S. HRG. 98-732

LONG-TERM HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

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LONG-TERM HEALTH CARE

THURSDAY, NOVEMBER 3, 1983

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

The subcommittee met, pursuant to notice, at 1:33 p.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Packwood, Heinz, Baucus, and Bradley.

[The press release announcing the hearing and the prepared statements of Senators Dole and Packwood follow:]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SCHEDULES HEARINGS ON LONG-TERM HEALTH CARE

Senator Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced that the Subcommittee would be holding hearings on long-term care.

The first hearing will be held on Thursday, November 3, 1983, beginning at 1:30 p.m., in Room SD-215 of the Dirksen Senate Office Building. A second hearing, will be held on Monday, November 14, beginning at 11:30 a.m., in Room SD-215 the Dirksen Senate Office Building.

The first hearing will examine the magnitude of the long-term care problem and current activities directed at addressing this issue. The second hearing will focus on pending long-term care legislative proposals as well as other possible approaches to providing access to needed long-term care services for the elderly and disabled. A third hearing will be scheduled at a later date to examine ways of providing for the long-term care needs of the Nation's developmentally disabled population.

Senator Durenberger said that "one of the most difficult social issues facing our Nation is to determine how best to provide for the long-term needs of our frail elderly and disabled populations. We must prepare ourselves for substantial increases in the number of individuals requiring long-term care. The U.S. Bureau of the Census projects that by the year 2050, 21.7 percent of the population is expected to be over 65, up from the present 14 percent. In addition, the percent of the total population who are 85 years or older will increase from 1 percent to 5.2 percent. During this period, however, the ability of the public sector to provide needed care for these individuals will be reduced, because the ratio of individuals of working age to individuals over 65 will drop from its present level of 5.4 to 1 to 2.6 to 1.

"At the same time", said Senator Durenberger, "we must strive to develop an integrated long-term care delivery system which provides more appropriate and humane long-term care services." Current federally supported programs emphasize the provision of long-term care in costly institutional settings. We must foster innovation today in order to develop a rational delivery system for tomorrow. In fiscal year 1982, for example, the Medicaid program spent nearly $13 billion on institutional long-term care, or 43 percent of total program expenditures. Medicaid expenditures on home-health care during the period amounted to only $495 million.

Senator Durenberger stated that the Subcommittee is interested in hearing from the administration, the States, local organizations, providers, and consumers on this most important topic. The Subcommittee anticipates that the experiences and information shared at these hearings will enable it to address pending legislative proposals, as well as to develop possible additional legislative initiatives which will foster the development of a rational national policy on long-term care.

SUMMARY OF S. 410—THE COMMUNITY NURSING CENTERS ACT OF 1983 SPONSORED BY SENATORS INOUYE, PACKWOOD AND DECONCINI

The purpose of this bill is to cover services that are provided by Community Nursing Centers (CNC's) under medicare. States would have the option of covering these services under their medicaid programs.

The Secretary of Health and Human Services shall establish CNC service areas and designate one CNC to serve each such geographic area. CNC's would be established primarily through existing Visiting Nurses' Associations and the local nursing component of public health departments which are already medicare providers.

To qualify as a CNC, a public or private entity must be a freestanding center primarily engaged in providing nursing services and it must provide a sufficient number of services to provide for the needs of two of the three following groups: individuals who are in need of medicare home health services; individuals who are eligible for CNC coverage because they would otherwise be institutionalized, and infants and children in need of well-baby or health supervision services.

The services which must be offered by a CNC because they are necessary to meet the needs of its patients include: part-time or intermittent nursing care or home health aide services; medical supplies (other than drugs); use of medical appliances; well-baby and supervision services for children and infants; physical, occupational, or speech therapy; social services; and certain other related supportive services. Additionally, CNC services must be provided under the supervision of a registered nurse professional.

To qualify as a CNC, an entity must provide services at a substantially lower cost than any other medicare provider in the area. Medicare reimbursement for CNC services provided to long-term individuals will be made on a prepaid capitated basis.

CNC's will be responsible for providing an assessment and developing a plan of care for each long-term patient under its care. Each plan of care will be submitted for review and approval to the individual's physician or other qualified physician not employed by the center and to an independent review committee.

The U.S. Comptroller General will be responsible for submitting reports to Congress which assess the impact of CNC services on expenditures under the medicare, medicaid, and the maternal and child health programs; the incident of institutionalization; and certain other issues.

SUMMARY OF S. 1244—THE SENIOR CITIZENS INDEPENDENT COMMUNITY CARE ACT SPONSORED BY SENATORS PACKWOOD, BRADLEY, HEINZ, MATSUNAGA, RIEGLE, MOYNIHAN, WALLOP, AND COCHRAN

1. General Purpose.—To allow States to establish a Statewide prepaid capitation program for providing acute and long-term services for individuals aged 65 or older in need of long-term care by reason of impairment.

