possessing a valid certificate of approval issued pursuant to sec-*
22 *tion twenty-eight hundred one-c of the public health law and shall*
23 *consist of one or more of the following: (i) part-time or intermit-*
24 *tent home nursing care by or under the supervision of a registered*
25 *professional nurse (R.N.), (ii) part-time or intermittent home*
26 *health aide services which consist primarily of caring for the*

1 *patient*, (iii) physical, occupational or speech therapy if provided
2 by the home health service or agency, and (iv) medical supplies,
3 drugs and medications *prescribed by a physician*, and laboratory
4 services by or on behalf of a hospital to the extent such items
5 would have been *covered or provided* under the contract if the
6 covered person had remained in the hospital. For the purpose of
7 determining the benefits for home care available to a covered
8 person, each visit by a member of a home care team shall be con-
9 sidered as one home care visit; the contract may contain a limita-
10 tion on the number of home care visits, but not less than forty
11 such visits in any calendar year *or in any continuous period of*
12 *twelve months, for each covered person*; four hours of home
13 health aide service shall be considered as one home care visit.

14 The term health service, as used in this article, includes the types
15 of services referred to in this paragraph which are hereafter author-
16 ized by appropriate amendment to its certificate of incorporation
17 to provide the types of services described in this paragraph pro-
18 vided by a corporation heretofore and hereafter organized and
19 governed by the provisions of article nine-c of this chapter. Such
20 health service corporation engaged in providing medical care
21 through medical groups to persons insured under contracts and
22 policies issued by a corporation created pursuant to this article,
23 to provide for hospital services as herein defined and the provi-
24 sion of dental care as defined herein, may include as a component
25 of its rate a sum of five per centum of such rate to be used for the
26 purchase or construction of facilities for the conduct of its busi-

- 1 ness, and for the implementation of its program, or for making
 2 loans for the purposes of implementing the program of such health
 3 service corporation.
 4 § 5. This act shall take effect April first, nineteen hundred
 5 seventy-three and shall apply to policies written, renewed, modi-
 6 fied or altered on or after such date.

NOTE.—Section 221(5)(f) of the Insurance Law, which is repealed by Section 3 of this bill, added provisions with respect to home care coverage in group accident and health insurance policies which were duplicated in Section 162(7) of the Insurance Law. Further amendments to Section 162(7) in Bill Section 1 fully prescribe home care requirements for group coverages and render the repealed provisions redundant.

NEW YORK STATE LEGISLATURE

Assembly 4983

Senate 5969

By Mrs. C. Cook

AN ACT to amend the social services law, in relation to providing homemaking and housekeeping services as an item of medical assistance.

Section 1. Paragraph (d) of subdivision two of section three hundred sixty-five-a hundred sixty-nine, is hereby amended to read as follows:

(d) home health care services, including home nursing services and services of home aids; and homemaker or housekeeping services in the recipient's home, if rendered by an individual other than a member of the family who is qualified to provide such services, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse;

Section 2. This act shall take effect immediately.

Referred to Social Services Committee.

NOTE: This bill is introduced at the request of the New York State Department of Social Services.

PASSED AND SIGNED BY GOVERNOR

Now Chapter 595 of the Laws of 1973

ITEM 5. COALITION FOR HOME HEALTH SERVICES IN NEW YORK STATE, TASK FORCE ON SCOPE OF HOME CARE SERVICES*

PROPOSED CATEGORIES OF HOME HEALTH SERVICES

Core health services.—Health services required by a majority of patients in the program: Homemaker-home health aide services (including light housekeeping), medical services, medical supplies and equipment, nursing services, nutrition services, patient transportation services, pharmaceutical services, social services, technical diagnostic services, physical therapy, environmental evaluation and correction.

Specialized health services.—Health services just as important as those listed above, but needed by fewer persons in the program: Audiological services, dental services, mental health services, peripatology services, podiatry services, prosthetic/orthotic services, occupational therapy, respiratory therapy, speech therapy.

General services.—Services used by the whole community for which home health agencies may need to extend special effort, or make special arrangements on behalf of patients: Barber/cosmetology services, handyman services, heavy cleaning services, legal and protective services, pastoral services, personal contact services, recreation services, translation services.

Note: It should be borne in mind that the needs of the patient will determine which services are most important for *him* and make it possible for him to be cared for at home.

ITEM 6. IMPROVING HOME HEALTH CARE SERVICES; EDITORIAL FROM THE AMERICAN MEDICAL NEWS, JANUARY 8, 1973**

The need for home health care services in the United States becomes increasingly important in view of the changing age composition of the population and the proportionate increase in long-term illness and disability.

The growing prevalence of chronic diseases such as hypertensive and arteriosclerotic heart disease, cerebrovascular disease, arthritis, neurological disorders, malignancies, and pulmonary disorders has resulted in an increased demand for long-term care. Often these diseases require long periods of convalescence, rehabilitation, and supportive care. In many cases, some portion of this care can and should be provided in the home, rather than in more expensive hospital or nursing home settings.

The benefits are numerous: many patients prefer care in the home; many home-bound people can be taught to live relatively independently; hospital admissions can be reduced and hospital stays shortened; through use of a team approach, the physician's efficiency can be increased; home care staff members can help identify day-to-day problems and reduce the possibility of emergency situations.

No home care program is successful unless the quality of its care is high and is effectively utilized. Physicians, individually and, through their medical societies, collectively, have important responsibilities in assuring that this standard is met. During last November's Clinical Convention, the Council on Medical Service offered a series of suggestions for the physician in meeting these responsibilities. Among them:

- Each MD should be aware of available home care services and how they can be developed or improved.
- He should help develop local innovations to provide more efficient, more economical, and more appropriate home care.
- He should become familiar with various methods of financing home care services, including federal, state, and private insurance programs.
- He should, when referring patients for home care, establish a plan of therapy for each patient and periodically review it and the patient's progress with the personnel providing the care.
- He should make certain that he receives regular reports, observations, and progress notes from the personnel or program providing the services.

The medical society's role also is important, and particular stress should be given to stimulating physician interest in and acceptance of home care. The society also must take the lead in improving the coordination of existing home care services and stimulating the development of new ones where they are needed. In addition to the medical society and, in many cases, its woman's auxiliary,

*Submitted by Mrs. James H. Starr.

**Submitted by Dr. Henry Smith.

many other local organizations must be involved, including health departments and their nursing bureaus; visiting nurse associations or community nursing services; hospital, nursing, and nursing home associations; health financing organizations; chambers of commerce, and other business and government leaders.

The medical society must also help to ensure that the local community health planning agency has broad representation from all organizations concerned with providing care, and it must stimulate physician involvement in these planning activities. Further, medical directors of hospitals and other health facilities should be encouraged to develop continuing education programs on utilizing home care services, and the public must be educated on the value of the home care programs.

In all discussions of home care, it must be kept in mind that effective programs can offer high-quality care and be an extension of the physician's services at little cost and effort to the physician and at a considerable saving to the patient. But home care programs cannot flourish without the support and guidance of the medical community. Physicians owe it to themselves and to their patients to meet that responsibility.

**ITEM 7. BUREAU OF HEALTH INSURANCE INTERMEDIARY LETTER
NO. 395, SOCIAL SECURITY ADMINISTRATION, BALTIMORE, MD.,
AUGUST 1969***

Subject: Skilled nursing care provided as a home health benefit.

August 1969.

INTRODUCTION

The home health benefits provided under parts A and B were intended only for those beneficiaries whose conditions do not require the "around-the-clock" medical and related care provided in hospitals and extended care facilities, but, nevertheless, are of such severity that the individuals are under the care of a physician and confined to their homes. Accordingly, payment may not be made for home health services unless the services were required because the individual needed skilled nursing care on an intermittent basis, or physical or speech therapy. The purpose of this letter is to clarify several areas of confusion which have arisen in the application of this statutory requirement.

(A) *Skilled nursing requirement.*—In defining covered home health services, the law also lists occupational therapy, medical social services, the part time or intermittent services of home health aides, the use of medical supplies and appliances, and the medical services of residents and interns. Since the patient must be certified as needing skilled nursing care on an intermittent basis or physical or speech therapy in order to qualify for home health benefits, payment may be made for these other home health services only so long as the provision of skilled nursing care or physical or speech therapy is an essential element of the patient's plan of treatment.

The plan of treatment, which must be established and periodically reviewed by a physician, should indicate the types of skilled services required to treat the patient's illness or injury. If the plan of treatment does not indicate a need for skilled nursing care or physical or speech therapy but prescribes only the provision of supportive services, such as personal care services which are rendered by a home health aide, the patient cannot be considered as meeting the certification requirements and is, therefore, ineligible for home health benefits. Consequently, when an intermediary receives an SSA-1487 which shows charges for only, say, home health aide visits or for only medical supplies and appliances, the intermediary should investigate the claim to ascertain whether the physician has certified to the need for skilled nursing services or physical or speech therapy services and made provision for such services in the patient's plan of treatment, whether the patient is receiving such services, and whether the provision of skilled nursing services represents a needed element in the treatment of the patient's illness or injury.

(B) *Definition of skilled nursing care.*—Additional questions have been raised as to what services would constitute "skilled nursing care" for the purpose of applying the above requirements. In defining this term, attention must be focused

*Submitted by Dr. Henry Smith.

on the level of skill needed to render the nursing services required by the patient. In this connection the definition of a skilled service found in section 3118.1 should be applied. Specifically, in the home setting skilled nursing care is a nursing service which must be furnished by or under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. Of course, a service is not considered to be a skilled nursing service merely because it is performed by or under the supervision of a licensed nurse. When the nature of the service is such that it can be safely and adequately self-administered or performed by the average, nonmedical person, without the direct supervision of a licensed nurse, it is a nonskilled service without regard to who actually provides the service. The classification of a particular service as skilled is based on the technical or professional health training required to assure the effective performance of the service. Neither the importance of a particular service to an individual patient nor the possibility of adverse effects from improper performance of an otherwise unskilled service will change the nature of a service from unskilled to skilled.

In the home setting, skilled nursing services generally include two components which require specialized health care knowledge and are thereby distinguished from supportive care not requiring such knowledge: (1) The rendition of direct skilled nursing services, and (2) Observation and evaluation of the total skilled nursing needs of the patient. Direct skilled nursing services include such skilled services as the administration of prescribed medications which cannot be self-administered, the changing of indwelling catheters, the application of dressings involving prescription medications and aseptic technique, etc.

Skilled nursing observation and evaluation may be required in those cases where symptoms are quite likely to occur which will indicate the need to revise the patient's treatment regimen. In the home health setting, the most frequent examples of skilled observation are in cases in which the patient is receiving direct skilled nursing services and the nurse must visit the patient between the rendition of direct nursing services to evaluate his reaction to the treatment and the possible need to modify the treatment plan. The incidence of situations in a home health setting in which skilled observation is the only nursing service needed is not expected to be frequent since in most cases such patients will need to be more closely observed than is possible under the usual pattern of home care visits. Consequently, where a patient is receiving no direct skilled nursing services, the intermediary should assure that the patient's medical condition is such as to require skilled observation due to the present danger of a sudden adverse change. The immediate post-operative period prior to total stabilization of a condition is one possible example of a case in which a patient may require only the skilled observation of a nurse.

To conserve her time, a nurse may make a skilled evaluation of the nursing needs of the patient at the same time that she makes a visit to supervise the home health aide providing personal care services to the patient. In such cases, the visit may be reimbursed as a skilled nursing visit. (This is not to be confused with a visit for the sole purpose of evaluating a patient's personal care needs and supervising the home health aide. Such a visit is not reimbursed as a skilled nursing visit. See section C below.) Also, while assessing a patient's nursing care needs, the nurse may at times perform services considered as unskilled, such as bathing the patient and/or routine skin care. In such cases where the primary purpose was to render a skilled evaluation, the visit is reimbursable as a skilled nursing visit.

(C) *Role of personal care services.*—In addition to skilled nursing care or physical or speech therapy, a physician may indicate in his plan of treatment that the patient will need personal care services such as help with bathing, ambulation, use of the bathroom, taking ordinarily self-administered medications, and other duties appropriately performed by a home health aide. Since a home health beneficiary must be under the care of a physician for the treatment of an illness or injury which requires skilled nursing care or physical or speech therapy, the home health regulations require that a registered professional nurse assign the duties of the aide and see to it that the duties are carried out. Such duties cannot, of course, be construed as skilled services since they are of the type which can be performed by the average, nonmedical person without the direct supervision of licensed nurses or allied health professionals.

The fact that the conditions of participation require a nurse to visit the patient's home at least every 2 weeks in order to provide *general supervision* to the

aide and to evaluate the patient's continuing *personal care* needs does not affect the unskilled nature of the service rendered by the home health aide. Neither would such activities of the supervising nurse represent skilled nursing care of the patient. Consequently, such supervisory visits may not be billed as skilled nursing visits but are considered an administrative cost of the agency. For example, a stroke patient whose condition is stabilized and has no more potential for rehabilitation may require help in getting in and out of bed, getting meals, and meeting other activities of daily living. A nurse would visit this patient to evaluate his personal care needs and, subsequently, to assure that the home health aide is performing necessary duties and that the patient's social and personal care needs continue to be met. While the role of the home health agency in the community may make the furnishing of such services by home health agency personnel entirely appropriate, the patient cannot be considered as meeting the physician certification requirement for payment of home health benefits by the Medicare program. On the other hand, the stroke patient whose condition is not stabilized and, therefore, continues to require medications which cannot be self-administered, restorative nursing care, skilled observation to detect the occurrence of further deterioration, and, perhaps, physical therapy may also require personal care services and help in meeting the activities of daily living. Such a patient would, of course, meet the physician certification requirement and be able to receive all necessary covered home health benefits.

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

ITEM 8. TABITHA HOME HEALTH CARE (HEALTH ON WHEELS), LINCOLN, NEBR.

Diagnosis	Age	Length of stay (days)	Number of visits	Disciplines	Cost of services					Savings
					Home health services	Charity	Hospital	Nursing home	Teaching and maintaining independent living	
Arthritis.....	78	117	15	VN and HHA.....	119.00	49.00		1,638.00		1,519.00
Other chronic.....	81	118	41	VN and HHA.....	323.00			1,652.00		1,329.00
M.S.....	56	119	103	VN, RPT and HHA.....	1,227.00					370.50
Scleroderma.....	37	39	14	VN.....	175.50			546.00		5,986.00
Other chronic.....	70	117	19	VN.....	189.00		6,175.00			1,440.00
Ortho.....	76	119	25	VN and HHA.....	226.00	66.40		1,666.00		13.50
Osteoporosis.....	85	75	3	VN.....	16.50			30.00	Doctor's office call.....	8,449.50
C.V.A.....	76	92	26	VN and RPT.....	290.50		8,740.00			413.00
Other chronic.....	84	32	5	VN and HHA.....	35.00			448.00		1,545.00
Ortho.....	82	119	16	VN and HHA.....	121.00	93.00		1,666.00		100.00
Ortho.....	69	20	17	VN, RPT and HHA.....	180.00			280.00		1,305.00
M.S.....	70	106	16	VN and RPT.....	179.00			1,484.00		1,507.50
Other chronic.....	87	118	19	VN and HHA.....	144.50	59.50		1,652.00		1,396.50
Ortho.....	83	119	33	VN and HHA.....	269.50	114.50		1,666.00		4.50
Other chronic.....	73	1	1	VN.....	5.50			10.00	Doctors office call.....	
Ortho.....	85	111	18	VN and HHA.....	127.50	52.50				3.00
Other chronic.....	63	47	2	VN.....	27.00			15.00	Doctors office call.....	658.00
C.V.A.....	75	59	13	VN and RPT.....	168.00			826.00		31.50
Mental health.....	34	92	7	VN.....	38.50			70.00	Doctors office call.....	286.50
Ortho.....	67	27	11	VN RPT and HHA.....	91.50			378.00		1,128.50
CVA.....	85	119	53	VN and ST.....	537.50			1,666.00		235.00
Ortho.....	83	29	13	VN and RPT.....	171.00			406.00		1,479.00
Other chronic.....	89	110	10	VN and HHA.....	68.00	7.00		1,540.00		639.00
Ortho.....	74	71	30	VN and RPT.....	355.00			994.00		996.00
Paraplegia.....	20	120	36	VN.....	684.00			1,680.00		1,529.00
Other chronic.....	84	116	21	VN and HHA.....	165.50	70.50		1,624.00		
Total.....	171	2,212	567		5,934.50	512.40	14,915.00	21,937.00		82,364.50

¹ Average age.

ITEM 9. HEALTH ON WHEELS, LINCOLN, NEBR., REPORT OF SERVICES PROVIDED, MARCH-AUGUST 1972

Home health services provided to—	Number of cases	Number of visits	Hours of direct service	Cost of home health services	Cost of alternative service	Savings
Enable early hospital discharge.....	64	632	453:15	\$5,874.00	\$117,325	\$111,451.00
Enable early nursing home discharge.....	3	8	4:45	58.50	252	193.50
Prevent hospitalization.....	22	57	38:40	527.50	13,585	13,057.50
Prevent nursing home admission.....	32	883	682:43	9,242.00	45,010	35,768.00
Supplement physician's home visit.....	22	143	66:40	1,135.00	1,716	580.50
Improve living condition through teaching....	6	91	45:50			
Assist patient in maintaining independent living.....	39	901	902:55			
Total.....	173	2,715	2,194:48	16,837.00	177,888	161,050.50

Note: Basis for comparative costs: Average cost per hospital-day in Lincoln equals \$95 (per Blue Cross-Blue Shield). Average cost per nursing-home-day in Lincoln equals \$14 (per Nebraska Nursing Home Association and the Nebraska Nursing Home Advisory Council). Average cost per physician visit equals \$12 (per 3 family doctors). Last 2 categories, intangible or unmeasurable services, see addendum No. 1. A total of 173 people were represented in this survey, 15 of whom fell into more than 1 category.

[Enclosure.]

WHY HOME HEALTH SERVICES?

Much attention is being given today to the need for "alternatives to institutionalization." Certainly well organized home health services, related to other components of an overall health delivery system, should rank high as a satisfactory alternative.

Who, as a patient in need of less acute but essential skilled services, would not prefer to remain in his own home, if assured that such services were available, more appropriate and less expensive?

Who, as a public official, appalled by the mounting costs of institutional care, would not welcome services that enable the patient to remain at home when it is appropriate for him to do so?

In terms of personal preference (84 percent of patients interviewed in a recent nationwide survey expressed preference for being at home) and in terms of public policy, then, the arguments for the use of established agencies and for the development of new agencies in our state seem irresistible.

I was requested to "prove irrevocably" that home health services can and do indeed "save money." I have developed the accompanying survey based on 6 months of home health services provided by agency staff. The results seem almost unbelievable but are comparable to surveys done in other parts of the country. Based on a 1971 cost analysis the average cost per visit in our agency is \$12.20. The average cost per visit nationwide is \$15.58. Also significant is the fact that a considerable amount of charity allowance is available to Tabitha Home Health Care because we are the recipient of two Federal grants. During this 6-month period \$3,653 in charity allowance was extended to our clientele. We use a sliding fee scale based on percentage of income. See addendum No. 2.

