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THE COMMUNITY HOME HEALTH SERVICES ACT OF 1981 (S.234)

INTRODUCTION

The number of elderly Americans has been growing rapidly and this expansion is expected to continue for many years. Each day there is a net increase of 1,600 persons over the age of 65. By the year 2030, the elderly are expected to comprise 18.3 percent of the total population, up from the current figure of 11.3 percent.[1] Even more dramatic are the projected increases in the over-75 and over-85 age groups. These changes in the population of the elderly portend a corresponding future need for expanded long-term health care services.

Today, some 1.3 million Americans, including 5 percent of those over the age of 65, are confined to nursing homes or similar institutions.[2] Because elderly persons typically have poorer health than other groups in society, their use of health services, particularly nursing homes, is expected to grow swiftly in the future. By the year 2000, some 2 million people may be living in nursing homes unless the present policy toward long-term care is changed and the trend toward over-institutionalization is reversed.[3]

The cost of nursing home care services is high. In 1979 alone, these expenditures amounted to $17.8 billion, with 56.7

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1 Statement of the National Retired Teachers Association and the American Association of Retired Persons in Hearings before the Committee on Labor and Human Resources, U.S. Senate, on S. 234 -- The Community Home Health Services Act of 1981, March 4, 1981, p. 113 (hereafter Hearings).

2 U.S. Department of Health and Human Services, Long Term Care: Background and Future Directions (HCFA 81-20047, January 1981), p. 15.

3 Hearings, p. 114.

percent paid by the federal government.[4] While the need for long-term care is rapidly escalating, the government's ability to raise the revenues necessary to provide such care is limited. To avoid the prospect of a costly build-up of nursing home facilities, a thorough re-evaluation of federal programs that finance long-term care must be a top priority.

One alternative to institutionalization is increased use of home health care services. However, movement in this direction has been retarded, largely by Medicaid and Medicare policies that create financial incentives which favor care for the chronically ill elderly in nursing homes. Senator Kennedy commented in recent hearings that: "The lack of adequate alternatives to institutionalized care for our Nation's disabled and elderly is a serious gap in our health delivery system."[5] One reason for this void is the problem of verification of home care services under Medicare or other insurance programs. With the proper incentives, however, greater reliance on home care can help to meet the growing health needs of the American people at a reasonable cost.

BACKGROUND

Medicare, Medicaid, Title XX of the Social Security Act, and the Older Americans Act are the four principal government programs that provide home care services to the elderly. Medicare is the largest and fastest growing of these government programs, with a projected spending level of $1.146 billion in fiscal year 1982 -- an increase of about 300 percent over the 1976 level.[6] Medicare funds for home health services are used to provide skilled nursing; physical or speech therapy; home health aide assistance; and medical supplies and appliances. To qualify for home health coverage under Medicare, a person must be homebound, under a physician's care, and in need of skilled nursing care and/or physical or speech therapy on a part-time or intermittent basis. The care must be prescribed by a physician and the services furnished by a certified home health agency.

The home health services offered by Medicaid are similar, although they may vary from state to state. States may impose restrictions such as visit and reimbursement limits, and prior authorization of services. However, a patient need not be homebound or in need of skilled care to receive benefits.

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4 U.S. Department of Health and Human Services, op. cit., p. 15.

5 Hearings, p. 2.

6 Statement of Eleanor Chelimsky, Director, Institute of Program Evaluation, United States General Accounting Office, before the Committee on Labor and Human Resources, United States Senate, on Expanded Home Health Care, November 10, 1981, p. 6.

Despite the growth in home health care expenditures, there still appears to be an unmet demand for home care services. In a 1977 report, the Congressional Budget Office (CBO) compared the potential need and the available supply of home health care and found that 1.7 to 2.7 million people were in potential need of expanded home services, but only 300,000 to 500,000 were receiving them. In addition, between 20 and 40 percent of all institutionalized persons were inappropriately placed and could be cared for in less intensive settings if adequate community care were available.[7]

CBO further estimates that in 1976, 90 percent of all public long-term care expenditures went to provide nursing home services, with less than 10 percent for home health services.[8] The lack of adequate financial assistance for community-based health care services has forced many elderly to enter a nursing home even if they prefer to remain at home.