2. Population Served.—Individuals who: are entitled to benefits under Part A of medicare and enrolled under Part B, are age 65 or over, are not in an institution or scheduled to be discharged from an institution within 90 days, reside in a state participating in the program, are willing to participate in the program, are certified to be in need of certain types of support services: preparation of meals, administration of medication, housework or shopping assistance, etc., have a physical or mental impairment which results in a degree of impairment of activities of daily living.

3. Benefits.—All medicare Part A and B services, plus: homemaker/home health aide, adult day care, respite care, individual preadmission assessment and development of treatment plan, service coordination, up to 20 days of intermediate care facilities (ICF) care per calendar year (the number of skilled nursing facility (SNF) days available under medicare will be reduced as these ICF days are used). The medicare skilled nursing and homebound requirement is lifted for home health services as is the posthospitalization requirement for skilled nursing facility services. Home health services provided without regard to whether the individual is homebound or needs skilled nursing care, physical, speech or occupational therapy (limitations currently contained in medicare statute). Certain limitations on nursery home utilization are also modified.

4. State Participation.—During the first four fiscal years during which this program is in effect the number of participating States is limited to 4 to be selected by

the Secretary. Beginning with the fifth year the Secretary may continue to limit the number of states participating.

5. Financing.—Payments under this program will be made from the medicare trust funds in such proportions as are determined appropriate based upon the types and amounts of services provided under the program.

6. Provider Reimbursement.—Entities providing (either directly or through arrangements with others) services covered under this program will be paid a fixed per capita fee. These fees are to be developed jointly by the Secretary of DHHS and the State agency administering the program. They should reflect urban/rural differences, be updated annually, and not exceed 60 percent of the average monthly rate for services paid by such state in free-standing SNFs.

7. Patient Cost Sharing.—Cost-sharing requirements for services covered under medicare part A and B continue to apply. For homemaker/home health services, adult day care, and respite services, a copay equal to 20 percent of reasonable charges will apply. A sliding-scale maximum for all copayments is established as a percent of the individual's previous year's income. The maximum ranges from 0 percent for individuals with incomes less than $3,500 to 8 percent for those with incomes above $40,000.

8. Administration.—Participating States will designate a specific State agency to administer the program. The State will be responsible for determining client eligibility, provider designations, establishing capitation rates, monitoring of quality of care, and preparing necessary reports.

9. Reports.—Interim reports from DHHS to Congress on program impact by January 1, 1986. Final report on 4 demonstration States by January 1, 1988. Reports should address potential problems for nationwide implementation. OMB to prepare budgetary analysis of nationwide implementation. Interim report by January 1, 1986; final report by January 1, 1988. DHHS to prepare report on feasibility of establishing program under which state medicaid programs provide capitated coverage of medicare and medicaid benefits for dual enrollees. Due to Congress by June 30, 1984.

10. Other Provisions.

SUMMARY OF S. 1614—THE HEALTH CARE COORDINATION ACT OF 1983 SPONSORED BY SENATORS HEINZ, HATCH, BRADLEY, PACKWOOD, MELCHER, STEVENS, WALLOP AND ANDREWS

1. General Purpose.—To allow States to implement coordinated programs of acute and long-term care for individuals eligible for both medicare and medicaid.

2. Population.—Individuals in participating States who are eligible for medicare Part A (excluding those with endstage renal disease), enrolled under Part B, and eligible for medicaid can voluntarily enroll in the program. Individuals residing in the community or in nursing homes may enroll, although no more than 25 percent of total of a State's enrollees may be nursing home residents. In addition, the percentage who are disabled or frail elderly must be approximately equal to or greater than the percentage of the dual eligible population in the area served by the program. Individuals enrolling in this program may disenroll anytime within the first month of enrollment and at 6-month intervals thereafter. States may request a waiver to provide medicaid eligibility to certain individuals in the community who if they were residing in an institution would be eligible for the program except for the higher income standards applying to that population.

3. Benefits.—The program will cover all medicare Part A and B services, plus all medicaid services to which the individual would otherwise be eligible; case management services, including assessments and periodic reassessments; homemaker and home health aide services; adult day health services; and any other community-based services requested by the State and deemed to be necessary to maintain the individual in the community. Limits and restrictions on these services may be established, but only to the extent that they are not more restrictive than those imposed under the medicare program or under either the State's regular medicaid program or its 2176 home- and community-based care waiver program.

4. State Participation.—States wishing to participate in the program must submit a waiver request to the HHS Secretary. Prior to October 1, 1986, the Secretary may not grant waivers to more than 20 States, although program authorized by these waivers need not be Statewide. Individual States may operate more than one program under this waiver authority.