There has been much criticism by physicians, other medical personnel, and patients of the excessive charges for in-home services. Physicians say that they charge less for their home visits than do nurses and therapists. It seems significant, however, that skilled services by agency personnel include assessment of patient needs, family involvement in care, teaching, personal care, therapy, emotional and psychological support, evaluation, supervision, and skilled observation and treatment. When one looks at this wide range of services, as compared to a physician's visit, perhaps the charges are not excessive.

Institutions imply that the cost of home health services is exorbitant when compared to 24-hour service. Patients who need 24-hour care do not fit the criteria for home health services. The reasons for discharge to his home are: (1) His need for independence, (2) the satisfaction he gains from being in familiar surroundings which often leads to faster restoration, and (3) the savings which result from supportive, intermittent services instead of 24-hour care.

The cost of home health services, the hours of direct services, the number of visits, and the number of cases are firm figures. The cost of alternative service is

a judgmental component arrived at by the director of the agency through consultation with the three visiting nurses, who are at the bedside and who best know the patient and his needs. If anything, these decisions are conservative. The case load was considered patient by patient and the worksheets are available for your inspection.

ADDENDUM NO. 1

In the last two categories listed in the table, it is impossible to apply a dollar value when indeed we are not avoiding institutionalization but rather helping the patient to more happiness and independence by improving his living conditions.

ADDENDUM NO. 2

[Percent of total costs]

Gross yearly income	Number in family			
	1	2	3	4
(1) 0 to \$999	10	10	10	10
(2) \$1,000 to \$1,999	20	10	10	10
(3) \$2,000 to \$2,999	30	20	10	10
(4) \$3,000 to \$3,999	40	30	20	10
(5) \$4,000 to \$4,999	50	40	30	20
(6) \$5,000 to \$5,999	60	50	40	30
(7) \$6,000 to \$6,999	70	60	50	40
(8) \$7,000 to \$7,999	80	70	60	50
(9) \$8,000 to \$8,999	90	80	70	60
(10) \$9,000 to \$9,999	100	90	80	70
(11) \$10,000 to \$10,999	100	100	90	80
(12) \$11,000 to \$11,999	100	100	100	90
(13) \$12,000	100	100	100	100

ITEM 10. CASE STUDIES, NEBRASKA HOME HEALTH AGENCIES

Age	Diagnosis	Length of stay (days)	Home/family situation	Progress report	Costs of—			Saving
					Hospital	Nursing homes	Home health Agency	
13	Other chronic (psudomonis—ear infection).	4	Small home, cluttered and messy. Mother cooperative, appreciative. 4 children, no father.	Ear infection; progress in hospital impeded because of homesickness. Patient improved rapidly at home. Sole reason for continued hospitalization was antibiotic injections 3 times daily for 4 days. Patient seemed completely recovered when series of injections completed, no pain, no drainage from ear.	\$380		\$60.50	\$319.50
69	Diabetes	137	Indian family; wife cares for patient. Home in poor repair, but clean. 6 children, many grandchildren—in and out, but little help with care.	Diabetic ulcer; dressing changes and diabetic supervision; September 1972, amputation of toe; continued support at home; purulent drainage; dressings changed daily, then 3 times a week; Mar. 30, 1973, wound healed. Arrangements made with United Indians of Nebraska for purchase of special shoes.		\$1,918	806.74	1,111.26
72	Other chronic (cerebral thrombosis).	160	Lives with husband much younger than she; 6 children by previous marriage; husband has drinking problem; home is in fair/poor repair; daughters help with catheter care; Homemakers and Home Health aides and visiting nurses. Exercises provided, personal care, treated severe decubiti and supervised catheter care given by daughters. Meals on wheels provided, nutritional balance.	November 1972, patient up in chair, walks with walker. Major problem: incontinence and decubiti on heel and corcyx. Though mentally alert her condition deteriorates due to series of small strokes—intermittent hospitalizations. Daughters assisted with care until last hospitalization on February 6, 1973. Patient expired February 1973. Family and case worker were anxious to maintain patient in home as long as possible for psychological reasons. Patient resisted institutionalization.		2,240	408.77	1,831.23
74	Other chronic (colostomy).	12	Small apartment—cluttered, clean. No family, cleaning lady stays days.	Patient noisy, uncooperative, re: colostomy care. Refuses to learn. Colostomy irrigation and bowel program accomplished. Colostomy closed—patient much improved physically and psychologically. Now lives alone and completely independent.	1,140		98.56	1,041.44
80	Other chronic (diabetes).	641	Rundown; small cottage; cluttered, dusty, odorous. Large family but little support. Patient dependent on aides, R.N., physical therapist, meals on wheels, Homemakers. Wheelchair bound due to accident early in life.	Treatment of diabetic lesions on legs, much psychological guidance. Ulcers intermittently healed, but progress impaled by unsanitary conditions. Admitted to nursing home.		8,974.00	1,931.54	2,704.46

474

¹ Less charity allowance in the amount of \$809.04 = \$1,122.50.

² Plus charity allowance in the amount of \$809.04 = \$7,851.50.

ITEM 11. STATEMENT ON THE ROLE AND RESPONSIBILITIES OF HOSPITALS IN HOME CARE, BY THE BOARD OF DIRECTORS OF THE AMERICAN HOSPITAL ASSOCIATION*

The American Hospital Association and its member hospitals recognize home care as an element of continuing care and as an essential component of comprehensive patient care. They accept their responsibility to foster the availability of home care services of high quality. This responsibility must be fulfilled at the community level and requires the active participation of the Association's member hospitals.

The goal of the Association is to assure each patient adequate care at a cost that the patient and community can afford. For certain patients in certain situations home care is the mode of care that best attains this goal.

Hospitals have long accepted the responsibility to try new approaches to care and to seek methods of controlling costs, but their attention has focused primarily on inhospital services. Home care is an added dimension of health service that has its own intrinsic merit. For certain selected patients home care is more appropriate than hospitalization, and it releases an acute hospital bed for a patient who may have greater need for it. Home care should be put into wider use and its further development encouraged.

DEFINITION OF HOME CARE

In its broadest sense, home care is the provision of health care and supportive services to the sick or disabled person in his place of residence. It may be provided in a wide range of patterns of organization and service. At one end of the range is the simplest form, nursing service. At the other end is the coordinated home care program, which fulfills the concept of comprehensive patient care.

The generally accepted goal of a coordinated home care program is to provide selected patients who do not require all the facilities of a hospital but otherwise would have to be in a hospital or other institution with a range of medical, nursing, dietary, social, and rehabilitative services in their own home, the services coordinated through one central administration.

The coordinated program is the ideal. In many communities, it is a practical ultimate objective for programs that begin modestly. In others, particularly in small communities or in large areas with a low population density, the practical objective must remain more limited. The essential requirements for all home care programs, whatever their organization or scope, are high quality of service and proper selection of patients.

SELECTION OF PATIENTS

Successful operation of a home care program demands selection of patients in accordance with their needs and the availability of services. Today it is recognized that home care services are applicable to patients within all categories of illness and disability, including the acutely ill, the convalescent, the long-term ill, and the chronically ill. This recognition has come about as a result of experimental programs that have been extended to include all these kinds of patients. Home care is equally applicable to all ages, infants to the aged, and to all socioeconomic levels. However, because home care services are intermittent, the home situation and family relationships must be capable of supporting the home care program to make it work.

Home care can work for short-term convalescent patients recovering from acute illness, the homebound chronically ill, those who usually receive treatment on an outpatient basis but are temporarily unable to do so, and certain patients with terminal illnesses. For the patient who needs a program of rehabilitation, home care may be superior to inpatient care if the home is suitable and if he does not need continuous nursing attention or use of equipment that cannot practicably be provided outside the hospital.

For the patient with a long-term or chronic illness, medical care becomes a way of life and all too often results in his institutionalization. Although the home is not appropriate for all chronically ill patients in all stages of illness, often it can provide a desirable setting for far more patients than at present. Home care need not be elaborate in order to meet the requirements of thousands of patients now receiving care in hospitals or chronic disease facilities.

*Submitted by Dr. Andrew Jessiman.

THE HOSPITAL'S ROLE

Whether the hospital or another community agency provides the administrative structure, the hospital has a key role to play in stimulating development of home care, in factfinding to determine extent of need, in identifying the desirable and appropriate scope of service, and in helping to secure stable financing.

Another basic function of the hospital is to develop and maintain an effective mechanism for identification of patients potentially suitable for home care and for their prompt referral to the program. Involvement of at least the medical and nursing staff is necessary for successful performance of this function. Suitability for home care should not be related to the patient's financial condition: many patients who can pay for the service either are unaware of the service or are denied access to home care.

The hospital must also back up the home care program by ensuring that the patient will be admitted immediately or readmitted to the hospital if a change in his condition requires hospitalization. The fear on the part of patient, family, and physician that the patient will need hospital care but will not receive it promptly is an important psychological barrier to their acceptance of home care. Technical services and equipment usually available only in hospitals should be made available to the patient, either by bringing him to the hospital or by taking them to the home.

When the hospital is the administrative agency for the home care program, its role includes direct provision of professional and related services to the patient at home. Nursing, social service, physical therapy, occupational therapy, and, in some programs, physician service are among these. As the coordinating organization, the hospital seeks the participation of other community agencies in planning, staffing, and financing.

THE HOSPITAL'S RESPONSIBILITIES

The responsibilities of the hospital vary in relation to its degree of involvement in the administration of the home care program. Whatever the auspices or administrative structure of the program, the hospital must ensure that the program is patient-centered. This requires close cooperation and coordination among the several health care and related services that may be called upon to share in this responsibility.

The hospital has a basic responsibility to the community to ensure that services are of acceptable quality, used efficiently, and available to patients who can pay for the service as well as to those who cannot.

When the hospital administers the program directly, its responsibility for the quality of all services, including those supplied by other agencies, and for their proper use is necessarily greater, because it is directly accountable for all aspects of the program. As the administrative agency, it must recruit competent personnel and provide for their orientation, training, and supervision. It must work with all funding agencies to effect adequate financing; maintain records—administrative, financial, and medical; and establish and maintain effective communication with other community agencies, both those that participate directly and those that have an interest in all services to the community.

As part of its discharge planning function, the hospital should identify patients who are suitable for home care and refer them. A plan for home care after the patient is discharged should be an integral part of the continuing care plan for the patient.

CONCLUSION

No longer can a hospital's service program be defined in terms of inpatient care alone. The hospital must assume its proper responsibility to ensure a continuum of preventive, acute, rehabilitative, and long-term care to the patient, wherever he may be. The extension of hospital service to the patient in his home is both desirable and feasible when his needs can be met there and the home is suitable.

Home care programs are desirable primarily for the benefit of patients. They advance the goal of adequate care at the right time, at the right place, and at the most economical cost. In addition, the hospital itself benefits from participating in a program that extends services beyond its own walls. Its inpatient beds are utilized more efficiently, and in some instances addition of beds can be avoided.

Furthermore, the home care program provides concrete evidence that the hospital is moving toward a broader concept of its role as a health and social agency in the community. Not only is it concerned with the patient's care as an inpatient but with his care after he leaves the hospital.

The hospital is concerned with the health of the community as a whole.

**ITEM 12. AMERICAN HOSPITAL ASSOCIATION BOARD OF TRUSTEES
APPROVES STATEMENT ON HOME HEALTH CARE SERVICES,
JUNE 25, 1973***

June 25, 1973.

CHICAGO.—The board of trustees of the American Hospital Association (AHA) has gone on record as saying home health care services should be fully utilized to "prevent costly and inappropriate admission to institutions, to reduce readmission to institutions and to contribute to the health and well-being of the patient and his family."

In making the announcement today, John Alexander McMahon, president of the AHA, said the statement was developed in conjunction with representatives from the assembly of ambulatory and home care services, AHA; Council of Home Health Agencies and Community Health Services, National League for Nursing; the National Association of Home Health Agencies; and the National Council for Homemaker-Home Health Aide Services, Inc., and also endorsed by the boards of directors of those organizations.

"The economic realities of the cost of health services to individuals, families and communities make it imperative that health service at home be included in all present and future health care delivery systems," said the statement.

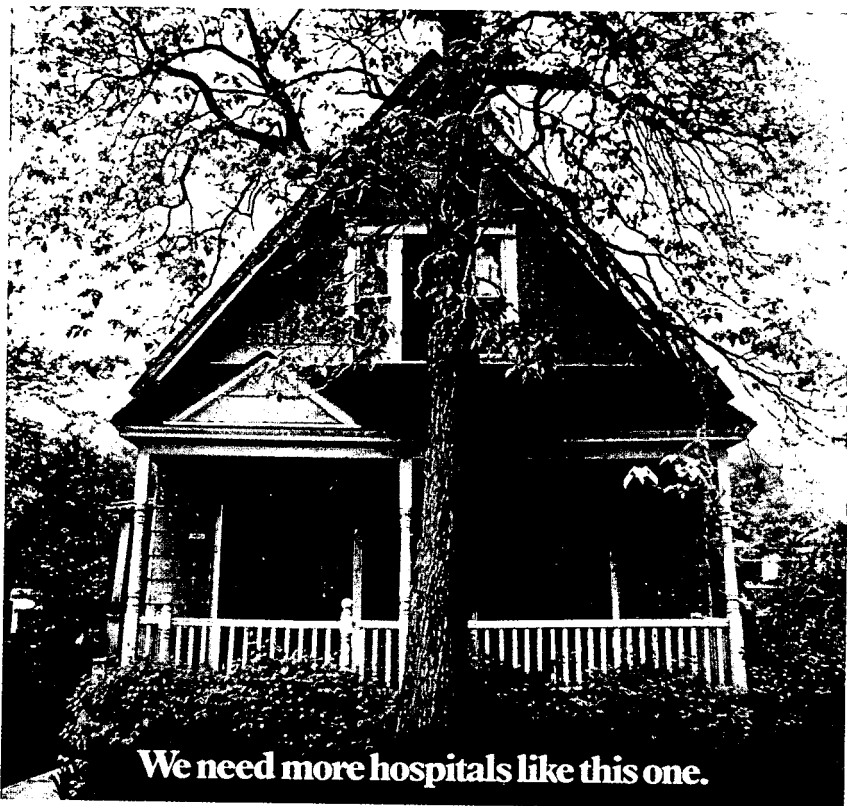
"The home environment plays a significant role in promoting health and facilitating the healing process. Properly coordinated and administered home health care provides a meaningful health service for ill persons, speeds recovery and rehabilitation of individuals with acute or chronic health problems,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

McMahon said of the new position statement: "Home care programs now exist in about 600 hospitals in the country and we hope this number will increase. We feel strongly that home health care services, which include medical care, dental care, nursing, physical therapy, speech therapy, occupational therapy, social work, nutrition, and homemaker-home health functions can contribute to the maintenance and restoration of health and help patients reduce costly hospital expenses."

The 25-member board, in defining ideal home health services, said programs must be characterized by: Provision of high quality care to patients; professional coordination of the various services delivered to the individual patient and family; evaluated techniques to ensure the appropriateness and the quality of care provided; and appropriate administrative controls.

*Submitted by Dr. Andrew Jessiman.

ILLINOIS BLUE CROSS/BLUE SHIELD ADVERTISEMENT



We need more hospitals like this one.

No matter how modern and well-equipped a hospital is, it can't provide the one thing that makes most patients feel better right away.

The feeling of being home.

Now, we've got a program that provides it.

It's called the Coordinated Home Care Program.

Under its provisions, a patient, when his doctor discharges him into our program, can go home. And take the care he needs to get well along with him.

That can include medication, medical supplies, lab tests, x-rays, inhalation and physical therapy. Besides regular nursing visits, and visits by the patient's doctor.

All can be covered by us. Just so long as the patient's Blue Cross and Blue Shield plan includes Coordinated Home Care.

Most of them do.

And that his hospital is participating in this program with us.

Because Coordinated Home Care gets people home sooner, it helps them feel better, both emotionally and physically.

It should also make everyone feel better financially. Because, in Illinois hospitals, the average cost for a day of in-patient care is \$103.25. Versus a \$14.30 a day average for a patient who's well enough for Coordinated Home Care. A savings that ultimately influences health care premiums.

Right now, 44 Illinois hospitals are

participating in this program with us.

We hope that soon, there'll be more. Because it lets hospitals use their facilities more efficiently, keeping the cost of health care down.

And because it gives the patient the one thing he can't get at the hospital. The comforts of home.

If you'd like to learn more about our Coordinated Home Care Program, write to our Public Affairs Department. Or call us at (312) 661-4487.

We'll send you a copy of a new booklet that fully describes the Coordinated Home Care Program.

How it works. How much it means. And how much it saves.



Blue Cross & Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601

ITEM 13. SURVEY OF HOSPITAL-ADMINISTERED HOME CARE PROGRAMS, FROM THE MAY 1, 1972 ISSUE OF HOSPITALS, THE JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

INCREASED INTEREST IN "PROGRESSIVE PATIENT CARE" REQUIRES GREATER UNDERSTANDING OF THE HOSPITAL'S ROLE IN DELIVERING HOME CARE SERVICES

(By LORRAINE RICHTER AND ALICE GONNERMAN *)

AMBULATORY CARE

Several of the proposed national health insurance plans recognize home care as an important part of progressive patient care. Their primary goal is the development of a system of health services that provides access to adequate health care for everyone. As conceived by the American Hospital Association, optimum health care goals are to be accomplished in a system where financial incentives encourage utilization of ambulatory facilities, extended care and nursing home facilities, and home care programs, rather than incentives that encourage reliance on hospitalization.¹

With this focus on the use of ambulatory facilities and home care programs in the future delivery of health services, what will be the role of the hospital? What patterns of home care and what interrelationships between hospitals and other home care agencies will emerge? To better understand the patterns that will evolve it is important to understand the current organization of medical and related services for persons in their homes.

WHAT IS HOME CARE?

Simply stated, home care is the provision of health care to the patient in his place of residence. It may be provided through a broad range of service and organization patterns. A coordinated home care program is one that is centrally administered and that, through coordinated planning, evaluation, and followup procedures, provides for physician-directed medical, nursing, social, and related services to select patients at home.²

There have been two major avenues of development in home care during the past 25 years. In one, the hospital extends some of its services into the community to provide coordinated care. In the other, a community agency, such as the visiting nurse association or the local health department, builds upon its existing program to provide home care services in collaboration with the hospitals of the community.

At least four administrative auspices for home care programs are recognizable: visiting nurse associations, public health or welfare departments, community home care agencies, and hospitals. In addition, there are a number of specialized programs such as those providing family care and foster home placements for psychiatric patients and Federal hospital programs for veterans and members of the military force.

Home care programs are found in metropolitan, urban, and rural settings. Factors such as the framework of the total community health programs, the available resources of services, personnel, and funds, and the leadership of particular individuals or groups have been determinants in the specific community patterns of home care that have emerged.