THE PROBLEM

The main reason for the relatively low level of long-term care in the home seems to be because Medicare, Medicaid, and other federal programs offer little or no financial coverage for such care. In fact, Medicaid actually discourages long-term care in the home by providing full or partial coverage of the patient in a nursing home.

Medicare's home health care coverage is aimed primarily at serving the elderly with acute care needs and, as a result, it largely excludes those who require extended care. Requirements that the recipient be homebound and that the services be performed by skilled professionals are particularly restrictive. Clarifying the definition of homebound and eliminating skilled care provisions would enable those who are not confined to their homes but require care to be treated in the home.

Medicaid's home health coverage, like Medicare's, is oriented toward the delivery of acute care services. This is apparent from comparing the fiscal year 1979 total state and federal Medicaid expenditures of $346 million on home care with the $8.8 billion spent on skilled and intermediate care facilities.[9] There are two reasons for this inherent bias. First, the elderly poor who are not eligible for Medicaid coverage in the home, but cannot afford long-term care, may qualify if they enter a nursing home because of different income standards for nursing home

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7 Congressional Budget Office, Long-Term Care for the Elderly and Disabled, February 1977, p. x.

8 Ibid.

9 Hearings, p. 126.

residents in many states. Second, family members are held financially responsible for Medicaid patients only while they are all residing in the same household. If the Medicaid patient is placed in an institution, no financial liability is imposed on other members of the family. Thus, the elderly not eligible for Medicaid outside a nursing home may transfer their assets to relatives and become eligible for Medicaid coverage of nursing home care, or, as is increasingly the case, they may enter a nursing home, deplete all of their financial resources, and then become eligible for Medicaid's nursing home benefit.

THE COMMUNITY HOME HEALTH SERVICES ACT OF 1981

Medical advances have extended the human lifespan dramatically. With advancing age, however, people are more likely to suffer from chronic conditions that require treatment over an extended period of time. As the elderly population grows relative to the total population, there will be a smaller proportion of young people in the labor force to pay the taxes which finance programs aiding our older citizens. As public funds become scarce and the need for long-term care grows, every effort possible should be made to encourage alternative arrangements, such as among family and friends, church groups and community-based organizations. The idea of shifting the provision of health care to families and other groups also fits in with the Administration's approach to meeting the nation's health care needs. Until recently, however, policies designed to help the elderly not only failed to utilize these human resources, but often supplanted them, leaving many persons no reasonable choice other than nursing home care.

There is finally some support for an effective alternative to institutional care. Legislation has been introduced in Congress to encourage establishment of home health programs, to provide expanded coverage of home health services under Medicare and Medicaid, and to encourage individuals to provide for the care of elderly dependents in the home. The Senate bill (S. 234) is sponsored by Senator Orrin Hatch (R-Utah), and the House bill (H.R. 2414) by Representative Guy Molinari (R-NY).[10] The proposed legislation opens the door for alternatives to premature and unnecessary institutionalization. It emphasizes the need for treatment, not the setting, and stresses that the home may often be the most appropriate and cost-effective setting for needed health care.

The measure has considerable bipartisan support in the Congress. Although the Administration has not taken a position,

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10 The bills were identical when introduced, but the Senate has modified its version somewhat. The discussion in this paper will be restricted to the Senate bill.

Robert Rubin, Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, notes home health agencies and other innovative approaches to health care have "much long-run potential for cost-savings."

PROVISIONS OF THE BILL

Grant Authority

The bill would amend the Public Health Service Act to provide grants to public and non-profit private entities and loans to proprietary home health entities for the specific purpose of meeting the initial costs of establishing and operating home health programs. Further, the grants could be used to provide training to professional and para-professional home health personnel. Priority in awarding grants and loans would be given to areas that do not have home health services and/or those without adequate transportation to serve the elderly.

Medicare and Medicaid Amendments

The bill would broaden eligibility standards for those needing home health care under Medicare to include skilled nursing care, the services of a homemaker/home health aide on a part-time or intermittent basis, or physical, speech, occupational, or respiratory therapy. The decision to provide a homemaker/home health aide would be contingent upon an evaluation of all available alternative resources in the community in an effort to maintain and not displace current support if already received.

Home health care services such as skilled nursing care and physical and speech therapy would be reimbursed at the current level of 100 percent, as would occupational and respiratory therapy and the homemaker/home health aide services needed in connection with these services. To discourage the participation of individuals who are not in absolute need, those homemaker/home health aide services received alone or without additional services would only be reimbursed at 50 percent.