Waiver requests must be accompanied by assurances from the State that the program it will operate will meet all legislative requirements, that the total cost of the program to the Federal and State governments will not exceed what they would have been in the absence of the program, and that quality and access to health care will be maintained.

Waivers are granted to States for a 3-year period and shall be renewable for additional 3-year periods unless the Secretary demonstrates that the State programs do not conform with program requirements.

5. Financing.—Federal payments for medicare covered services will be made from the medicare trust funds to participating States for individuals enrolled in the program on a predetermined capitated basis. The amount of this payment for "non frail" individuals would be equal to 95 percent of the Adjusted Average Per Capita Cost (AAPCC) for the Medicare noninstitutionalized population.

Federal payments to States for individuals who are nursing home residents or would require nursing home care but for the existence of home care services and who have dependencies in at least two activities of daily living will be equal to 95 percent of the medicare AAPCC for institutionalized individuals.

Payents for medicare covered services in excess of the cost of those services may be used to provide other services or to offset expenditures under the State medicaid plan. Payment for nonmedicare covered services, Part B premiums, and administrative costs will be made with Federal and State funds at the State's regular medicaid matching rate.

6. Reimbursement.—Payments from participating States to providers may be made on (1) a prepaid capitated basis to HMOs or competitive medical plans meeting the requirements of section 1876 of the Social Security Act, (2) a negotiated payment method, or (3) a system which makes payments in accordance with Title XVIII for medicare-covered services and with State's medicaid plan to other services.

7. Cost Sharing.—Medicare and medicaid cost-sharing requirements remain in effect.

States may receive a waiver to impose cost-sharing requirements in excess of those currently allowable under medicaid only if it provides coverage of other community-based services in addition to those required under the program. The amount of these additional cost-sharing requirements may not be proportionately higher in relation to the cost of the additional services than the portion of previous cost sharing requirements to services otherwise provided under the State medicaid plan.

8. Administration.—Participating States are responsible for administering their individual programs. Each State or a designated entity will be responsible for assessing and periodically reassessing individuals covered under the program. States must provide for quality assurance reviews either through a contract with a Professional Review Organization (PRO) or other designated quality assurance entity.

Participating States must submit reports to DHHS at least annually which describe program performance. DHHS must submit a report to Congress within one year of enactment describing the steps taken to implement the program. Within three years of enactment, DHHS must submit a report to Congress assessing the impact and effectiveness of the program.

OPENING STATEMENT BY SENATOR BOB DOLE

I am deeply concerned that long-term care may well be the major health and social issue of the future, polarizing society over the next 20 to 40 years. When the baby-boom generation retires, the financial and resource needs of long-term care may compete fiercely with those of defense, education, energy, and welfare; creating much political controversy.

Before that happens we need to begin consideration of how the entire system of long-term care should be structured. Even today, as we face an approaching crisis of huge proportions in the medicare program, the elderly population in general is increasing rapidly and the population at risk of needing long-term care may be increasing especially fast. Various sources suggest that the long-term care needs of the elderly have intensified—patients are functionally more impaired and require more intensive care.

At the present time, we do not know what long-term care really is. We do know it is medical care, nursing care, mental health care, and social services care, funded in some instances through medicare or medicaid. We do know its purpose is to relieve the effects of illness, to maintain or enhance functional capacities and to maximize personal independence. But we have not defined long-term care in terms of an overall scheme for matching services to needs whether through a single program or by coordinating existing programs; whether through Federal or State programs; and to what extent the private sector and family members have a role to play.

Nursing home, health care, and hospice care—these are but a few of the many elements of providing long-term health care to the needy, the elderly, and the disabled through the medicare and medicaid program. They are complex aspects in and of themselves and they are interrelated. The more we know about those interrelations and complexities, the better we will be able to consider how they might be restructured to provide better care on a cost effective basis. Since long-term care dependency is very much a function of advancing age, the demographic realities present the United States with an extraordinary task in terms of both money and providing services over the next 40 years at least. We have, of course, been dealing with this task to some degree, but its real dimensions have only recently been recognized and raise some important policy issues:

We will continue the pattern of institutional development so characteristic of the years since the introduction of medicare and medicaid or will we attempt to develop more community-focused systems?

If we decide on a more community-oriented care system, will the community support be available to provide care? Will community-based care serve as a substitute for, or an add-on to, institutionalized care?

These are but a few of the questions that need answers. The Health Subcommittee, beginning with this hearing will seek out answers to these and other questions about long-term care. Most importantly, how much care should we provide and what portion of it should be financed through the Federal Government, State government, and private sources?