*Lorraine Richter is assistant director of the division of data collection, Bureau of Research, American Hospital Association. She studied business administration and psychology at Northwestern University and received her bachelor's degree from that institution. Alice M. Gonnerman is assistant director of the division of ambulatory care, Bureau of Professional Services, of the American Hospital Association. She holds a bachelor's degree in psychology and master's degrees in social work and medical care administration. She is a member of the National Association of Social Workers and of the American Public Health Association.

¹ American Hospital Association. *Policy Statement on Provision of Health Services* (Chicago: the Association, 1971).

² American Hospital Association. *Hospitals and Coordinated Home Care Programs* (Chicago: the Association, 1966.)

CHANGING CONCEPT OF HOME CARE

The concept of home care has changed since the first program in 1796. At that time the purpose of home care was considered from the welfare viewpoint, in which the poor in the city of Boston were viewed by their overseers as having the right to the dignity of staying in their own homes rather than being hospitalized. Sporadically since that time, a few home care programs have been established with that purpose in mind.³

Home care became more hospital-centered around 1946, when the Montefiore Hospital program began in New York City. Michael Bluestone, M.D., of the Montefiore program, believed home care was an extension of the hospital program—"a hospital without walls." He visualized the hospital staff taking care of home care patients, with the same record keeping system and the same services being rendered. Dr. Bluestone, who pioneered in the development of coordinated home care programs, explained the concept more clearly by saying, "If you have a 500-bed hospital and 50 patients on home care, you have a 550-bed hospital."³

By 1966, there were approximately 100 coordinated home care programs, some administered by hospitals and some by community agencies, but all capable of caring for sick people by extending hospital services into their homes.³ The Medicare legislation, by including a home health benefit, gave impetus to the development of home health services. To be certified for participation in Medicare, a home health agency must provide skilled nursing service in addition to at least one other therapeutic service such as physical therapy, occupational therapy, speech therapy, medical social services, or home health aide services. It is important to be aware that there are basic differences between coordinated home care programs capable of providing a wide range of hospital services to patients at home and programs providing only skilled nursing and one other therapeutic service. Both types of programs are necessary to provide services for ill persons at home.

AHA'S STUDY

Coordinated home care is not a new concept, but it is a concept that may become increasingly important as an alternative to hospitalization if there is adequate insurance coverage for home care services in the future health care system. Recognizing that shared knowledge and experience are essential factors in evaluating home care methods and accomplishments, the AHA conducted a survey in May 1970 in order to learn more about hospitals' involvement in home care programs and to identify basic features of hospital-based (administered) home care programs. Of special interest were organizational characteristics of the program, utilization, methods of charging for home care services, hospital plans for expansion of home care services, and the scope of services provided.⁴

The 547 hospitals that reported having a home care program in the AHA's annual survey in 1969 were mailed questionnaires. The response was very good, with answers from 492, or approximately 90 percent, of the hospitals. Of these, 263 hospitals were administering home care programs (243 were non-Federal hospital programs while 20 were Federal programs), and 216 were participating in other home care programs (116 were programs administered by agencies other than the hospital, 72 were psychiatric foster care programs, and 28 were limited programs, such as those offering only "Meals-on-Wheels" services or physician services, or those accepting only military personnel and their dependents). Six of the responding hospitals had discontinued or had never activated their home care programs; seven responded too late for inclusion in the survey results.

The major findings of the study are based on the 243 non-Federal hospital-administered home care programs. The study disclosed that some hospitals furnish extensive services to patients at home even though the hospital does not administer the home care program. Several hospitals participating in home care programs administered by another agency indicated that their involvement is so great that the hospital administrator and the hospital staff look upon the program as hospital-based even though this is not strictly the case. Whether or not the hospital or a community agency administers the home care program, the hospital plays a primary role in the determination of patients' needs for care at home and in the arrangements for home care services.

³ Ryder, C. F. *Changing Patterns in Home Care* (Washington, D.C.: U.S. Department of Health, Education, and Welfare—presented at conference on Coordinated Home Care, Rochester, N.Y., 1966).

⁴ Richter, L., and Gonnerman, A. *Home Care and the Hospital* (Chicago: the American Hospital Association, Feb. 1971.)

SERVICES AND CERTIFICATION

Sixteen services were selected for examination in the survey to determine the range of services provided by hospital-administered programs. These services are those of physicians, registered nurses, licensed practical nurses, home health aides, physical therapists, occupational therapists, speech therapists, psychologists, social workers with master's degrees, assistant social workers, and volunteers, as well as laboratory, radiology, pharmacy, medical supply, and transportation services.

TABLE 1.—SERVICES AND SERVICE PROVIDERS IN HOSPITAL-BASED HOME CARE PROGRAMS

Service	Programs providing service		Service providers			
			Hospital employee		Outside provider	
	Number	Percentage	Number	Percentage	Number	Percentage
Physician.....	243	100.0	(1)	63.0	(1)	48.6
Registered nurse.....	239	98.4	153	88.5	118	17.7
Medical supplies.....	225	92.6	215	72.4	43	29.2
Physical therapy.....	220	90.5	176	76.1	71	19.3
Laboratory.....	216	88.9	185	76.5	47	7.0
X-ray.....	191	78.6	186	75.3	17	11.1
Drugs.....	191	78.6	183	28.0	27	48.6
Home health aide.....	179	73.7	68	30.0	118	32.9
Speech therapy.....	148	60.9	73	52.7	80	10.7
Social work (master's level).....	146	60.1	128	25.9	26	31.7
Licensed practical nurse.....	140	57.6	63	31.7	77	20.6
Transportation.....	138	56.8	77	41.2	76	4.9
Occupational therapy.....	113	46.5	71	13.6	50	10.7
Social worker (assistant).....	107	44.0	100	14.0	12	8.6
Volunteers.....	54	22.2	33		26	
Psychologist.....	53	21.8	34		21	

1 Most hospitals provide 2 or more services.

TABLE 2.—ADMISSIONS TO AND YEARS IN OPERATION OF HOME CARE PROGRAMS, 1969

Indicators	Median admissions	Median years in operation
Bed size of hospital:		
Under 100 beds.....	83	3.0
100 to 299.....	136	2.9
300 to 499.....	167	5.5
500 or more.....	204	7.4
Services provided:		
1 to 4.....	100	2.8
5 to 8.....	85	2.8
9 to 12.....	143	3.7
13 to 16.....	177	4.8

As shown in Table 1, all of the 16 services except those provided by occupational therapists, social work assistants, volunteers, and psychologists are provided in 50 percent or more of the hospital-based home care programs. Although many hospitals did not specify their arrangements for obtaining physician services in home care programs, physicians employed by the hospital for this purpose and patients' private physicians were cited most often as the providers of this care. Services of a registered nurse are provided in 98 percent of the programs, and medical supply and physical therapy services are available in more than 90 percent of the programs. Eleven is the median number of services provided in the hospital-based programs surveyed.

Sixty-five percent of the hospital-administered home care programs have been in operation less than 5 years, and 84 percent less than 10 years. On an overall basis, the home care programs of responding hospitals have been in operation a median of 3.64 years, but, as Table 2 illustrates, home care programs in larger hospitals have been in operation longer. In general, the longer a program has been in operation, the greater the number of services provided by the program. Programs that provide one to four services have been in operation a median of 2.8 years, while programs that provide 13 to 16 services have been in operation a median of 4.8 years.

A total of 198, or approximately 82 percent, of the hospital-administered home care programs are certified by the Social Security Administration for participation in Medicare. Forty-five of the programs surveyed are not certified. As of May 1970, 45 percent of the programs had been certified 42 or more months, and the median length of certification was 36.3 months. (The maximum possible months of certification is 58.) Between May 1969 and May 1970, 26 hospital home care programs were certified. A followup study would be needed to assess all the reasons for nonparticipation as Medicare providers, although replies indicated that some of the noncertified programs are in special types of hospitals (such as orthopedic hospitals, rehabilitation hospitals, and children's hospitals) and that some programs serve patient's who are under 65 years old.

ADMISSION DATA

More than 40,000 home care patients were admitted in 1969 to the 211 hospital-administered programs that operated for the 12-month period and that reported admissions. The median number of patients admitted per hospital-administered home care program in 1969 was 135, with a median of 156 admissions for non-certified programs and a median of 129 admissions for certified programs.

It might be expected that home care admissions would be affected by the number and range of services provided by the program, by the bed size of the hospital, by Medicare certification, and by the number of years the program has been in operation. This would appear logical for a number of reasons. First, home care programs that provide many services are able to care for a greater variety of diagnostic groups and therefore should have more admissions. Second, larger hospitals have contact with a larger volume of patients that might need home care services and therefore should have a larger number of admissions. Third, certification of programs through Medicare should stimulate the growth and use of home care by providing a payment mechanism for these services. Finally, physicians, hospital personnel, and patients should be more aware of the availability and advantages of such services the longer a program has been in operation.

While the AHA survey showed that larger hospitals and hospitals providing more services do have higher median admissions, this relationship was not found in a comparison of certified home care programs with noncertified programs. The bed size of hospitals with certified and noncertified programs is similar, and there is no difference in the median number of selected services provided by these programs, yet noncertified programs have higher median admissions.

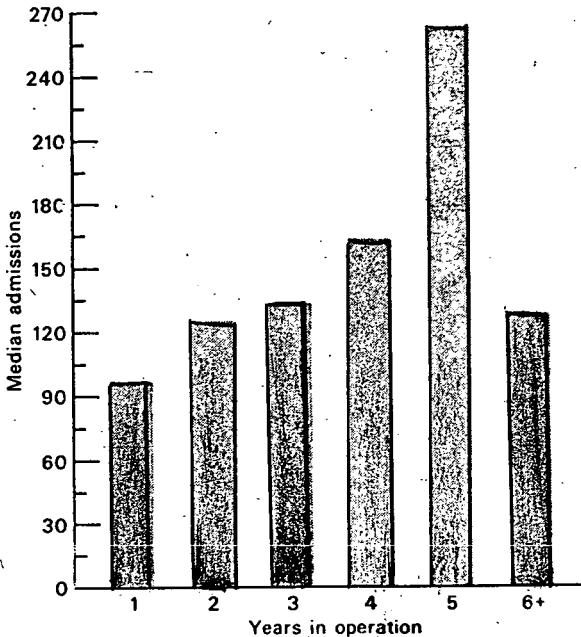


FIGURE 1—MEDIAN ADMISSIONS IN HOSPITAL-ADMINISTERED HOME CARE PROGRAMS, BY YEARS IN OPERATION

As shown in Figure 1, above, this study showed that a significant factor associated with increase in home care admissions is the number of years programs have been in operation. There is an increase in median home care admissions each year for the first five years the program has been operating. It is probable that noncertified home care programs have more admissions than certified programs because noncertified home care programs have been in operation a median of 4.12 years, as compared to 3.57 years for certified programs. It also is probable that larger hospitals have more home care admissions because they have had home care programs longer.

REIMBURSEMENT ARRANGEMENTS

The most frequently used reimbursement formula in hospital-based home care programs is payment per visit. This is so whether the paying source is Medicare, Medicaid, private insurance, or the patients. Eighty-four percent of the hospital-based home care programs charge per visit, and 22 percent charge per hour. Per diem, per-service, and per-months methods also are used for reimbursement. Many hospitals base reimbursement for home care on more than one unit of service.

Fifty-nine percent of the hospitals using per-visit as the unit of service for reimbursement allocate overhead to the per-visit charge. In about one-half of the programs using a per-visit charge for reimbursement, all visits are charged at the same rate; in the remaining programs, the rate per visit varies according to the service given. In programs in which the rate is variable, the average charge is \$6.30 per visit for home health aides, \$13.20 for nurses, \$14.30 for occupational therapists, and \$19.10 for social workers. These rate differences are a reflection of the number of visits as well as of variations in salary scales.

EXPANSION PLANS

Fifty-nine percent of the hospitals with home care programs had expansion plans for 1970. Most of these hospitals were planning to add services and staff, to cover more patients, or to improve utilization of their programs through renewed educational efforts with the hospital staff. Hospitals of all sizes had expansion plans for their home care programs, although greater expansion activity was planned in larger hospitals.

A comparison of the number of community hospitals with the number of home care programs administered by hospitals in each bed size category, as shown in Figure 2, indicates that a greater percentage of larger hospitals have hospital-based care programs.

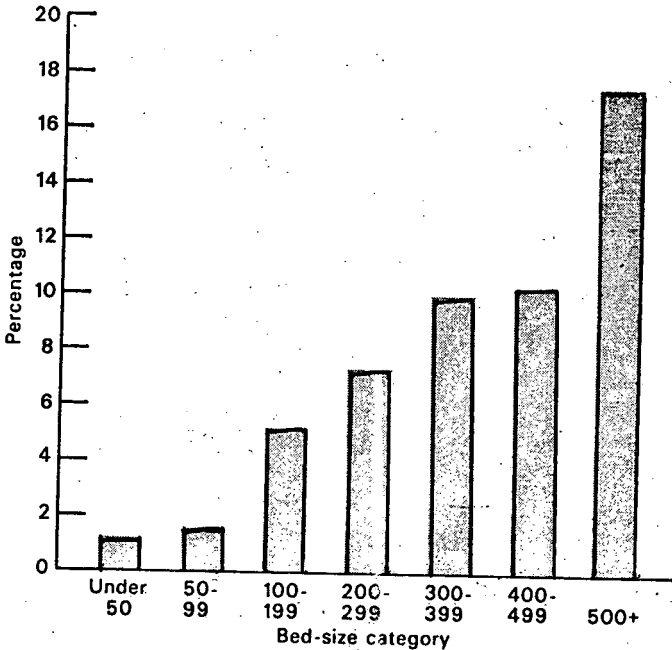


FIGURE 2—PERCENTAGE OF COMMUNITY HOSPITALS PROVIDING HOSPITAL-ADMINISTERED HOME CARE PROGRAMS, ACCORDING TO BED SIZE

ITEM 14. RESCINDING CURRENT FINANCING; LETTER TO ACTING COMMISSIONER OF SOCIAL SECURITY ARTHUR E. HESS, FROM DONALD D. TRAUTMAN, ADMINISTRATOR, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, DATED APRIL 30, 1973

April 30, 1973.

DEAR ACTING COMMISSIONER HESS: As you know, we presented information stating the effect removing Medicare current financing would have on home health agencies and estimating the impact this would have on the Medicare program in our February 14, 1973, telegram to Mr. Tierney and Mr. Ash. This information is based on what is happening to home health agencies out here in the real world, not a bureau's interpretation of how it is. In subsequent weeks we received two different responses saying basically that it was not intended that this provision cause home health agencies financial hardship and that our comments would be seriously considered.

Specifically, your April 16 letter to this office, Secretary Weinberger's March 27 letter to Representative John Young, and Mr. Tierney's March 13 letter to this office, all stated that our comments would be thoroughly considered after the notice of the proposed rulemaking was published.

In addition, Harold E. Eljerle, congressional liaison, OMB, wrote in his April 5 letter to Representative Wendal Wyatt, that:

"The proposed change in reimbursement policies is certainly not intended to affect the financial position of providers to the point where they are unable to continue to provide services. As indicated in Mr. Malek's letter it is this administration's intent to avoid such a result.

"We have discussed the specific problems mentioned in Mr. Trautman's letter with the Department of Health, Education, and Welfare staff with whom he has been in contact. The problems and alternatives for dealing with the situation in which they may arise are now under review by the Department."

The NAHHA board of directors met in Washington, D.C., February 26 through March 1 and met with 70 congressmen and senators, six Federal agencies, six legislative committees, etc. (see attached report) and discussed this matter in detail and found that it was not the intent of anyone to cause this type problem for home health agencies.

Consequently, we were disappointed to find no mention of this in the proposed regulations published in the April 2 Federal Registry under the proposed rule-making provision.

At the request of Dr. Peter Fox, we prepared the enclosed recommendations and are submitting them in a format that will permit them to be used to modify the proposed regulations or adopted as a permanent regulation. This regulation is so written that funding is available only until and to the extent the Medicare processing delays we identified are eliminated.

We feel the attachment entitled "Proposed Regulations for Home Health Agencies" is fair, is acceptable, fulfills the intent to avoid financial hardship and because we are presenting a working solution to the problems we identified. In addition we feel our recommendations should be implemented because:

(1) They directly address themselves to the daily operating problems of home health agencies.

(2) They are flexible and provide incentives to encourage prompt payment.

(3) Currently, home health agencies are not eligible for prospective reimbursements.

(4) Home health agencies are unique:

(a) Many are small and have no financial reserves. According to an SSA June 1970 report, 60 percent of the certified home health agencies have three or less staff nurses.

(b) They have limited accounting backup.

(c) They don't have high depreciation schedules.

(d) The nature of their services causes agencies to have a greater time lag from the initial service until the payment is processed than institutions.

Since we have discussed these specific problems with HEW and have justified why our proposed solution for dealing with the situation is fair, reasonable and necessary and since the formulas are written so prompt and current payment can eliminate the amount of advance funding, we urge that it be adopted without delay as a permanent regulation.

Sincerely,

DONALD D. TRAUTMAN,
Administrator.

[Enclosure.]

N.A.H.H.A.

Attachment to April 30, 1973, letter to Commissioner Hess

"Proposed Regulations for Home Health Agencies"

Principle--Medicare shall pay the provider the current costs of medicare patients to avoid adversely affecting the financial position of home health agencies and to avoid causing non-medicare patients to pay the costs of the medicare program.

Cash Advance--Home health agencies because of their unique problems are eligible to receive advance relief from the fiscal intermediary when they can demonstrate that their liquid assets cannot cover current expenditures, that no borrowing is available at prudent rates of interest, and that no resources or unrestricted funds are available.

Please Note--Both of the following formulas should be implemented because they address themselves to two different kinds of processing lags.

FORMULA #1

To determine cash flow processing lag: (to be computed of 6 mos.)

Average number of days from 1st serviced date to payment date in period _____
 _____ ÷ 30 = _____ average months
 (av. days) (av. days)

_____ x \$ _____ = \$ _____
 (av. mos.) Av. claims monthly amount of entitlement

EXAMPLE:

Facts:

Average amount reimbursed = \$8,901

Average from payment date to 1st service date = 56.9%

Computation:

$\frac{56.9}{\text{days}} \div 30 = 1.9 \text{ months}$

$\frac{1.9}{\text{mos.}} \times \$8,901 = \$16,911 \text{ amount of entitlement for cash advance}$

N.A.H.H.A.