Both chronic and acute care would come within the purview of home health benefits. In addition, the definitions and terms used to describe home health services under Medicare would also be the same under Medicaid.

The bill would request the Department of Health and Human Services to assemble and study all available information on alternative reimbursement mechanisms for home health agencies in order to determine the most cost-effective and efficient ways of providing home health services.

In an effort to provide Medicare/Medicaid reimbursement to established, responsible, and cost-effective programs, the Secretary would have waiver authority over the certification requirement

of the home health agency, if the provider of the home health program can prove he is worthy of the waiver.

Income Tax Credit

Finally, a $500 tax credit would be available to individuals who support a dependent person in their home.

ARGUMENTS IN SUPPORT OF THE BILL

Supporters of the bill point out that home health care is a more humane way of treating individuals who do not need to be institutionalized. One patient at the Chelsea Village home health care program expressed the sentiments of many when she said, "Thank God you are here, if only you will help me stay out of a nursing home."[11] Her fear of institutionalization appears to be common among the elderly. Older people placed in hospitals or nursing homes when they do not need to be there suffer from the regimentation and lack of independence that is all too common in institutionalized settings. Furthermore, persons in institutions tend to acquire a sense of dependence, and their chances of returning to the community are reduced.

A number of studies report that patients who received home health care services experienced reduced mortality rates and slightly higher contentment levels.[12] For example, reports from the Triage program and the On Lok Day Health Services program reveal that participants were significantly more satisfied with their condition than nursing home residents with theirs. This bill makes these benefits more readily available to those persons that need care. Because rural areas, in particular, have lacked comprehensive health services, patients from

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[11] Bernard Weinraub, "Taking the Hospital to Homes of Aged," The New York Times, June 18, 1981, p. B14.

[12] In one such study, Dr. William Weissert noted a caveat with regard to the finding of higher contentment levels and increased longevity:

> [T]his may have been due directly to eagerness on the part of homemakers to call in health care professionals who hospitalized the patient in time of crisis. When patients who were not hospitalized were compared, homemaker services showed no beneficial effects. Thus, it may have been hospitalization, not homemaker care, that kept alive and thereby sustained their contentment levels. If so, there are probably less expensive ways than providing homemaker services to do case findings and surveillance that gets old people into hospitals in a timely fashion.

See William G. Weissert, "Toward a Continuum of Care for the Elderly: A Note of Caution," Public Policy, Volume 29, No. 3 (Summer 1981), p. 33.

these areas have been forced either to travel long distances for health care or to do without it. The bill addresses the present void in coverage by encouraging providers of home health care to extend their services to these areas as well. Moreover, it would reduce the need for extended hospital and nursing home stays because it would provide more services for homebound patients.

Because home health care can often be provided at a lower cost per day than nursing home care, supporters of the bill claim that expanded home health services can reduce public expenditures on health care. Dr. Philip Brickner, director of the Chelsea Village program, reported considerable savings in the use of home care compared to nursing home care. In recent testimony before the Senate, he contrasted the $833 per month home care costs for an 83-year-old woman with Medicaid's local payments of $2,122 a month for skilled nursing home care. Dr. Brickner found that the costs of long-term care at home average about 40 percent less, even when including the value of rent, food, clothing, telephone, medications, professional health services, and the help of community agencies.[13] According to Congressman Molinari, "It [the bill] will help to allow more of the aged to stay in their own homes while receiving quality care on a regular basis at a fraction of the cost of full-time institutionalized care."[14]

The expanded coverage of home health services under Medicare and Medicaid provided by this legislation would be a big step in countering the present bias toward institutionalization. In addition, the $500 tax credit would promote greater family participation in support of their elderly by providing a financial incentive to care for older relatives in the home rather than sending them to an institution. This credit may not offset all of the costs associated with the care of a dependent in the home, but it may make a sufficient difference to enough families to result in a real reduction in spending on health care. Families are the most valuable support system for our nation's older people. It is families, not the government, that provide the most care for the elderly. For every senior citizen in a nursing home or similar institution, there are at least two equally impaired elderly people receiving care at home.[15] This legislation strongly emphasizes the continuation of such family responsibility.