Attachment to April 30, 1973, letter to Commissioner Hess

FORMULA #2

To determine current reimbursement percentage: (to be computed annually)
 Items which cause this are amount of medicare bad debts, time to compute year-end settlement, and the amount of unprocessed claims over six months old. The following formulas allow for each of these time lags:

A. Medicare Bad Debts:

Formula:

$$\begin{array}{l} \$ \underline{\hspace{2cm}} \div \$ \underline{\hspace{2cm}} = \underline{\hspace{2cm}} \% \\ \text{Med. Bad Debts} \qquad \text{Total amount of} \qquad \text{Bad debts per-} \\ \qquad \qquad \qquad \text{patient charges (gross)} \qquad \text{centage of} \\ \qquad \qquad \qquad \text{Health Ins. Program} \qquad \text{charges} \end{array}$$

EXAMPLE: (Medicare Bad Debts)

Facts:

Medicare Bad Debts = \$9,700
 Amount of patient charges to Health Ins. Program = \$119,000

Computation:

$$\begin{array}{l} \underline{\$ 9,700} \div \underline{\$ 119,000} = \underline{8.1} \% \\ \text{Med. Bad Debts} \qquad \text{Total amount of} \qquad \text{Bad debts per-} \\ \qquad \qquad \qquad \text{patient charges (gross)} \qquad \text{centage of} \\ \qquad \qquad \qquad \text{Health Ins. Program} \qquad \text{charges} \end{array}$$

B. Year End Settlement Processing Lag:

Formula:

$$\begin{array}{l} \$ \underline{(a)} \times \frac{\underline{(*)}}{12} = \$ \underline{(b)} \\ \text{amount y.e. settlement} \qquad \text{Time in months from end of fiscal year until final settlement} \\ \\ \$ \underline{(b)} \div \frac{\underline{\hspace{2cm}}}{\text{Total amt. of patient charges (gross) Health Insurance Program}} = \underline{\hspace{2cm}} \% \\ \qquad \qquad \qquad \qquad \qquad \qquad \text{y.e. processing lag per-centage of charges} \end{array}$$

EXAMPLE: (Year End Settlement Processing Lag)

Facts:

Amount of year-end settlement = \$24,000
 Time from fiscal y.e. until final settlement = 9 mos.
 Amount of patient charges = \$119,000

N.A.H.H.A.
Attachment to April 30, 1973, letter to Commissioner Hess

Computation:

$$\frac{\$24,000}{\text{amt. y.e. settlement}} \times \frac{9}{12} = \$18,000$$

$$\frac{\$18,000}{\$119,000} = \frac{15.1}{100} \%$$

Total amt. of patient charges (gross) Health Ins. Program

y.e. processing lag percentage of charges

C. Unprocessed Claims:

Formula:

$$\frac{\$ (a)}{\$ \text{Total amt. of patient charges (gross) Health Ins. Program}} = \frac{\text{Unprocessed claim}}{\text{percentage of charges}} \%$$

(a) Claims that the provider can document have been submitted and over 6 months old which no reimbursement has been made.

EXAMPLE: (Unprocessed Claims)

Facts:

Agency can document claims amounting to = \$ 8,000
Patient charges to Health Ins. Program = \$119,000

Computation:

$$\frac{\$ 8,000}{\$119,000} = \frac{6.7}{100} \%$$

Total amt. of patient charges (gross) Health Ins. Program

Final computation to determine interm reimbursement rates:

The percentages for A, B and C are totaled and this percentage is added to the reimbursement percentage paid by the F.I. For example:

Facts: Example A, B & C

Medicare bad debts	8.1%
Y.E. processing lag	15.1%
Unprocessed claims	<u>6.7%</u>
Total	29.9%

Final Computation:

$$100\% + 29.9\% = 129.9\%$$

ITEM 15. LETTER TO DONALD D. TRAUTMAN, ADMINISTRATOR, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, FROM ARTHUR E. HESS, ACTING COMMISSIONER OF SOCIAL SECURITY, DATED JUNE 26, 1973

June 26, 1973.

DEAR MR. TRAUTMAN: Thank you for your letter about the change in Medicare regulations relating to "Current Financing Payments."

Notice of this change was published some weeks ago in proposed form, to give interested parties an opportunity to comment on the change before its adoption in final form. The major concern voiced by hospital administrators and other interested parties had to do with the timing for repayment of outstanding current financing amounts held by providers of services. With consideration to those concerns, recovery of the outstanding current financing payments has been extended over a 12-month period rather than by June 30, 1973. A longer period can be established in situations where extreme financial hardship would otherwise occur.

The reason for ending the current financing procedure was that it represented an unusual device for meeting concerns that existed at the inception of Medicare but now have little basis. Many institutional health care providers were concerned about participating in Medicare at the outset because they feared that long delays might occur in their receiving reimbursement from the program. In the years since, the claims reimbursement process has become well established, and provides for payments periodically on a regular basis. Thus, it was concluded that the procedure for placing substantial Medicare funds with providers of service in advance of their billings—resulting of course in a loss of interest earnings to the Medicare trust fund—had become inappropriate.

I should like to emphasize that the regular Medicare reimbursement mechanism will continue to provide for accelerated payments to a provider of services where the provider has experienced financial difficulties due to a delay by a Medicare intermediary in making payments or, in exceptional situations, where the provider of services has experienced a temporary delay in preparing and submitting bills beyond its normal billing cycle.

Sincerely,

ARTHUR E. HESS,
Acting Commissioner of Social Security.

ITEM 16. TESTIMONY PRESENTED BY THE NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES TO THE HEALTH INDUSTRIES SERVICES COMMITTEE, JANUARY 15, 1973

PROBLEM

Section 233 of the 1972 Medicare amendments (Public Law 92-603) coupled with the Price Commission's current 5 percent limitation on charges will cause 80 percent of the certified home health agencies to reduce services or discontinue service unless an exception is granted by both the Price Commission and the Bureau of Health Insurance for noninstitutional home health agencies. Effective January 1, 1973, section 233 of Public Law 92-603 request the Social Security Administration to reimburse Medicare and Medicaid providers the lesser of *charges* or *costs*. Prior to this, Medicare has reimbursed home health agencies "*full costs*." A September 23, 1972, Price Commission ruling requires individual exception for increases in charges over 5 percent for noninstitutional home health agencies. Based on our surveys, many home health agency charges will have to increase an average of 25 percent to equal current costs.

Home health agencies' charges are below their costs because:

- (1) Agencies did not wish to lose their charitable status by overcharging.
- (2) Medicare reimbursed costs and did not require home health agency charges to equal costs.
- (3) Medicare staff has encouraged agencies to *undercharge* and after the annual audit made a lump sum adjustment payment to the home health agency, rather than have the agency owe Medicare money.

IMPACT ON HOME HEALTH AGENCIES

Within the last month, we have surveyed in excess of 200 home health agencies in the following states: Oregon, California, Colorado, Alabama, New York, Missouri, Kansas, Nebraska, Wyoming and Pennsylvania. This survey reveals that on the average, agencies received 75 percent of their income from Medicare and Medicaid. Because of this dependency upon Medicare, and Medicaid, the impact of this amendment upon home health services nationally can be expected to be devastating.

There are approximately 2,300 certified home health agencies in the United States at the present time. Extrapolating from our survey sample, we have found the following regarding cost versus charges:

- (1) Approximately 437 home health agencies will have to increase their charges from zero to 5 percent to equal their cost.
- (2) Approximately 1,122 home health agencies will have to increase their charges 6 to 50 percent to equal their cost.
- (3) Approximately 495 home health agencies will have to increase their charges 50 to 100 percent to equal their cost.
- (4) Approximately 246 home health agencies will have to increase their charges in excess of 100 percent to equal their costs.

This means that if positive action is not taken immediately at the national level to remedy the situation, approximately 1,863 individual exceptions will have to be filed and processed within the next three to six months.

If home health agencies are to *survive* under this new Federal statute, which is effective January 1, 1973, they must be allowed to increase their charges up to cost. If this is not allowed, the survey done of Missouri agencies indicates that 81.8 percent (18 to 22) will be forced to terminate operation.

IMPACT ON ECONOMY

The granting of an exemption for home health agencies will not be inflationary. Since 1966, agencies have received a lump sum retroactive reimbursement after audit to equate charges to cost. We are requesting that agencies be permitted to make a one-time adjustment to get charges current with costs.

If we do not get an exception immediately, there will be serious and negative effects upon your efforts to control cost in the health field. If a substantial portion of home health agencies are forced to discontinue operation, there will be no choice but to keep patients in institutions. As you well know, the cost of health care in such settings is at least two and one-half times more expensive than the same service delivered in the home. Based on the 1972 estimated Medicare expenditures for home health services, this would cost an additional \$340 million. It would be the ultimate irony if such an inflationary situation were allowed to come into being through the implementation of rules and regulations aimed at reducing cost.

Home health agencies have received absolutely no relief to date. We cannot afford to continue to wait. Time has become one of our most serious problems because the Price Commission's September 22, 1972 decision increasing 2.5 percent to 5.0 percent has not been implemented by Medicare. The Bureau of Health Insurance staff claims that their current Medicare guidelines of 5.5 percent consisting of 2.5 percent plus a 3.0 percent intensity of service allowance exceeds the 5.0 percent allowance. The Price Commission granted the increase from 2.5 percent to 5.0 percent because home health agencies have a *high labor intensity*. This is entirely different from the intensity of service allowance defined in the Medicare guidelines.

Intensity of service is an allowance necessary to provide for increases in costs that arise from variations in the volume of visits or occasions of service. Intensity of labor describes an organization that has a high labor cost factor. Intensity of services is related to variations in usage or productivity while intensity of labor describes an organization that has a very high labor cost factor. Home health agencies are effected by both factors. Seventy-five percent to 85 percent of our per-unit costs are for salaries and wages, and we have variations in our volume of visits per day.

The severe hardship and gross inequity caused by this change in the Medicare statute and the inability of the Bureau of Health Insurance to implement current Price Commission guidelines must be corrected immediately.

You can help solve this problem by adopting the following provisions for the services furnished by home health agencies in accounting periods beginning after December, 1972:

(1) By permitting noninstitutional home health service providers a one-time adjustment to bring their charges up to their current costs.

(2) By placing controls for all home health agencies on cost increases, instead of charges. This should include a base cost of 6 percent plus an intensity of service allowance. All cost increases should be justified.

We feel this is a reasonable and necessary request that takes into consideration your responsibilities to control inflation, takes into consideration the consumer's viewpoint, and is not just what is best for home health agencies.

Home health services must be used to curtail rising medical care costs. Our case is not a case of developing more agencies but a case of survival.

Agencies must be paid *at least* their cost to remain in business. It is your responsibility to act immediately and help save this vital service.

ITEM 17. POLICY STATEMENT BY THE BOARD OF DIRECTORS OF THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES ON SAFEGUARDS FOR DELIVERY OF HOMEMAKER-HOME HEALTH AIDE SERVICES

Homemaker-home health aide services should be efficient, effective and given with safeguards to protect the people served. Therefore, any agency—Government, voluntary nonprofit or proprietary—which provides homemaker-home health aide services should meet basic standards, established by a national voluntary not-for-profit standard setting body. The standard setting body determines through objective review whether an agency meets basic standards.

Adherence to basic standards requires that homemaker-home health aide services, under whatever auspices:

(1) Be provided by a team composed of both professionals and homemaker-home health aides. The homemaker-home health aides are to be employed and paid by the agency; the agency must provide training, and professional supervision.

(2) Be soundly administered, including maintenance of sound statistical and cost data.

(3) Insure that appropriate services are given as needed, but only for the period required, as determined by professional evaluation and continuing re-assessment of the individual's or family's needs.

(4) Be described accurately and adequately to the public. Information as to the availability and quality of service shall be readily accessible to those to be served.

The above principles are equally essential when the services are delivered directly to an individual or family and when the services are purchased on their behalf from another agency.

Communities provide homemaker-home health aide service in various ways. Whatever the system, the interests of those served must be protected. Government, voluntary nonprofit and proprietary agencies all have responsibility to work actively toward comprehensive, quality homemaker-home health aide services in each community.

ITEM 18. TENTATIVE DRAFT OF POSSIBLE FEDERAL LEGISLATION TO PROVIDE FOR HOMEMAKER-HOME HEALTH AIDE SERVICES TO ALL INDIVIDUALS AND FAMILIES IN NEED OF SUCH CARE, BY THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

July 9, 1973.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Comprehensive Homemaker and Home Health Aide Service Act of 1973."

Sec. 1. Title XI of the Social Security Act is amended by adding the following new sections:

FINDINGS AND PURPOSE

Sec. 1140. (a) The Congress finds that—

(1) sometime in their lives every individual and every family in the United States may need homemaker-home health aide service for a temporary or extended period of time because of illness, disability, or other personal or family crises;

(2) homemaker-home health aide service meets immediate crises and helps to prevent family breakdown and to maintain individuals and families in their own homes, and serves as an adjunct to other preventive, rehabilitative, and treatment services;

(3) most persons, including the very young and the very old, prefer to remain in their own homes when suffering from illness or disability and to return to their own homes as quickly as possible after specialized treatment;

(4) care in the home, through the services of a well trained and competently supervised homemaker-home health aide is usually far more economical than maintaining an individual in a foster home, an institution, or a hospital;

(5) care in the home should be available to all individuals and families who need it through insurance and health maintenance organizations, through programs to aid the financially needy, and for those who can pay part or all of the cost of such care;

(6) many individuals and families can be assisted to improve their level of living and quality of daily life through the teaching efforts of a homemaker-home health aide;

(7) it is public policy that all individuals and families who need homemaker-home health aide services should have such services available promptly and of assured quality in the community where they live;

(8) in current homemaker-home health aide programs a large proportion of the homemakers-home health aides were recipients of Aid to Families with Dependent Children until their recruitment, training, and employment as homemakers-home health aides enabled them to support themselves and their dependent children, in addition to performing a highly useful service;

(9) employment as homemakers-home health aides offers satisfying employment and career opportunities to persons who might otherwise continue to need public support.

(b) It is the purpose of this Act—

(1) to create a program of homemaker-home health aide service adequate to meet the needs of all Americans who could benefit from such care;

(2) to provide for homemaker-home health aide service in sufficient quantity on a State-wide basis in all political subdivisions, to prevent unnecessary care of individuals in foster homes, institutions, or hospitals;

(3) to provide for basic standards essential to quality care; and

(4) to provide training in the home which will make it possible for individuals and families to remain in their homes and to become as self-sufficient as their capabilities permit.

ELIGIBLE INDIVIDUALS

Sec. 1141. Every individual in the United States in need of, and choosing, this type of care shall be eligible to receive the benefits provided by this Act.

DEFINITIONS

Sec. 1142. For purposes of this Act—

(a) The term "homemaker-home health aide" means a trained, supervised person who works as a member of a team of professional and allied workers providing health and/or social services.

(b) The term "homemaker-home health aide service" means the care and service provided in the home to an individual or family when home life is disrupted by illness, disability, or social disadvantage, or when the family or individuals within the family are in danger of physical, social, or emotional breakdown because of disorganization or stress with which they are unable to cope effectively, or when a family needs help in improving the quality of its home life. Individual services to be performed include, among others, the following: care for children during the absence or incapacity of the parent; performing

or helping to perform essential household duties—insuring proper nutrition, maintaining a clean and hygienic environment, providing personal care as prescribed by health professionals; teaching through demonstration and practical suggestions how to care for children, the value of and how to prepare nutritious meals, how to budget, how to market and how to organize a household; providing emotional support and understanding; observing strengths and weaknesses in individual and family functioning to assist the professional members of the team to make an adequate plan.

(c) The term "supervision" refers to the direction given to the homemaker-home health aide by a social worker, a nurse, or another member of the professional team responsible for helping to resolve the problem that made the service necessary in a particular home.

(d) The term "provider of the service" means a family and child welfare service organization, a local public social services department, a visiting nurse association, a local public health department, and similar organizations. The service may also be provided by a multiservice public or nonprofit health or social welfare agency, an independent nonprofit health or welfare agency, or by a proprietary agency.

(e) The term "Secretary" means the Secretary of Health, Education, and Welfare.

SCOPE OF BENEFITS

Sec. 1143. (a) The benefits provided to an individual or family under this Act shall include full or part-time care and service whether rendered on a daytime, nighttime, weekend, emergency, or full 24 hour care basis.

(b) Persons who have been found to be in financial need under regulations prescribed by the Secretary of Health, Education, and Welfare shall receive the benefits of the service. The basis of payment shall be the full reasonable cost of the care and service in accordance with regulations prescribed by the Secretary.

(c) Payment for persons not meeting the above criteria shall be made on a sliding fee schedule in terms of full reasonable cost with persons who can pay only part of the cost having the remainder met under regulations prescribed by the Secretary.

(d) The homemaker-home health aide service in which payment must be made in full or in part from public funds shall be provided through a public agency providing other health and/or welfare services. The service may be provided directly by such agency or through purchase of service. Any agency whether public, nonprofit voluntary, or proprietary must qualify as meeting basic standards set by a responsible national agency, such as the National Council for Homemaker-Home Health Aide Services, Inc. No Federal funds may be used to pay for homemaker-home health aide service provided by a nonapproved agency. Federal matching funds at 75 percent shall be available without a fixed ceiling to the states to reimburse them for costs incurred in providing homemaker-home health aide services (under State plans approved under titles I, X, XIV, XVI, or parts A and B of title IV and including such additional applicants as may be approved by the Secretary).

(e) Receipt of needed homemaker-home health aide service shall not be conditional upon the receipt of any other health or welfare service.

AUTHORIZATION OF APPROPRIATIONS

Sec. 1144. There are authorized to be appropriated such sums as may be necessary to carry out this Act, including funds necessary for the proper and efficient administration of homemaker-home health aide service.

REPORT

Sec. 1145. The Secretary shall submit annually to the President and to the Congress a full report on the program under this Act, including recommendations for any improvements therein.

EFFECTIVE DATE

Sec. 1146. This Act shall apply with respect to care and service furnished on or after January 1, 1974.

ITEM 19. BASIC NATIONAL STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES; BY THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC., NEW YORK, N.Y.

- (I) The agency shall have legal authorization to operate.
- (II) There shall be an appropriate duly constituted authority in which ultimate responsibility and accountability are lodged.
- (III) There shall be no discriminatory practices based on race, color or national origin: And the agency either must have or be working toward an integrated board, advisory committee, homemaker-home health aide services staff, and clientele.
- (IV) There shall be designated responsibility for the planning and provision of financial support to at least maintain the current level of service on a continuing basis.
- (V) The service shall have written personnel policies; a wage scale shall be established for each job category.
- (VI) There shall be a written job description for each job category for all staff and volunteer positions which are part of the service.
- (VII) Every individual and/or family served shall be provided with these two essential components of the service:
- (A) Service of a homemaker-home health aide and supervisor.
- (B) Service of a professional person responsible for assessment and implementation of a plan of care.
- (VIII) There shall be an appropriate process utilized in the selection of homemaker-home health aides.
- (IX) There shall be: (A) Initial generic training for homemaker-home health aides such as outlined in the National Council for Homemaker Services' training manual; (B) an on-going in-service training program for homemaker-home health aides.
- (X) There shall be a written statement of eligibility criteria for the service.
- (XI) The service, as an integral part of the community's health and welfare delivery system, shall work toward assuming an active role in an ongoing assessment of community needs and in planning to meet these needs including making appropriate adaptations in the service.
- (XII) There shall be an ongoing agency program of interpreting the service to the public, both lay and professional.
- (XIII) The governing authority shall evaluate through regular systematic review all aspects of its organization and activities in relation to the service's purpose(s) and to the community needs.
- (XIV) Reports shall be made to the community, and to the National Council for Homemaker-Home Health Aide Services, as requested.

ITEM 20. HOME HEALTH SERVICES, DEFINITION AND POLICY STATEMENT, SUBMITTED BY THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

FOREWORD

The following definition and position statement on home health services was developed by a task force composed of representatives of the Assembly of Out-patient and Home Care Institutions, American Hospital Association; the Council of Home Health Agencies and Community Health Services, National League for Nursing; the National Association of Home Health Agencies; and the National Council for Homemaker-Home Health Aide Services, Inc.

The definition and statement have been endorsed by the following organizations: American Hospital Association, National Association of Home Health Agencies, National Council for Homemaker-Home Health Aide Services, Inc., and the National League for Nursing.

DEFINITION

Home health service is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence

for the purpose of promoting, maintaining, or restoring health, or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency/institution, or a unit of an agency/institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

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

STATEMENT ON HEALTH SERVICES IN THE HOME

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

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

Home health services can :

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

Health services at home must be characterized by :

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

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

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

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

ITEM 21. SUCCESS STORIES—INNOVATIVE AGENCY PROGRAMING TO MEET HEALTH NEEDS OF THE ELDERLY

(Summarized from testimonial letters from agencies affiliated with NLN/Council of Home Health Agencies and Community Health Services)

Many agencies reported establishing health center services in apartment buildings and housing units for the elderly or in area schools or churches. Frequently these are tenuous services funded as special projects since regular funding is difficult to secure. Services offered at these centers include: Health screening clinics—diabetes, blood pressure, glaucoma, tuberculosis, hearing, em-

physema, urinalysis, weight; refer people to physicians as needed; classes in nutrition, exercises, safety, etc.; immunization clinics; podiatry services; check medications the people are taking; counseling and emotional health care; care-of-sick services; personal problem sessions.

Helped establish areawide "gerontology task force" which sponsors: congregate onsite meals for elderly; socialization centers; health screening clinics; friendly visitors; telephone reassurance program.

Staff speakers bureau for senior citizens clubs in county (3).

Participates with institutions in area in coordinated discharge planning, frequently on contract basis.

Set up out-of-county transportation service to clinics at teaching hospitals 60 miles away.

Accepts gifts of wheelchairs and other equipment for loan to patients as needed.

Established telecare services—elderly persons phone into central area at specified time each day.

Meals-On-Wheels service sponsored by agency.

Conduct "well-aging clinics" at senior citizen center—audiometer, BP, glaucoma, and FBS screening clinics, flu immunizations, health classes and pamphlets.

Counseling service at agency for elderly with problems in daily living—housing budget, personal relationships, insurance questions, and emotional problems.

Service aides accompany elderly to physicians offices, purchase groceries, food stamps, cash checks, etc.

Special office clinics for foot care.

Liaison nurses from health department work closely with hospitals, attending rehabilitation team conferences and making rounds to all nursing units weekly—feedback between all referring agencies is functioning very effectively.

Established a thrift shop which supports a senior citizen center which includes regular health services.

Converted motorhome to mobile health unit staffed by nurses and visiting the area's 18 doctorless towns on a regular schedule (RMP funding). Primary purpose is early detection and prevention through health screening, teaching and counseling.

Agency's family nurse associate works with group of patients at the medical clinic at the local hospital.

Established a transfer unit staffed by auxiliary personnel for people needing "personal care" services only.

Organized friendly visiting service.

Twenty-four hour, 7-day-week nurse on-call service preventing long patient and family anxiety and unnecessary hospitalizations.

Worked with senior citizens of the county to have a "teach-in" for general health information pertinent to aging.

Nurses taught to function in expanded role to provide primary care for the aged. Services set up, as funding available throughout rural area of State.

"Rotating bed system" so that the chronically ill patient can enter hospital when needed for short-term tests, diagnostic and therapeutic studies.

ITEM 22. REDUCING COSTS IN PROVIDING HOME AND COMMUNITY HEALTH SERVICES FOR THE ELDERLY

(Summarized from testimonial letters from agencies affiliated with NLN/Council of Home Health Agencies and Community Health Services)

Increased auxiliary staffing—home health aides, homemakers, outreach workers.

Placed liaison nurse in local hospitals to assure continuity of nursing and other therapeutic care services.

Health center services in housing units: Reducing tenant visits to physicians and clinics; reducing transportation problems and costs; providing referral information for community resources; preventing hospitalization with early recognition of health problems that can be treated at home.

Rural agency moved into the hospital: Easy access to laboratory facilities, classroom facilities for health classes, easy referral and physician contacts, easy access to drugs and supplies.

Continual utilization review including efforts to effect efficiencies and reduce costs.

Centralized buying.

Savings in clerical area by letter productivity.

Surplus supplies from local hospital and home-made dressings.

Part of staff go on 4-day week or half-time when caseload fluctuates.

Consumer response to service is requested with every patient bill.

Prepare medications for a full week for self administration—insulin, etc.

Community loan supply of sickroom equipment.

Increasingly terminally ill patients are being maintained at home with patient and family support by agency team.

statement on home health care

introduction

The Committee on Community Health Care reviewed the AMA position on home health care and prepared this report, which consolidates information previously contained in several different publications. The report includes discussion on:

1. Background
2. Patterns and levels of care
3. Homemaker-Home Health Aide Service
4. Financing of Home Health Care
 - A. Private Insurance Programs
 - B. Federal Programs
5. Benefits of Home Care Services
6. The Role of the Practicing Physician
7. The Role of the Medical Society
8. The Role of the Institution Medical Staff

The American Medical Association defines home health care as: Any arrangement for providing, under medical supervision, needed health care and supportive services to a sick or a disabled person in his home surroundings. The provision of nursing care, social work, therapies (such as diet, occupational, physical, psychological, and speech), vocational and social services, and homemaker-home health aide services may be included as basic components of home health care. The provision of these needed services to the patient at home constitutes a logical extension of the physician's therapeutic responsibility. At the physician's request and under his medical direction, personnel who provide these home health care services operate as a team in assessing and developing the home care plan.

1. Background

The changing age composition of the U.S. population and the proportionate increase in long-term illness and disability have resulted in the medical profession's increased recognition of the need for examining and improving traditional methods of delivering health care services.

Over the past half century, the increase in prevalence of such chronic diseases as hypertensive and arteriosclerotic heart disease, cerebrovascular disease, arthritis, neurological disorders, malignancies, and pulmonary dis-

orders has expanded demand for long-term medical and supportive care. Many of these diseases, after a dramatic acute phase, are followed by long periods of convalescence, rehabilitation, and supportive care often punctuated by additional acute episodes. Other medical problems have a less acute onset phase that requires definitive diagnosis followed by a long course of definitive therapy. Congenital defects (in structure or metabolism) and disabilities resulting from accidents also contribute their share of long-term care problems.

Such diseases or disabilities present difficult problems of medical, social, and economic significance. The long periods of time involved in treatment and rehabilitation, with the resulting social and financial burdens placed on the individual, the family, and society in general, necessitate that physicians become concerned with optimal methods by which needed services and facilities can be furnished to the patient.

Obviously, during the acute phase of illness the complex and costly services of the general hospital are often necessary. In the period of continued disability, however, hospital stay on a continuous basis frequently is neither necessary nor desirable. The patient may be moved from the hospital to a skilled nursing home. At any time when part-time services are needed, the patient may well benefit from the provision of medical and other needed services at home. In addition to those patients who are referred from an institution, many patients are ill in their own homes, and they may need the same kind of services. Although not currently needing an institutional setting, they need home care as preventive and therapeutic measure. Home care is of benefit for many categories of patients--the acutely ill, the convalescent, and those recovering from surgery. In December 1960, the AMA House of Delegates recommended that "physicians be urged to participate in organized home care programs for any patient who can benefit from the program and to promote such programs in their communities." A 1972 report, Home Health Services in the United States prepared for the U.S. Senate Special Committee on Aging, verifies the fact that many patients in nursing homes could better utilize home care services.

2. Patterns and Levels of Home Care

Home care services are available from a variety of sources. They may be provided through: (1) a single service agency such as a homemaker-home health aide services program or a meals-on-wheels program; (2) a multiple-service agency that arranges for two or more types of services, such as home nursing care, physical therapy, and homemaker-home health aide; or (3) a coordinated home care program that arranges for a wide range of home services designated to meet the patient's individual needs through one centralized administration. The coordinated home care program also is responsible for planning, evaluation, and follow-up procedures to provide physician-directed medical, nursing, social, and related services to selected patients at home.

Home care is generally considered to be categorized into three component levels: (1) concentrated or intensive care; (2) intermediate service; and (3) basic services.

The most concentrated or intensive service is for patients who would ordinarily require admission to inpatient institutions. Some patients require complex professional services on a coordinated and continuing basis for brief periods of time. They do not require full-time resources and can benefit from intensive home health care services.

Intermediate services are those needed on a less intensive basis. Patients requiring intermediate services may have long-term problems or may have been recently discharged from an acute care facility.

Basic services are those that provide an effective level of health care for an individual within that person's home. Basic service should be sufficient to sustain patients adequately so that they can remain relatively independent. Assuming they have stabilized physical conditions, they do not have to return to an inpatient facility for more intensive care.

Home health services, including follow-up, can be provided by many different kinds of private and public agencies, including Visiting Nurse Associations (VNAs), Departments of Public Health, and hospital-based programs. VNAs are voluntary nonprofit groups that deliver nursing services in the home. The public health departments are governmental units that may provide, in addition, a variety of services such as case finding, preventive services, observation, and follow-up. Hospital-based home care programs serve as an extension of hospital services and can provide nursing care plus a variety of other supportive services to noninstitutionalized and post-hospital patients.

Since enactment of the Medicare law, programs that were previously providing nursing care of the sick at home have expanded their functions to include other services, such as physical therapy, homemaker-home health aide services, and social services. Whether a VNA, a public health department, or a hospital-based program, a home health agency certified under Medicare must receive referrals from physicians. It provides services for both noninstitutionalized and the post-hospital patients.

Whatever the organizational mechanism, home care services at any of the described levels should be viewed as an alternative to hospital, nursing home, or other institutional care and as part of a total medical care plan. As such, home care can enable the patient to remain in, or return to, a home environment that may be psychologically therapeutic and probably result in a cost saving. The patient must want to receive care in the home environment and family relationships should be conducive to care.

Training of the patient in self-care and instruction of family members are of prime importance in achieving maximum effective utilization of available professional health personnel. For example, institutional efforts devoted to careful instruction of a diabetic or a post-coronary patient and his family before the patient goes home provides for continuity of care and reinforcement of the educational process in the setting of the patient's home. Home care will be enhanced by having instructions start in the hospital because they will then be reinforced in the home.

3. Homemaker-Home Health Aide Services

Homemaker-home health aide service programs offer a type of home health care to a variety of patients. Homemaker services originated in the 1920s. Services are provided by homemaker-home health aides who are mature and specially trained persons with skills in both homemaker and personal care. They help maintain and preserve a family environment that is threatened with disruption by illness, death, ignorance, social maladjustment, and other problems. They can assume full or partial responsibility for child or adult care, for household management, and for maintaining a wholesome atmosphere in the home. Their activities are performed under the general supervision of a nurse, social worker, or other appropriate health professional.

Home health aide services is a term that refers to the personal care services for the patient. This term was first used in the Medicare regulations to describe the services eligible for reimbursement under that program. Home health aide services can be broadened to include certain functions of home-making directed toward maintaining the environment of the patient.

Homemaker-home health aides can perform a number of routine duties: light housekeeping, light laundry, preparation and serving of meals, shopping, simple errands, teaching of household routine and skills to well members of the family, and general supervision of the children of the patient. There is a need for the expansion and extension of this service in new and imaginative ways.

The AMA and its Woman's Auxiliary have long promoted the use of effective homemaker-home health aide services. The AMA supports the appropriate development of homemaker-home health aide services. Physicians and medical societies as well as hospital administrators and other health professionals should appreciate and understand the important role that the homemaker-home health aide can play in the proper operation of a coordinated home care program.

The National Council for Homemaker-Home Health Aide Services, Inc., is a nonprofit, tax-exempt, voluntary membership organization whose purpose is the development of quality homemaker-home health aide services as an integral part of health and welfare services delivered in the home. In 1969, it was named as the national standard-setting body for homemaker-home health aide services for the program administered by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare. In this role, the National Council has developed and is implementing a national approval program that can offer help in assuring the quality of homemaker-home health aide services. The AMA has actively supported the National Council since its beginning and, in November 1970, the AMA urged support and extension of homemaker-home health aide services.

Homemaker-home health aides help a community maintain and improve its physical and mental health by providing high quality homemaker-home health aide services. The medical profession should cooperate with and support individuals and organizations that are capable of delivering these high quality homemaker-home health aide services in communities where they are needed.

4. Financing of Home Health Care

The financing and the cost of home health care services are complex subjects. From the standpoint of coverage and reimbursement, home health services have been almost ignored by most third parties in the past. In recent years, however, home care coverage is more available as a result of patient and provider satisfaction and the recognition by all parties of the potential cost savings. The AMA believes that home health services should be an integral part of any health insurance program.

The appropriate use of home health care services can reduce unnecessary utilization of institutional services. Earlier discharges from hospitals release more hospital beds and can reduce the costs of hospital stays. The National Association of Home Health Agencies has reported that if the average hospital stay were shortened by one day for only five percent of all hospital patients, the potential cost savings would be about \$100 million annually. However, this figure does not include the operating cost of maintaining empty institutional beds that must also be assumed by communities. Also, it must be understood that home care programs may merely shift a portion of the total health care costs from the inpatient category to the outpatient category. This outpatient home care service can normally be provided at a fraction of the inpatient costs and thus an overall savings can be expected. This shift in costs from the inpatient category has usually resulted in out-of-pocket expenses for the patient because the inpatient care was reimbursable whereas home care or ambulatory services are frequently not covered.

A. Private Insurance Programs

Third party payors, including Blue Cross-Blue Shield and commercial insurance companies, are recognizing that effective utilization of home health care services potentially can result in significant cost savings. As a result, a greater number of health insurance policies are beginning to include coverage of home health care services. Insured home care programs in two areas--Philadelphia, Pennsylvania, and Rochester, New York, have been in operation for several years and have reported significant cost savings.

The Blue Cross of Greater Philadelphia Home Care Program was developed to serve as an effective alternative to institutional care for patient and physician use. Blue Cross of Greater Philadelphia worked with selected member hospitals and community home health agencies in a collaborative effort to develop an administrative mechanism to facilitate coordinated home health care delivery as an alternative to inappropriate and unneeded institutional care. Under this program, Blue Cross subscribers were provided a broader range of benefits. The patients who have made use of the home care have generally accepted the opportunity for care. They have been released from hospitals an average of 13 days earlier than they would have been without the availability of the coordinated home care service. Expressed in the value of inpatient days saved on 3,940 home care cases, this amounted to a gross savings of approximately \$2.5 million. Net savings amounted to approximately \$1.3 million, or \$330 per case after deducting the cost of providing home care

services and the related program administrative costs. More than 800 private physicians have participated and referred patients to the home care service. Most of the physicians indicated they preferred coordinated home care to continued hospitalization. Better cooperative relationships, high quality programs, and professional skills have been developed within the participating hospitals and community home health agencies.

The Rochester (New York) Home Care Association Program is also underwritten through the Rochester Blue Cross Program. Home care services are purchased primarily from the VNA and the public health nursing department. Direct social services are also provided in this well organized program that offers continuing care. Patients are referred to the home care program in many ways and from a variety of providers, including practicing physicians, and organizations within the community. The program grew from a total of 141 referrals in 1961 to over 1,500 referrals in 1970.

The national inpatient per diem cost rose from \$36 in 1961 to \$92 in 1971. In 1961, the Rochester home care cost per day was about \$8 and in 1971 it was \$16, and it offered approximately a \$76 saving over charges for a patient day in the hospital in 1971. The average hospital length of stay for the type of patient served by the program was about 40 days. However, through utilization of home care services a savings of 21 inpatient days per case was realized. For the calendar year 1970, the Rochester Home Care Program achieved a net savings of over \$1 million.

Both of these programs illustrate that effective programs of home care services can reduce costly inpatient stays and thus achieve significant savings.

Blue Cross, Blue Shield, and other insurance companies will underwrite almost any service for which the insured group is willing to pay the premium. It must be remembered that labor and management play a large part in determining what goes into an insurance contract.

B. Federal Programs

Government programs generally provide for reimbursement of home health services to the extent that such coverage is specifically included in the law. Thus in Medicare and Medicaid, in which home health services are identified in the statutes as reimbursable, the service is generally provided. In the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) and the Federal Employees Health Benefits Program (FEHB), home care is normally provided and reimbursed as an adjunct to physician services.

Medicare - Title XVIII

Medicare reimburses for home health services under both Parts A and Part B of Title XVIII. After a minimum of 3 days' stay in a hospital or after a discharge from an ECF, Part A pays for up to 100 hospital-related home health visits within a 12-month period. These visits must be ordered by a physician according to a plan established within two weeks after institutional

discharge. The home health agency must be a participant in the Medicare program and the patient must be treated for the same condition for which he was hospitalized. Part B of Medicare pays the providing home care agency for up to 100 home health care visits each year when a patient has no prior hospital stay, if such services are provided according to a plan of treatment approved by a physician. Part B of Medicare also may be used if the patient's Part A visits have been exhausted.

It should be emphasized that Part A pays reasonable costs of home health services, while Part B pays 80% of the reasonable cost of services after the patient has met the overall annual \$50 deductible for Part B services.

Medicare cost data for fiscal year 1971 indicate that both the number of claims and the amount paid comprise an extremely small portion of the total expenditures for the program. Home health services accounted for less than 20% of the number of claims and less than 1% of the dollars paid out under Medicare.

Medicaid - Title XIX

Medicaid statutes list services that are eligible for federal matching, including home health care services. Home health care services are defined in Medicaid regulations to include nursing and therapy services, as well as other services provided through a home health agency under direct supervision of the physician. About 80% of the individual state Medicaid programs have included home health services either for the categorically indigent or the medically indigent. As of July 1, 1970, all states were required to provide home health services for eligible individuals entitled to skilled nursing home services. All home health agencies participating in the Medicaid program must meet Medicare standards.

Unlike Medicare, the Medicaid program does not require payment of reasonable costs or reasonable charges but rather the law states that payments may not be in excess of reasonable charges. There is no minimum payment level set. In general, the method of determining payment levels is a state option.

In the overall Medicaid program, home health expenditures again are a small part, totalling less than a half percent of the dollars paid out.