Encouraging family cooperation in the support of the elderly may also reduce the rate of growth of overall health care costs by addressing the problem of moral hazard. One of the principal causes of escalating health care costs has been the increasing tendency for third parties to pay medical expenses. Third-party

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13 Weinraub, op. cit., p. B14.

14 Ibid., p. B1.

15 Michael A. Smyer and Margret C. Plantz, "Caring for the Elderly," The New York Times, November 14, 1981, p. A23.

payments artificially inflate the demand for health care because covered patients perceive such services as being free. This misconception not only drives up the price of medical care, but also creates vast inefficiencies by encouraging people to use health care services beyond a level commensurate with costs. Moreover, providers of health care have every incentive to over-provide care, because they know it often appears to be costless to the consumer and the provider will be rewarded with greater revenues. As a result, excessive costs will be imposed upon taxpayers and consumers of insurance. Present Medicare and Medicaid policies artificially lower the price of institutionalized care relative to other forms of care, thereby encouraging excessive use and driving prices upward. Family members caring for their elderly at home are likely to be more cost-conscious if they have increased out-of-pocket costs. Similarly, the providers of health care will have to take costs into account if they want to keep their patients.

Finally, the bill would allow for the experimentation of alternative reimbursement systems for Medicare and Medicaid. The current retroactive cost reimbursement system is unsatisfactory. In testimony before the Senate, Donald W. Wortley of the Council of Home Health Agencies and Community Health Services of the National League for Nursing, described the problem with the present system:

> Currently, Medicare payments to home health agencies are based on the lesser of reasonable cost or customary charges. Home health agencies are paid during the year based on estimated costs, but final settlements are limited to those costs found by intermediaries to be proper, reasonable, and related to patient care. Final cost settlements often take two or more years.
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> Now I ask you, Mr. Chairman, don't you think that there would be a problem in providing a service when you had no idea what you would be paid for it until two years later?"[16]

Among the alternatives being looked at are fee schedules, prospective reimbursement, and capitation payments.

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16 Statement by Donald W. Wortley, Chairman of the Executive Committee of the Council of Home Health Agencies and Community Health Services of the National League for Nursing, before the Committee on Labor and Human Resources, U.S. Senate, on S. 234 -- The Community Home Health Services Act of 1981, November 10, 1981, p. 12.

ARGUMENTS AGAINST THE BILL

Some Administration officials have expressed uncertainty regarding the potential savings, arguing that a national home health care program would create new demands by many people now cared for in their communities by family or friends. According to one official, "A daughter or son obliged to take care of their elderly mother would have no such obligation if the Government took care of them."[17] Critics of the bill point out that the cost comparisons made by Dr. Brickner and others are somewhat misleading because they are based solely on physician estimates of "probable" institutionalization. Federal expenditures on health care actually may increase if the expanded availability of home health services is used as an add-on to existing care, rather than substituting for nursing home care. If the substitution effects are minimal, as some studies seem to point out, problems relating to moral hazard are exacerbated.[18] In other words, if the increased coverage induces an increased demand for scarce resources, costs may rise. The tax credit may have similar problems. It makes it easier for families to shift the cost of care to the federal government and may be used for purposes other than long-term care purchases, thereby defeating the objective of the bill.

This is not to say that home health care cannot be used as an effective cost control measure. However, if savings are to be realized, the services must be targeted to those who would otherwise be institutionalized. The bill emphasizes just that point.

CONCLUSION

Studies by the General Accounting Office and others have concluded that a significant proportion of the nursing home population could be cared for in a less intensive and less expensive setting. One report noted that "until an older person becomes greatly impaired, the cost of nursing home care, both financial and personal, often exceeds that of home health care."[18] Because resources are limited and the demand for long-term care is expected to grow, it is important to find other ways of providing care at lower cost. This bill recognizes that quality care can be provided in a cost-efficient manner in a continuum of settings ranging from one's own home to a hospital or nursing home. By offering older people who need long-term care a choice, this bill minimizes both the monetary and social costs that will

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17 Bernard Weinraub, "Home Care is Pushed in Senate as Alternative to Institutions for the Aged," The New York Times, April 16, 1981, p. A20.

18 See U.S. Department of Health and Human Services, op. cit., pp. 43-45.

19 See Statement of the National Retired Teachers Association and the American Association of Retired Persons in Hearings, p. 117.

accompany the inevitable expansion of long-term care services in the coming years.

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