Civilian Health and Medical Program Uniformed Services (CHAMPUS)

The Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) is one of the most comprehensive federal health programs, and it is administered through a number of private insurance carriers and/or state medical societies. There is no specific listing of home health services in the enabling legislation or in descriptive materials issued by the program. The program attempts, where feasible, to pay for any appropriate legitimate services ordered by the physician for treatment of a patient. Apparently most, if not all, of the individual services provided by home health agencies could be ordered by a physician and paid for under the program, but each would be paid and reported under the category of the specific individual service such as nursing, speech therapy, physical therapy, etc., rather than as organized

home health services: CHAMPUS will pay for home care by registered nurses, and by licensed practical nurses, as well as by other health providers.

Federal Employees Health Benefits Program (FEHB)

The Federal Employees Health Benefits Program (FEHB) has no statutory mention of home health service. Enabling legislation, P.L. 86-382, speaks of "general care rendered in the patient's home," "ambulatory patients' benefits," and "other medical supplies and services" but makes no statutory requirement for specific coverage of home health services. Statistical reports on the program do not identify utilization of such services but generally combine all hospital benefits. It is estimated that approximately 95% of those enrolled in the high option FEHB program are covered for home nursing, but the patient often pays a deductible or has some other limitation, such as a coinsurance payment. Coverage by the two largest plans--the Blue Cross-Blue Shield and Aetna (the contractor for the other insurance companies)--includes a variety of home health care services.

There are limitations in most of the federal programs. Some limitations in home health service under the Medicare program are: (1) Focus is on acute or short-term illness; (2) There are inherent contradictory definitions of the eligible home health service patient as applied to the insured group's need; (3) Reimbursable services are not necessarily those most needed by the majority of the insured group; (4) Definitions of reimbursable services are susceptible to a great degree of interpretations; (5) Many agencies have been placed in financial jeopardy by delays in reimbursement resulting from administrative complexities; (6) Difficulties are encountered in establishing and maintaining comprehensive services because reimbursement from the insurance system is limited to selected services; (7) Strong institutional bias exists with a 3-day hospital stay required prior to entitlement for home health services under Part A, and non-hospital related home health services under Part B are dependent on the individual's paying the insurance premium and 20% of the cost of service; (8) Cost of home health services under Medicare has remained at less than 1% of insurance expenditures and appears to be diminishing while expenses for institutional services are increasing. Similarly, many of these criticisms have been leveled against the state-administered Medicaid program.

The United States Senate's Special Committee on Aging's 1972 report, *Home Health Services in the United States*, stated that there were minimal federal resources allocated for the creation of appropriate home health service programs and that, where there were resources, strict regulations had hampered the success of such programs in meeting the needs for home care. A question might also be raised as to what degree any open-ended need for home health services can realistically be met.

5. Benefits of Home Care Services

The benefits of effective home health care programs can be summarized as follows:

- Patients prefer care that can be provided in the normalcy of their home environment.
- Home-bound people can be taught to live in a relatively independent status.
- The need for initial admission or readmission to inpatient institutions can be diminished.
- For the necessary institutional admission, unnecessary days can be eliminated through early discharge to home care.
- Unnecessary capital construction costs for inpatient facilities can be decreased.
- The efficiency of the practicing physician can be increased by expanding the team approach. The physician can care for a greater number of patients through a home care program because he does not have to assemble and coordinate individually the services needed for his patients in their home settings.
- Home care staff can readily interpret medical orders, explain treatment regimes, and offer reassurance and support.
- Home care staff can identify day-to-day problems and thus help to reduce the possibility of emergency situations arising.

6. The Role of the Practicing Physician

Depending upon the needs of the patient, home health care may require many persons and organizations to combine their efforts and form a health care team under physician direction. Leadership by physicians is essential to the efficient and successful provision of home care services. This leadership role can be expressed in many ways. Examples are as a: (1) medical director in a hospital; (2) medical director of a community-based home health agency; (3) member of a board or advisory committee of a home health agency; (4) coordinator of a hospital-based home care program; (5) a member of a home care committee or similar body of a hospital, health center, medical society, etc.; or as (6) a private practitioner who makes appropriate use of home health services in his patient care management.

Whatever the role, some suggestions for physicians are:

- The physician should be aware of the home care services available in his community and the various methods by which they can be developed or improved.
- The physician should assist in initiating innovative ways in his community that encourage the delivery of more efficient, more economical, and more appropriate care in the natural home setting of the patient.

- The physician should become familiar with the various financing alternatives that can be used in paying for home health services.
- When referring patients for home care, the physician should establish a plan of treatment for each patient and should periodically review this plan and the patient's progress with the home health personnel providing the care. Special efforts (or arrangements) may be needed to maintain this communication when a patient is cared for at home because of the separation in time and distance between the different services and personnel involved. The physician may, therefore, wish to support the establishment of coordinated home care programs that can fulfill this role.
- The physician should ensure that he receives regular reports, observations, and progress notes from the health personnel or home care program providing the services.

7. The Role of the Medical Society

The medical society has a proper concern with the availability and adequacy of health care services for the population in its service area. The medical society, therefore, should stimulate physician interest in and acceptance of home care as an integral part of the overall continuum of care. Along with this, the society should provide community leadership in both improving the coordination of existing home care services and stimulating the development of new services where they are needed.

Adequate community home care services will be dependent not only upon the actions of the local medical society but also upon the sound cooperative planning efforts of many public and private health and service agencies in the community, especially the community health planning agency. In addition to the medical society and its woman's auxiliary, other agencies that might properly become involved in the overall community planning for home care include local and state health departments (particularly their bureaus of nursing); local visiting nurse associations or community nursing services; local or state nurse, hospital, and nursing home associations; local or state health professional provider organizations; health financing organizations; chambers of commerce; and other important community business and government leaders.

Medical societies should help to ensure that the community health planning agency has broad representation from all organizations concerned with providing home care. The medical society, in particular, can stimulate the involvement of physicians in these planning activities. Some of the activities that the community planning agency may want to consider in the development of adequate community home care services are:

- Measure the need for such services in the community by making in-patient population analyses and demographic studies that show who can use such services and show what significant economic benefit can be reaped by a community.

- Measure the capability of the community to provide home care from the standpoint of manpower, financial, transportation, and institutional resources, and any other necessary resources.
- Stimulate the development and use of home health care programs in the community in whatever setting is considered most appropriate.
- Identify expected sources of income for the program and urge expansion of existing insurance payment mechanisms for appropriate types of home care.
- Make use of medically and ethically sound promotional and educational material on available home care programs.
- Provide technical advice and assistance in developing and operating home care programs.
- Encourage the public to demand insurance coverage for a needed home care alternative.

The medical society should also urge the medical directors in hospitals and other health facilities to develop continuing professional education programs on the utilization of home care services. Communitywide public education programs should be initiated as a means of promoting community acceptance.

The medical society should emphasize the need for medical schools and internship programs to educate medical students, interns, and residents in the value and proper use of home care programs.

The medical society should emphasize in all of its deliberations concerning home care that effective home care programs can offer high quality medical care and can be an extension of the physician's services at very little cost and effort to him.

Each medical society should create a home care committee to coordinate the medical society's activities on the subject of home care.

8. Role of the Institutional Medical Staffs

As an integral part of a health care institution, the organized medical staff should be particularly sensitive not only to that institution's specific needs and goals but also to the important community problems of the needs of the patients and the alternative patterns of care that can most appropriately answer those needs. Because the medical staff's decisions affect the general utilization of institutional beds and services, it is important that the hospital medical staff be fully aware of the value and proper use of home care programs. The medical staff's primary concern is to ensure that all patient care is appropriate and of high quality. These concerns should lead the medical staff to seek active and involved representation on the institution's home care committee. If there is not a home care committee, the medical staff should stimulate its development.

The interests of an institutional home care committee should extend beyond acute inpatient care and they should determine the appropriate and effective use of home care programs for the patients served by the institution. The home care committee should coordinate its efforts with the activities of the medical society, the community planning agency, other appropriate community agencies, and organizations concerned with home care services.

The medical staff and the home care committee should urge the medical director of the institution to develop and offer continuing professional education programs on the use of home care services. The home care committee should ensure that any interns, residents, and other health professional students in the institution are trained in the value and use of the home care program. The committee should also encourage the development of appropriate professional review and evaluation of home care programs. The effective use of the home health care services can only be realized when well designed criteria for selection of patients for home care and standards for evaluating the effectiveness of home care are used.

Council on Medical Service Report C

Adopted by the House of Delegates
American Medical Association
Clinical Convention December, 1972

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Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT SUBMITTED BY ALLEN LESSER, WASHINGTON, D.C.

I appreciate the opportunity to submit this statement on Home Health Care for the Elderly.

As a former executive assistant to Senator Jacob K. Javits (Republican of New York), I was assigned the responsibility for the development of legislation on health care for the elderly (Medicare) for the years from 1959 to 1965, which culminated in the passage of title 18 of the Social Security Act.

My interest in the development of home health care is the result of my study of such services in Great Britain and Germany in 1962. I am deeply convinced that if Medicare costs are to be controlled and reduced, and delivery of needed services to the elderly improved, a national comprehensive system of home health care services is the way to do it.

In 1965, when Medicare became law, the average cost per patient for hospital care in New York State stood at \$50 to \$58 per day. At that time health economists were predicting that by 1975, the cost of hospital care would raise to \$100 per day. As a matter of fact, such costs reached that high point in New York in 1970. According to the American Hospital Association, the national average for that year was \$81.01, and in 1971 it climbed to \$92.31. Today, it is even higher.

The accelerating rate of increase in hospital care costs has far exceeded congressional estimates made when the Medicare program was enacted. While the demand for hospital beds continues to remain high, it seems futile to hope that greater efficiency, automation, consolidation and improved management skills will somehow halt the rising spiral of costs, much less lead to substantial cost reductions.

It is important to note that current proposals for catastrophic illness insurance and national health insurance emphasize coverage for payment of costs rather than their control or reduction. As a matter of experience, there is sound reason to believe that such proposals, if enacted, would have the effect of skyrocketing costs, just as in the case of Medicare. No insurance program by itself can reduce costs; it is much more likely to result in increases by encouraging greater use of already costly facilities.

The largest single factor in the high cost of health care for the elderly is the hospital. Therefore, if the use of hospital beds can be substantially reduced without impairing necessary health care, Medicare costs could at least be stabilized. The Medicare program, however, is hospital centered. It does not have to be. Hospital and skilled nursing institutional care are not the only kinds of health care indicated for an elderly patient nor are they necessarily the best kind of health care in every case. Sharp reductions in health care costs can be effected if such institutional care were to be employed exclusively for cases of emergency or acute illness or surgery.

Emphasis on hospital health care has discouraged the development of badly needed home health care services. While home health care is authorized in the Medicare legislation, it has been used relatively little primarily because it is hospital centered and can be prescribed only after a stay in hospital. Posthospital home health services under Medicare are limited to 175 visits after at least a 3-day stay in hospital. Where available, these services must conform to a plan prescribed by the physician in charge of the patient, and must be directly related to the patient's condition. These restrictions and lack of available services have discouraged use of this provision and encouraged the use of costlier skilled nursing home services for posthospital care.

Home health care efforts are sporadic and limited in kind. Only rudiments of a program exist in most part of the country, much of it on a volunteer basis, and only with state support when it involves children of a family on welfare. A major share of the health care for the elderly, however, could be taken up at far less cost by a comprehensive wide range of home and ancillary health care services such as exist in Great Britain, for example. Cost runs have demonstrated that home health care on an organized adequate scale can be provided for a fraction of the cost of hospital care, something on the order of about \$15-\$20 a day, depending upon the community.

Under State and local administration, a home health care program can become an effective and economic way to treat chronic disease and long-term disability. As outlined below, the program I advocate can be used satisfactorily not only for posthospital care but also when illness strikes and hospital beds are not immediately available, and the ailing person can be taken care of temporarily in his home. Furthermore, the psychological advantages of home health care offer a distinct benefit and should not be overlooked by the physician. Gerontologists are agreed that aging patients almost without exception would be greatly relieved if they knew that they did not have to go to a hospital for care and could remain in their own familiar surroundings while undergoing treatment.

To establish a national comprehensive program of home health care, legislation amending title 18 of the Social Security Act will be necessary to authorize such services without a prior stay in hospital and on the prescription of an attending physician. There should be no limitation on the number of days such services can be provided. Legislation will also be necessary to amend the Public Health Service Act to provide for Federal-State sharing in financing these services. With the Federal Government setting standards and providing overall national coordination, home and ancillary health care services can be set up as the responsibility of state and local health authorities. They should be as readily available as police or fire prevention services, or as current ambulance services. Abuses should not occur if the following organization of services is established and made available:

(1) A health supervisor. This is usually a woman who is trained to assess the health care needs of the household as a whole, and particularly the health care needs of infirm old people who are living alone. Her basic concern should be to provide for preventive care, but in all instances she should be the one responsible to the physician for the execution of his orders and the one to negotiate with the physician for any other services she believes are required.

(2) Home nurse. This is a professionally trained practical nurse capable of caring for the sick and coping with the complications arising from social breakdown and mental confusion. Where possible she would enlist and instruct relatives to care for their elderly sick. In cases of acute illness, her services might be employed—day or night—under the direct guidance of the physician in charge until a hospital bed becomes available. (In rural or sparsely populated areas, the functions of the health supervisor and the home nurse may be combined in the same person.)

(3) Technicians and therapists. Ancillary services of all kinds should be available to the physician on prescription through the centrally administered service.

(4) Social worker. This person may be called in to help where problems arise concerning the accommodation, care and family adjustment of those who become tubercular, disabled, chronically ill, or otherwise handicapped.

(5) Home helpers. These persons are primarily concerned with domestic duties such as washing, cooking, cleaning, and purchase of food. For elderly men living alone, male home helpers may be indicated.

(6) Hospital equipment. Wheel chairs, walking aids, hospital beds, sanitary equipment, appliances, etc., should be made available for temporary loan in the home.

(7) Meals-on-Wheels. This service should be available in order to provide housebound patients with at least one hot meal a day.

(8) Supplementary services. Voluntary groups and organizations should be encouraged and assisted. Working in coordination with local health authorities and in some cases partially subsidized by them, church, fraternal, local industry, senior citizens and golden age volunteers could provide a wide range of specialized services including shopping, visiting and socializing, repairing, reading aloud, holiday and outing programs, organized entertainments, transportation,

library services, staffing for day centers, and special housing for the elderly. There are no limits to the quality and number of services that a properly motivated community can provide on a volunteer basis.

Physicians could be alerted to the availability of ancillary services as they are organized and encouraged to make maximum use of them in order to enable the elderly to remain independent and in their homes as long as possible. Increased emphasis and professional quality of home health care services could reverse the present tendency to refer aging persons to hospitals and other institutions simply because there is no other way to take care of them.

We have hardly begun to tap the community resources, voluntary as well as professional, out of which ancillary and home health care services can be developed and supplemented. There would also be side benefits of such a program through opportunities for greater employment of low-income groups. The kind of home health care services suggested in this statement would require the training and employment of large numbers of paraprofessional workers and thus help reduce unemployment.

To a large extent the costs of a comprehensive home health care program can be met out of savings effected in the reduced use of hospital services. Extension of the program to cover Medicaid and some veterans' health services could result in further substantial savings.

A comprehensive, fully staffed and adequately funded program in each state would take home health care services out of their present piecemeal and limited existence, help control and reduce Medicare and Medicaid costs, reduce unemployment, and make a vital contribution to the health and morale of the infirm poor and elderly in urban and rural communities. As the number of men and women over 65 years of age continues to rise—it is expected to total 25 million in 1980—we shall have to make use of all our community resources and services in order to keep the cost of delivering health and medical care viable and within a manageable range. Home and ancillary health care services outside of the hospital point the way in which this can be done.

Respectfully submitted.

**ITEM 2. LETTER AND ENCLOSURE FROM VIRGINIA A. STILLMAN, OTR,
CHAIRMAN, METROPOLITAN NEW YORK SPECIAL INTEREST GROUP
ON OCCUPATIONAL THERAPY IN HOME HEALTH CARE, TO SENATOR
MUSKIE, DATED JUNE 28, 1973**

June 28, 1973.

DEAR SENATOR MUSKIE: We request to submit this paper to the records of the Senate Subcommittee on Health of the Elderly. It was prepared for the hearings on "Barriers to Health of the Aged" on July 10-12, 1973. It represents the position of the Metropolitan New York Special Interest Group on Occupational Therapy in Home Health Care.

The Council on Community Home Health Agencies and Community Health Services of the National League for Nursing, will be presenting our concerns in its oral testimony to your committee on July 10-12, 1973.

We would appreciate your thoughtful consideration of our position.

Respectfully submitted,

VIRGINIA A. STILLMAN, OTR.

[Enclosure.]

**BARRIERS TO PROVISION OF OCCUPATIONAL THERAPY SERVICES
TO THE AGED**

STATEMENT OF POSITION

The underlying philosophy of occupational therapy in the treatment of the aged, is the promotion of optimal independence and adjustment to physical, visual, and other limitations imposed by the aging process. The application of our body of knowledge is best carried out in the home and community. Current legislative restrictions prevent this.

As allied health professionals we registered occupational therapists urgently request to be recognized as primary providers of home health care to the aged

in the home and community. Our services may be delivered through a variety of channels: Home health agencies; community or hospital based; other voluntary and proprietary community agencies and facilities; other health insurance programs; e.g. HMO.

We currently experience a severe barrier in providing home health services to the aged. The barriers are contained in the Federal Health Insurance for the Aged:

(I) Title 18, section 1814(a) (II) (D), and part B, section 1835(a) (II) (A) (i), specifically exclude occupational therapy as a primary and qualifying service for home health benefits. To qualify for home health benefits under either part A or B, a beneficiary must be in need of skilled nursing on an intermittent basis, physical therapy or speech therapy.

(II) Title 18, section 1832(a) (II) (C) of the Federal Health Insurance for the Aged, excludes occupational therapy as a covered outpatient service in either a rehabilitation center or skilled nursing facility.

CONSEQUENCES OF BARRIERS

The Federal Health Insurance for the Aged restricts the ability of home health agencies to provide occupational therapy services. The consequences are:

(1) In some cases the aged patient in need of occupational therapy primarily may fail to receive these services because an agency cannot first justify the need for skilled nursing, physical therapy, or speech therapy.

(2) In other cases, there may be unnecessary duplication or over-utilization of these other qualifying services in order to make occupational therapy services available. The latter leads to excessive and unnecessary costs.

FUNCTIONS OF THE OCCUPATIONAL THERAPY IN A HOME HEALTH SETTING

The areas of expertise in occupational therapy which are ideally suited to working with the aged in the home and community setting are:

(1) Assessing an aged patient's ability to live at home independently, including activities of dressing, personal hygiene, transfers, communication, meal-time and homemaking skills.

(2) Training and making recommendations in problem areas of self management through: New techniques to substitute for physical or visual loss; energy saving techniques; self-help appliances; alterations of physical barriers in the home; splints to prevent or correct deformities, or promote use of a hand.

(3) Use of manual activities and/or exercises to restore muscle strength, joint mobility, coordination, and general physical tolerance.

(4) Evaluating avocational interests and abilities to assist the aged in constructively utilizing his capabilities so that he retains a sense of purposeful living. Assisting in making referrals to appropriate community agencies, such as Senior Citizen Programs or homebound work programs.

(5) Teaching, supporting, and when necessary, supervising nurses, home health aides, family members, and others who may be working with the patient, as well as the patients themselves, to promote optimal use of his rehabilitation gains or remaining capabilities.

COST SAVINGS

Our stated areas of expertise enable us to assist the allied health team in recommending appropriate utilization of home health services, and thereby helping to reduce costs by:

(1) Preventing expensive institutionalization of the aged by providing services to keep him at home safely and independently.

(2) Preventing further deterioration and the need for rehospitalization.

(3) Promoting the best utilization of existing hospital facilities by encouraging early mobilization and independence, and thus shorten hospital stay.

A Stroke Study conducted by Nancy Bryant, RN, at St. Luke's Hospital in New York City in 1972, compared the outcome of care and costs for stroke patients with and without home care services. The occupational therapist played a key role, together with the physical therapist, visiting nurse, home health aide, speech therapist, and social worker.

The conclusions of this stroke study show that the home care stroke patients had a shorter hospitalization, had fewer readmissions for recurring strokes, re-

ceived continuity of care for as long as needed, had their overall costs reduced by \$5,000 per patient over a nine month period, had fewer deaths, and were able to be discharged to themselves or family, and remain self-sufficient in the community.

EDUCATIONAL REQUIREMENTS

The educational requirements of the occupational therapist are equivalent to those of the professional nurse, physical therapist, or speech therapist.

An occupational therapist is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the council on medical education of the American Medical Association in collaboration with the American Occupational Therapy Association and engaged in the required supervised clinical experience period prerequisite to registration by the American Occupational Therapy Association.

An occupational therapy assistant has successfully completed a training course approved by the American Occupational Therapy Association and is certified by that body as a certified occupational therapy assistant.

RECOMMENDATIONS

We recommend that the above named sections of the Federal Health Insurance for the Aged be revised or amended to:

(1) Include occupational therapy as a primary and qualifying service for home health care eligibility.

(2) Include occupational therapy as a covered outpatient service in an organized rehabilitation center or skilled nursing facility, as it is in a general hospital outpatient clinic.

CASE ILLUSTRATIONS

The following cases are typical examples of the types of patients served by occupational therapists in a home health setting.

(I) Age, 67; diagnosis, stroke with paralysis of left arm and leg, secondary to surgery for arthritis of both hips.

Mrs. D., a widow without family, was very active and independent until she sustained a stroke, resulting in the loss of use of her left arm. Home health services were offered as an alternative course after 3 months in an expensive nursing home, which was a "living death" for Mrs. D. While skilled nursing and physical therapy were needed initially for training in walking, it was primarily the expertise and training by the occupational therapist that enabled Mrs. D. to live independently in a single room hotel.

Specifically the occupational therapist rearranged her hotel room furniture, and recommended certain appliances to reduce energy expenditure, promote safety, and one-handed independence. Such appliances include a can opener for one-handed use, safe broiler oven, wheeled kitchen table, and a raised toilet seat and bathtub seat. Mrs. D. was taught one-handed or substitute techniques for self bathing, dressing, laundering, meal preparation, writing and use of a telephone. Clothing adaptations were made, including alternations of bras, back-opening dresses, shoelaces, and closure on leg brace. The occupational therapist enabled Mrs. D. to get to and participate in social and craft activities at her local senior citizen program. The home health aide was appropriately used to further encourage complete independence, except to get out of doors alone. The occupational therapist worked closely with a voluntary community service to assist Mrs. D. with shopping after she was discontinued from home care. Expensive institutionalization in a nursing home or rehabilitation center was prevented.

(II) Age, 74; diagnosis, multiple fractures, including left clavicle, pubis and femur.

Mr. C. was hit by a car and hospitalized for multiple fractures. In-hospital rehabilitation included training in nonweight bearing walking, some self-care activities and an exercise program. His rehabilitation was carried out by Home Care after one month of hospitalization. Mr. C.'s wife has a severe cardiac condition and is unable to assist him in personal care. The occupational therapist recommended an appropriate wheelchair, raised toilet seat and bath tub bench, and trained him in use of these appliances to promote complete independence and safety. An exercise program was instituted to improve motion in Mr. C.'s left arm and leg; energy saving methods were also taught. Mr. C. now comes to the hospital

as an outpatient for further rehabilitation. Expensive institutionalization in a convalescent home or rehabilitation center was thus prevented.

(III) Age, 69; diagnosis, left below-knee amputation, blindness, arthritis of arms and hands, and diabetes.

Mrs. B. lives with her working son in a one-family house. Two months after hospital discharge, the visiting nurse requested the services of the occupational therapist, because the patient spent her entire day alone in bed, unable to do anything for herself. The occupational therapist trained Mrs. B. to become more independent in the following ways:

(1) By teaching her new techniques to compensate for her blindness, in order to dress, bathe, toilet and feed herself, and to prepare simple meals and use a telephone.

(2) By training her to move from her bed to a wheelchair safely, and to get around her own home.

(3) By teaching exercises to overcome some of the disabling effects of her arthritis, including the use of a manual activity to improve hand function.

The occupational therapist also referred Mrs. B. to:

(1) A physical therapist for training in walking, using an artificial leg.

(2) A social worker for her financial problems and lack of knowledge about available services.

(3) The Industrial Home for the Blind.

(4) A voluntary community agency to provide her with transportation to her doctors, and to help with shopping.

(IV) Age, 82; diagnosis, rheumatoid arthritis.

Mrs. L. lives alone in a senior citizens housing project. The severity of her arthritis necessitates the help of a home health aide during the day. She walks with a walker. The occupational therapist recommended a raised toilet seat for toileting safely when alone at night, and trained the patient in self bathing and grooming. The patient was instructed in a self-exercise program, including a manual activity to increase strength and mobility. The home health aide was instructed by the occupational therapist to carry over the exercise program and to encourage independence in areas of self-care. Mrs. L. continues to remain in her own apartment instead of being transferred to a nursing home.

(V) Age, 67; diagnosis, severe emphysema.

Mr. K. lives with his wife in an apartment. For 3 years now he has not been out of his apartment and has progressed to bed-bound status, requiring oxygen supply continuously. He had deteriorated to the point of being unable to do anything for himself, or to sit up for more than ten minutes at a time. He was severely depressed and had reached a state of despair about his condition. The home care occupational therapist was requested to visit Mr. K. to recommend an activity to improve his general physical tolerance, to improve use of his arms and hands for self-care activities, and restore a sense of purposeful living. Mr. K. and his wife were taught rug-making, which accomplished all of these goals. The occupational therapist visited periodically as he progressed, to re-evaluate his status, and to instruct the patient in conservation of energy techniques for dressing, getting to toilet, and managing four steps at entrance of apartment building. He now is able to get out of doors with a small oxygen tank in a wheelchair for the first time in 3 years.

**ITEM 3. LETTER AND ENCLOSURES FROM MATHEW H. AHMANN,
ASSOCIATE DIRECTOR FOR GOVERNMENTAL RELATIONS, NATIONAL
CONFERENCE OF CATHOLIC CHARITIES, TO SENATOR MUSKIE,
DATED JULY 13, 1973**

July 13, 1973.

DEAR SENATOR MUSKIE: I am responding to your very kind letter of July 3 to Monsignor Lawrence J. Corcoran, Secretary of the National Conference of Catholic Charities. We are sorry it was not possible for us to have someone to attend the hearings or to prepare a preliminary statement on such short notice.

At our request however, Rev. Msgr. Robert P. Slattery, director of the Cardinal Ritter Institute in St. Louis did prepare a statement based on that institute's experience with home health care for the elderly. On the assumption that

the record may still be open, I am forwarding a copy of his statement as well as a description of the program of the Cardinal Ritter Institute in St. Louis for inclusion in the record.

We will look forward to working with you further on this subject.

Sincerely,

MATHEW H. AHMANN,
Associate Director for Governmental Relations.

[Enclosures.]

STATEMENT OF REV. MSGR. ROBERT P. SLATTERY, DIRECTOR,
CARDINAL RITTER INSTITUTE, ST. LOUIS, MO.

"We will have to put Grandma in a nursing home, she can no longer take care of herself and we don't have any room." That statement is just as archaic as a modern day attempt to practice medicine without X-ray, laboratories, or drugs.

In a society which places an exaggerated emphasis on physical strength or agility, financial and economic wealth, and mental dexterity we tend to become overly concerned about failing abilities to care for oneself. In evaluating the needs of an older person, we tend to consider only their weaknesses. Our primary concern should be their strengths and abilities and then to build on these. Treatment goals for the sick or elderly which focus on infirmities will tend to quickly deteriorate abilities.

Nursing home care is expensive both in terms of money and manpower. For some it is the only alternative but this is an extremely small proportion of older people. It should not even be considered until every alternative has been objectively eliminated. Any excess in the amount of help given the older person, beyond that which they need, will result, and often quickly, in less ability for them to help themselves.

The increased abilities of medical science to enable so many people to live much longer has been accomplished by just as dramatic a growth in their ability to remain more or less independent longer. Social Security, pension programs and health insurance have provided at least a modicum of financial independence. Automatic heat, electrical appliances, modern cooking and laundry equipment and synthetic fabrics have all decreased household chores to a capacity far beyond the abilities of older people a generation or two ago.

This country was founded to gain independence and two centuries later we still must exert every effort to give our older neighbor or relative just as much independence as they wish. But this takes effort, it takes cooperation, planning, initiative, coordination of programs and services. First of all it takes a willingness to open our minds to fresh ideas and probably the most difficult of all it takes the readiness to cast off those comfortable old familiar cliches and traditional values.

Cooperation—because one institution, regardless of how excellent it may be, can only offer the services of that institution. However, a coordination of programs and services can offer a variety of options which can build on the persons physical, mental and financial assets. This may require admitting that this institution of which we are so proud (and justifiably so) and for which we have worked so hard, and has a long waiting list, in spite of the costs, is not really the answer for everybody.

We have heard and read a lot recently about "appropriate levels of care." To me, this represents a negative approach. A more realistic attitude, which would assess the need in terms of a person's abilities might be "appropriate levels of lack of care." We can easily facilitate physical and mental deterioration by too much care or we can prolong and even increase mental and physical health by providing both adequate opportunities and care.

Alternatives to nursing home or institutional care must begin both with the person and with the community. Planning with the person can be best accomplished at a central place which has the staff capable to evaluate his abilities and needs. This central place must also have at its disposal the facilities, either of its own or by agreement or contract, to enable those abilities to be fully utilized and needs met.

Planning within the community should be aimed at providing independence and using the talents of the elderly. This includes the whole gamut from job opportunities to nursing homes.

It would include: Information counseling and referral services (often just to provide peace of mind); volunteer services (including telephone reassurance programs); these should be both by and for older persons; home health services; homemakers; day care centers for the elderly; senior centers and drop-in lounges; apartments for independent living or congregate living; employment services.

Sounds like a big order? It really isn't. The need is there and the opportunity is greater. All of it is easier and more economical than nursing homes.

In 1961 the Cardinal Ritter Institute was founded in St. Louis to provide for the needs of the elderly and chronic sick through coordination of existing services and the development of new services. The majority of its efforts have been directed towards noninstitutional care or to paraphrase: To safeguard the scarce and expensive institutional bed for those who lack the ability to stay out of it. In 1972 the Cardinal Ritter Institute served 13,585 elderly people who were not in institutions. The growth of the Cardinal Ritter Institute and its ability to solidly establish and develop most of the above-mentioned programs demonstrate that it can be done and rather quickly. Attached are a brief history and the annual report of the institute which describe what has been accomplished in 11 years.

[Enclosure.]

In this era of scientific progress, prosperity, vitamins, and greater longevity how do you keep from building more, more and more facilities for care of the aging? *You invent a Cardinal Ritter Institute.*

And once you start a place like the Institute there are those who say it's like rolling down a hill without brakes, falling into an ocean of tantalizing possibilities.

It can be reduced to a crackling page or two of statistics.

It can be described in a few simple sentences.

But the Cardinal Ritter Institute is neither dry statistics nor simple procedure. This is its story. (With a little history thrown in.)

As a seedling, Cardinal Ritter Institute was the department of aging housed in Catholic Charities offices. It began with three people, \$3,000 and hope. That was 11 years ago. In time it grew out of house . . . had to find its own home . . . and did, at 4532 Lindell. That year, 1965, it was renamed—after one of Christian St. Louis' prime innovators, Cardinal Ritter.

Today, 1973, Cardinal Ritter Institute is a nest of projects, wholly absorbed in and by the problems of aging. Its major program . . . home care . . . relates directly to the challenge of caring for the elderly and chronically ill in their homes. It is based on a simple discovery. Even if old people have money, and even if there were enough institutions to go around, most would never step foot inside one if they could help it. Old folks are happier in their own surroundings. Yet, in the face of increasing frailties or illness, how to sustain them?

Instead of building an institution, Cardinal Ritter Institute built a home health team, agency based, in direct cooperation with DePaul Hospital in St. Louis.

Since money was certainly an object, major resources were contacted and made aware of the goals of the infant program, United Fund . . . Blue Cross . . . the U.S. Government. Response was friendly, interested and concrete.

In September, 1964 a most significant opportunity presented itself in the form of a Federal grant of \$400,000 under the Community Health Services and Facilities Act. That 3-year grant allowed Cardinal Ritter Institute to gather its team. Medical coordinator, nursing services, social casework, homemaker services, physical, occupational and speech therapy. From the start it was understood that the patient's physician remained in charge—that the health team would "fill the prescription."

With everyone on staff, there was a policy of the open mind as well as heart. How can we change? How can we improve? When do we add? Subtract? Take a big new step. Take no step at all.

The grant money also allowed for research, a study of the services from a quality as well as cost standpoint. At first, two groups were selected for this study: Those discharged from DePaul Hospital and those who lived within the boundaries of 10 neighborhoods which represented a socioeconomic cross-section of the community. The minimal age for candidates was 55. These were paying patients, indigent patients, and those whose private insurance covered.

By December 1966 the Cardinal Ritter Institute program had expanded to include four hospitals, and in order to provide more complete home care service for these, it became necessary to abandon the criteria of age and chronic illness.

With the advent of Medicare, Cardinal Ritter Institute, designed and directed as it is, was immediately certified. Another great blessing . . . for even though the age criteria had been dropped, 81 percent of the institute's clients are over 65.

The simple statistics of home care are dazzling.

During the 6 months which included the beginnings of Medicare . . . from July through December, 1966 . . . there were 1,879 nursing visits, 471 physical therapy, 67 speech therapy, 54 occupational therapy, 529 medical social service, 2,880 home health aide visits (or 17,197 hours). Friendly visitors, a volunteer service, gave 1,070½ free hours.

In 1972, 2,478 people received 18,918 nursing visits, 3,978 physical therapy visits, 314 speech therapy, 201 occupational therapy, 1,833 social work, 33,771 home health aide visits and friendly visitors gave 15,946 hours.

The *home care* program has formal affiliation with ten hospitals and also accepts referrals from physicians anywhere in St. Louis, St. Louis County or St. Charles County.

And the whole sophisticated array of care dedicated to one purpose . . . keeping the client functioning as normally as possible in his own dear surroundings. Some patients may need the "works." Others only nursing service. Or physical therapy. Or both. Or maybe a home health aide can hold the family on an acceptable level of activity.

After a case is referred by a physician for one or more of home care services, the nurse or therapist goes into the home to evaluate the need. As soon as possible, or perhaps even first, the social worker goes, particularly if there is indication of a disturbance, anxiety, or economic need. (And there very often is one of these problems present.)

The evaluative efforts on the part of medical personnel and social worker, provide the client with promise of help for the *whole* man. Subsequent visits by any others of the team are tuned in to the original needs as recognized and prescribed first, by the doctor, then by these Cardinal Ritter Institute evaluators. Weekly staff meetings at the Institute keep everybody in touch with current developments in the active cases.

The client, who may or may not be fully aware or appreciative of the sophisticated spectrum of attention he receives is nevertheless at the same time becoming a happy statistic on his own . . . in that each one successfully cared for in the home adds to the growing number kept out of institutions or released from hospitals sooner, because of Cardinal Ritter Institute home care.

There is correlative beauty in the team work.

Problems overlap, intertwine, trip over each other. People have physical difficulties aggravated or perhaps even caused by emotional pressures. Families react badly. Little worlds explode with tension, pain, loneliness.

The Cardinal Ritter Institute nurse is all independent performer, able to make decisions, working freely and creatively within the fences of her commitment . . . to doctor's wish, agency policy, her own humanity. She helps her patient's physical discomfort to the best of her ability. She's quick to observe change. Her smile is the beginning of a nice piece of social work. Comes the social worker and the underside of a worry is disclosed. "How are we going to manage?" "I haven't been getting my checks on time." "If I have to go to an institution *why* do I and where will I go?" "How much do they cost?" or "I'll never get used to being blind." "What good is a person without two good legs?" "I'm lonely." "Afraid." The social worker listens. Since he's a trained answer-finder he sets to work. Getting an answer is somewhat like trying on shoes. The social worker seeks the right fit for the given problem. Some are a breeze. Others . . . well. Maybe that cranky, hostile old man just wants attention, or maybe he's afraid that if he stops fussing he'll remember how frightening it is to be old. Maybe he's had enough of sore bones, poor appetite, and \$74 a month, or maybe he's a born grouch who now no longer cares who knows it.

The social worker seeks to discover. Then to help. Sometimes the nurse or therapist gives him a valuable clue. Or sometimes the home health aide, another member of the team, who because she stays in the home several hours at a time, can observe physical changes or the development of emotional problems and report them. (If not expertly at least perceptively and empathetically.)

Nurses, therapists, social workers, aides . . . each "sees the patient differently." As a result, the client gets the benefit of much highly skilled attention. Sometimes the "reason why" in a problem case gets pieced together like a jig-saw puzzle, from several members of the team. Everybody works . . . cares . . . succeeds or fails . . . together.

Cardinal Ritter Institute is proving the truth of home care. It works. Efficiently, and with heart.

Part of the "heart" is provided by a sort of kid-sister project . . . the friendly visitors. Because there are so many ways old people who can be helped outside the aegis of expensive professional care, this particular volunteer program was developed. It takes into consideration the prime fact of loneliness among the aging. Visitors not only visit, read for or perform little tasks in the home of the aging but may also take them to church, shopping, to a movie. The program is literally designed in with home care. Regular reports of visits . . . how many . . . how satisfactory, are made at weekly staff meetings.

What is a home health aide? Certainly not a nurse, but she is trained to do some simple personal care in giving baths, feeding, transfer of patient from bed to chair, etc. She's not a day worker but will pitch in and strike order out of chaos in homes where it is necessary. She's not a cost accountant, but she can help people shop more wisely. She is also taught to observe signs of change in the patient, physical and emotional. She stays with the patient longer, gets to know him or her quite well. She assists the nurse, sometimes puts her finger on a complicated emotional problem. She can, under careful supervision perform supportive activities in the area of the three therapies. She's a little of everything, but most importantly, the valuable continuing link between agency and client. Under Medicare the need for her kind grows daily.

Started at the same time was the *counseling, information and referral program* which, at one location, gives people the opportunity to explore all possibilities for assistance both institutional and noninstitutional. Of the 3,405 people who availed themselves of this service in 1972, the majority decided that they did not need help at that time. Talking over their problems and learning that help would be available when needed relieved their anxieties and made them able to continue independently for some time.

The problems of the world of the elderly are as many as its populace. Finding answers for them is something Cardinal Ritter Institute wants to set its creative potential to work on more ambitiously. In its simplest term the service means "opportunity for the aged and their families to meet with trained caseworkers to help them evaluate their problems and then to work out satisfactory solutions." Any person, regardless of race or religion. To that end Cardinal Ritter Institute works very closely with other community agencies and services to acquaint itself with their scope and at the same time to allow them to learn about its own and each other's facilities. Thus, an exchange or language of service exists which more easily facilitates movement of clients from one to the other when necessary.

Central intake.—Again at one location admissions to five nursing homes is centered at the Cardinal Ritter Institute. In 1972, 2,286 people applied for institutional placement and in more than one-half of these instances home health service was determined to be the better answer for their needs. This program eliminates the necessity of people running from one institution to another before they can determine the availability of beds, their ability to pay the charges and the services offered at each institution.

The Foster Grandparent program.—Here are people with two needs. To receive, and as importantly, to give. Foster Grandparents are over 60 years old, from below poverty income levels, to comply with conditions of the Office of Economic Opportunity grant under which the program operates.

They function in one of the richest pools of need in the community . . . institutions for children who are dependent, retarded and emotionally disturbed. Youngsters who wouldn't eat, never laughed, refused to talk . . . hostile children; lonely, shy, explosive, inhibited, outrageous children are their challenge. Of 300 interviewed, 76 are now working among nearly 1,000 such children in five area institutions . . . State School and Hospital for Retarded Children, Child Center of Our Lady of Grace, Annie Malone Children's Home, Edgewood Children's Center, and Methodist Children's Home of Missouri.

The Foster Grandparent works a half day, 5 days a week. He or she is not assigned to a particular child. They discover each other. Once acquainted, what the two do together is pretty much their own business. They read. Talk. Maybe build something. Draw; sing. Some of the children have never had a parent, grandparent, other relative or friend visit them. Ever.

A Foster Grandparent is the gift of love to a lonely child. "Like sunshine to a tree." The child is the pleasant eruption of new challenge in the life of the older person. At Cardinal Ritter Institute, the Foster Grandparent program is another tantalizing possibility successfully explored.

The *senior aide program*, funded by ACTION, provides employment for 60 older low-income persons who perform useful jobs on a part-time basis in various community service agencies.

Social Services.—Trained social workers helped 263 older people in 1972 resolve problems relating to age. These problems included finances, housing, family tensions and emotional concern or loneliness.

The *homemaker program* served 180 older people most of whom were discharged from the city hospital to their own homes. They no longer needed medical attention but were unable to maintain their own home without temporary assistance, mostly in the areas of cooking and cleaning.

The *senior center* is maintained in two public housing buildings for the elderly and serves 638 people. Services include recreational and social activities, adult education, library services, nutrition and meals and health consultation by a nurse.

An *RSVP program*, also funded by ACTION, has 167 volunteers all of whom are elderly and who volunteer their services in a whole variety of health and welfare organizations. This program is expected to expand to 500 volunteers within the next four years, all of whom will be men and women age 60 or over.

Phonc-a-friend employs the services, on a volunteer basis of 60 retired people who everyday call another older person, most of whom are living alone, to relieve their social isolation and to reassure them that a friend is available. If the call is unanswered, an emergency number is called and help is immediately available as needed.

The *parish aide program* recruits part-time help for older people living in their own homes. In 1972, 616 older people obtained the part-time services of maintenance, custodial, cleaning, shopping, etc.

In an effort to alleviate the tremendous need for housing of the elderly who are able to care for themselves, the Cardinal Ritter Institute has several *housing programs* in operation. Through a contract with the Public Housing Authority of the city of St. Louis we manage over 1,100 units of public housing for the elderly. This management not only includes building maintenance, rent collections, rentals and repairs but also includes all of the social, recreational and health services that older people need. We cosponsored and manage a 195 unit apartment building, Santa Ana Apartments, for the elderly. At the time of the present freeze on public subsidized housing we had several other applications pending with HUD.

WHAT DOES IT ALL MEAN?

Cardinal Ritter Institute, which began with three people, stayed alive on a feast of ever-growing needs, grew with enthusiasm . . . now wants to be expert on a whole category of humanity.

Wants to know who's getting old. Why, how, when.

Wants to help old people laugh, cry, worry . . . grow, accept, fight. To help cure, certainly . . . or at least, to sustain.

Wants to take up more and more of those tantalizing challenges which can be born in a moment so small—as the timid look of hope on a fragile old face.

REPORT GIVEN TO THE BOARD OF DIRECTORS ON DECEMBER 21, 1972,
BY JOHN M. LALLY

140 terminally ill patients under care expired between January 1, 1972 and November 30, 1972.

These patients were under care for a total of 20,000 days.

7,000 miles were traveled in bringing service to them.

\$6,000 worth of medical supplies were used in their care.

\$15,000 worth of medical equipment was rented for their use.

6,200 visits were made to them by Cardinal Ritter Institute staff.

The total bill for this health service was \$94,000.

At current hospital rates in St. Louis it would have cost \$1,768,400 to have kept these patients in the hospital.

At current nursing home rates in St. Louis it would have cost a minimum of \$350,000 to have kept these patients in nursing homes.

If these patients had been hospitalized for only the last 2 weeks of their lives, it would have cost \$162,000—about 75 percent more than it cost Cardinal Ritter Institute to care for them on an average for nearly 5 months.

But monetary considerations pale into insignificance when we consider the human value of this service. Without this service many of these patients could not have remained at home in a place they love and surrounded by people they love. These 140 patients and their families were experiencing what surely is one of the most poignant times that man experiences in his lifetime—the time of death. Our staff was there to bring not only skilled care but also support and confidence to the patient and to those at home caring for the patient.

I can speak with some authority when I emphasize how much home health services mean to a dying patient and the family caring for that patient—because one of those 140 patients who died on our program in 1972 was my own mother and one of those families was my own.

You, as the board of directors, can be proud and can take satisfaction in knowing that the agency you direct is providing a most meaningful and necessary service—and is doing so with professional excellence and at the least possible cost.

ITEM 4. LETTER FROM HARRY F. WALKER, EXECUTIVE DIRECTOR, COMMISSION ON AGING, DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES, STATE OF MARYLAND, TO SENATOR MUSKIE, DATED JULY 11, 1973

July 11, 1973.

DEAR SENATOR MUSKIE: Thank you for your letter of invitation to the hearings on alternatives to institutionalization and inviting our comments and suggestions.

On the basis of studies that have been conducted in Maryland concerning alternatives to institutionalization, I would like to list the following priority areas:

(1) Expansion of payment mechanisms for community services under Medicare and Medicaid.

(2) Inclusion of home health benefits under all third party payment grants such as Blue Cross-Blue Shield.

(3) Expansion of geriatric evaluation screening, locating, and followup services.

(4) Reordering of local health department priorities to give greater emphasis to the needs of the elderly.

(5) The need for greater integration of community agencies.

As a further suggestion, you may want to consider inviting individual State units on aging to submit statements to you based on experience in their own States. I think this might be more effective than a "policy" statement from the National Association of State Units on Aging. However, if you would like to have such a statement from our national organization I will be glad to prepare one for you.

Sincerely yours,

HARRY F. WALKER.

ITEM 5. LETTER FROM EDWARD J. WILSMANN, PRESIDENT, HOMEMAKERS HOME AND HEALTH CARE SERVICES, INC., TO SENATOR MUSKIE, DATED AUGUST 16, 1973

August 16, 1973.

DEAR SENATOR MUSKIE: The following comments are respectfully submitted for consideration by the Subcommittee on Health of the Elderly of the U.S. Senate Special Committee on Aging dealing with "Barriers To Health Care of Older Americans" (Part Four: Home Health Care). This presentation will concern itself with primarily one "barrier to health care of older Americans"... the shortage of manpower and the exclusion of proprietary home health care providers under Medicare and Medicaid.

I am Edward J. Wilsmann, president and founder of Homemakers Home and Health Care Services, Inc., a wholly-owned subsidiary of The Upjohn Company of Kalamazoo, Michigan. Homemakers has offices in over 150 areas across the country employing approximately 35,000 health care personnel... the nation's largest provider of home health care. In 1973, Homemakers will provide 11.4 million hours of service. Approximately 1/3 of the offices are independently owned and operated by franchisees and the others are company owned. Homemakers plans 400-500 offices by 1975.

Personnel in each office include registered nurses, licensed practical (or vocational) nurses, nurse aides, homemaker-home health aides, companions, child care, home managers, housekeepers and others.

Because Homemakers is not an employment agency, the company is responsible for the services rendered by its employees. Homemakers personnel are skilled, reliable individuals, bonded and insured in the performance of their duties.

In addition to home services, Homemakers provides staff substitutions in hospitals, nursing homes, clinics, doctor's offices, and industry, as well as private duty in hospitals and nursing homes.

Homemakers provides services 24 hours a day, 7 days a week, 365 days a year. After regular office hours we can be reached through our answering service.

Homemakers recruits its own employees. Some of them are from that segment of the labor market desiring work on a part-time basis while others seek full-time employment with the challenge and interest of varied work assignments. Because of these latitudes, Homemakers is able to provide its many services efficiently, while making available to people with critical skills in the community a broadened opportunity to use them.

It is estimated that 30,000 homemaker-home health aides are employed in "certified agencies" (under Medicare and Medicaid) and that the estimated need is for 300,000. As I mentioned above, we employ about 35,000 health care personnel which could double the available number of personnel and services to older Americans if Medicare and Medicaid did not exclude proprietary providers.

It seems to me that in order to provide a complete, comprehensive and workable home health program, the resources of both public and proprietary providers must be involved. This can be stated as an axiom regardless of any suspicions cast on the for-profit sector or claims of bureaucratic inefficiencies directed at the public and non-profit sector for one simple reason: Combining all the public and private, tax-paying and tax-supported providers together, there still is currently and projected for in the future a shortage of health care facilities, manpower, financial resources and coordination. Therefore, there seems to be no alternative but to combine the resources of both the private proprietary health care industry with the public not-for-profit providers of health care.

Throughout history, there has been a tendency for the lay public to take a dim view of those who profit from others' misfortunes. The entire proprietary medical and health related industry has come under this attack. Drug and health equipment companies, private patient care institutions and even the medical profession itself has come under attack. Almost everyone that has experienced a medical misfortune has experienced afterthoughts that someone has taken advantage of their malady to further his own well being. How many times has it been mentioned that "My doctor took his family to Europe on my gall bladder," or "You know the new wing of the hospital, I paid for that with my kidney stones." Or as was written on a washroom wall in the current "hip" graffiti style, "Health care costs make me sick."

The not-for-profit and the for-profit health care providers have been equally attacked and have often been played against each other. The key to a successful co-existence of both types of providers is a set of adequate but not restrictive controls on standards, accountability, organization and incentives for efficiency. To determine the eligibility of a provider of health care on the basis of the provider's profit or non-profit structure is discriminatory and wasteful. Participation must be based on quality, availability and reasonableness of cost of service which will encourage competition for the provision of these services.

Many of the current proposals for national health care legislation encourage participation from the private sector of health care providers. This is particularly true in some of the variations of the Health Maintenance Organization concepts that have emerged. However, in all national health insurance proposals that we have analyzed, the standards of eligibility for providers of service are generally based on Section 1861 of Title XVIII of the Social Security Act. These standards are restrictive in that there is definitely a discriminatory approach taken against the private, for-profit provider. The regulations implementing Sec. 1861 further complicate the position of the proprietary provider.

The reason that the conditions of participation of the home health agency is being emphasized is that the qualifications for participation of proprietary home health agencies are the most restrictive of any requirements placed on proprietary providers. Therefore, using the home health agency as an example cites very clearly the inequities that should not be incorporated in any future legislation, regardless of the type of health care service provided.

I also feel that the provision for home health care as a coordinated alternate to institutional care should be emphasized in any future health program. The availability for home health care coverage in national health insurance, for instance, will complement the services of the institutional providers conserving facilities, capital and manpower.

Time after time proprietary home health care providers have been approached by non-profit certified home health agencies to provide supplemental services that the agency itself was unable to provide. In most instances the services of the proprietary agencies met every test of the Medicare regulations under 1861(O) except that they were and are tax-paying organizations. The results being that in many cases the required services that could not be provided by the certified agency went unprovided or, in some instances, the service was ultimately arranged with a public or not-for-profit agency at a higher cost to the certified agency.

We are actively involved with the Standards Committee for the National Council for Homemakers Home Health Aide Services, Inc. which has been designated in the Federal Register as one of the standard setting bodies under the Social Security Act. We are a firm believer and promoter of high standards for home health care and intend to promote this position regardless of our ability to participate in providing services under the Social Security Act. We feel, however, that the exclusion of the proprietary for-profit agency from providing basic and supplemental services is causing many home health needs to go unmet.

We have in the past made attempts to determine the rationale behind the discrimination of the private for-profit (taxpaying) organization in national health legislation. The answers to our inquiries have been in our minds weak and, if factual, without grounds.

We would like to extract a portion of a letter of reply to this question from Mr. Alvin M. David, Assistant Commissioner for Program Evaluation and Planning, Department of Health, Education, and Welfare.

"The primary objective of making the conditions for participation for proprietary home health agencies somewhat more demanding than those applicable to public and nonprofit home health agencies is to assure that participating agencies are in fact capable of providing skilled health services. When the Medicare program was enacted in 1965, organizations providing organized home care on a profit basis were practically nonexistent. Because it could not be known at that time what form profit-making home health agencies would take if they were established, the law permits participation by such agencies only if they are licensed and meet the high standards which existing nonprofit agencies offering organized care meet. So far, we have not seen sufficient evidence to change our views in this regard. Consequently, I cannot give you any encouragement on your proposed changes in the home health provisions of the Medicare law. Under the circumstances, it would seem that the most feasible means for achieving your objective is to encourage State legislatures to provide for licensing of proprietary home health agencies."

We would like to analyze this reply point by point.

1. The admission that conditions for participation of proprietary home health agencies are "somewhat more demanding" is an admission of unequal treatment. A demand that proprietary agencies *equal* those of the public and not-for-profit should assure that they (proprietary agencies) are "... capable of providing skilled health services."

2. It is true that proprietary providers of home health care were "practically nonexistent." However, we feel they were prejudged as potentially inferior. The qualification that they "meet the high standards which existing nonprofit agencies offering organized care meet" is certainly acceptable, but to require additional licensing (by State Legislation) is unnecessary if the proprietary can meet all Federal standards.

3. The next statement which states "... we have not seen sufficient evidence to change our views in this regard," is, of course, obvious. There can be no evidence of the ability of the proprietary agency to perform under Federal control if no demonstration project has been undertaken.

4. To pursue each State legislature to provide for licensing is an impractical task with built-in inefficiencies. To operate a national multi-location home health organization with economy and efficiency is all but impossible dealing with 50 different states with different standards of qualifications. Federal sanctioning of proprietary home health agencies and *all* proprietary providers of health care would greatly enhance the coordination of a national health care insurance pro-

gram. Compliance under a single set of Federal standards would add greatly to the program's efficiency.

The foregoing discussion is applicable to the HR 1 bill (Congressman Al Ullman—American Hospital Association), "The National Health Care Services and Reorganization and Financing Act." Section 141(a) assures for-profit providers of their rightful place in health care delivery by the language "(. . . through its own facilities and personnel or through other providers, non-profit or for-profit) . . ." However, for-profit, taxpaying home health agencies have once again been excluded from serving in all but seven (7) states when under Section 228 (d) (1) (B) it says ". . . through an affiliated provider that is a 'home health agency' as defined in Section 1861(o) of the Social Security . . ."

It is Section 1861(o) and the regulations promulgated under it that prohibit taxpaying, for-profit home health agencies from serving under Medicare and Medicaid in 43 states, and prohibit for-profit home health agencies from contracting their services to not-for-profit agencies in all 50 states.

From Section 141(a) of this bill, it is easy to see that the intent was to include proprietary providers of all kinds. The important point is, however, that whether this act or someone else's becomes law, home health agencies will be written in just as in this case—by reference to Section 1861(o) of the Social Security Act—which will prevent taxpaying, for-profit home health agencies from making their potentially tremendously beneficial contribution to health care delivery in this nation, unless we do something about 1861(o) and its regulations now.

I'm taking the liberty of attaching for your review recommendations for revision, changes and additions to the "National Health Care Services Reorganization and Financing Act" (H.R. 1).* As you will notice, these recommended revisions appropriately include home health care services as they should. However, you'll note that again the proprietary provider is clearly excluded as in Section 228 (d) (1) (B).

The value of the proprietary provider is slowly beginning to be recognized by some, however. May I call your attention to the publication "Alternatives to Nursing Home Care: A Proposal," prepared for use by the Special Committee on Aging United States Senate by staff specialists at the Levinson Gerontological Policy Institute, dated October 1971. This document deals with the concept of the "Personal Care Organization" (PCO), a health service system providing an alternative to nursing home and institutional care by providing maintenance and personal care services for the elderly and disabled in non-institutional neighborhood settings. The authors suggest on page 22, item H, "Alternatives in Administration," that "a family service agency, a health maintenance organization, even a proprietary organization (such as Homemakers, Inc. of The Upjohn Company) could equally well develop into a P.C.O."

As a provider of proprietary home health care services, we feel we can make a definite contribution in overcoming "barriers to health care of older Americans." We have facilities, manpower, operational methods, materials and systems. We also have the management expertise developed through competition and free enterprise to offer to those who might seek our advice. We have found that we are able to work in harmony with the public and not-for-profit providers to accomplish better and more comprehensive health care in many communities throughout the country. We feel that we can go even further with this relationship if we are allowed to participate on an equal basis with the public and private not-for-profit entities. If this creates competition for serving the nation's health needs, should this be feared? We think not. With adequate standards applied equally to all providers of health care, it should stimulate quality, quantity, efficiency and economy.

Thank you, Senator Muskie. We appreciate this opportunity to present our views as we are vitally concerned about the future direction of health care for the elderly. If we can be of further help to you or the committee, please don't hesitate to call upon us at any time.

Respectfully submitted,

EDWARD J. WILSMANN,
President.

*Retained in committee files.