STATEMENT BY SENATOR BOB PACKWOOD

Mr. Chairman, I am very pleased that the Health Subcommittee of the Senate Finance Committee is holding these hearings on the issue of long-term care and services to keep senior citizens at home. I believe is is important for public policy to be directed at helping people stay at home rather than at forcing them to live in an institution.

Senior citizens want to maintain a sense of independence and closeness with their families—and their families want to keep them at home. But, unfortunately, existing Federal policy has undermined home health care. Medicare has focused almost exclusively on short-term hospital care. While the medicare program includes some home health services, the eligibility requirements raise substantial barriers to many families' and seniors' efforts to stay at home. Only two percent of all medicare's expenditures go for home health services.

The major public program covering long-term care is medicaid and it is clearly directed at nursing home care. About 40 percent of Federal and State medicaid funds go for nursing home care, and medicaid is the source of 90 percent of all public funds spent on long-term care.

It is important to note how interested the States are in developing alternatives to nursing home care. As part of the 1981 Omnibus Budget Reconciliation Act, States are able to apply for a waiver of medicaid requirements to allow them to develop a wide range of home and community-based services. Thirty-eight States have been granted these waivers and eight have waiver applications pending at the Department of Health and Human Services.

I am proud my home State of Oregon was the first to get a medicaid waiver to develop home and community-based care. Oregonians have long recognized the value and importance of helping keep seniors in their own homes and out of a nursing home unless absolutely necessary. Oregon project independence is a State-funded program to provide homemaker, housekeeper, personal care and transportation services to allow Oregon seniors to remain at home. In place since 1976, the program has proven singularly effective in achieving its goal and along the way it has saved the State a substantial amount of money. In fact, the head of Oregon's State Senior Services Division has said the Oregon Project Independence and the State's medicaid waiver are saving the State $1 million a month. Just think what that savings would mean if these programs are implemented nationwide. I ask unanimous consent that a recent article from the Salem, Oregon Statesman-Journal be placed in the Record at this point.

Federal health care policy should be redirected to coordinated care at home for frail senior citizens, and families should be encouraged to help care for their elderly relatives at home rather than putting them in a nursing home.

To this end, my friends Senator Bradley of New Jersey and Senator Heinz of Pennsylvania and I have been working on a package of legislation to accomplish this end. These hearings are an important step in this process.

The first bill, S. 1244, is known at the Senior Citizens' Independent Community Care Act. Many seniors have health conditions requiring some regular medical treatment but they are not sick enough to stay in the hospital or need full-time nurses or therapists. Currently, medicare will not pay extended care costs unless a senior is in the hospital or requires specialized medical treatment and therapy. S. 1244 would provide medicare coverage for the non-medical, but necessary, services many seniors need to stay at home. Under this bill, medicare would pay for the services of trained personnel to help care for a senior at home or at an adult day care facility. Included would be the services of homemaker/home health aides to help the senior with things like bathing, dressing, preparing meals and light housework on a regular basis or when family members simply need to "get out of the house."

The second bill, S. 1614, allows states to coordinate their medicaid programs with medicare to provide home care for those seniors eligible for both programs. Medicaid is a program run by States to provide health care to the needy, no matter what age. Medicare is a Federal program to cover the health care costs of Americans age 65 and over. This bill would allow these two programs to coordinate the services provided to seniors, eliminating costly duplication and overlap, while ensuring the best possible care.

The third bill, S. 410, will encourage the health care industry to provide the services and staff families need to keep seniors at home. This bill, the community nursing center bill, will encourage the establishment of centers run by nurses to provide, coordinate, and oversee home care services. In addition, community nursing centers can provide many of the routine medical services such as changing dressings, giving shots, and monitoring blood pressure or diet without a costly or inconvenient doctor's appointment.

The final bill in this package does not fall under the jurisdiction of this subcommittee. Rather, I plan to have hearings on it in the Subcommittee on Taxation and Debt Management, which I chair.

This bill, S. 1301, provides a tax credit to families for some of the costs of caring for elderly family members at home. The credit would be similar to the existing tax credit for children's day care expenses.

I believe this package will be effective in redirecting health care policy toward providing more care in the home for senior citizens. Each bill provides encouragement and incentive for a different part—families, medicare, health service providers, and the States—to provide care for the elderly at home rather than in a nursing home. The whole package will help American families physically and financially to keep their elderly relatives as independent as possible and at home, in familiar surroundings and close to loved ones.

I thank the chairman and commend him on holding these hearings on this very important issue.

Senator DURENBERGER. The hearing will come to order.

I am going to start out this afternoon not by talking about long-term care but by talking about health care.

The Federal Government has been involved in health care much longer than it has been involved in long-term care, and I think there are lessons in the area of health care reform that can be applied to long-term care reform.

Health care financing depends on four basic elements: personal savings, private insurance, social insurance, and welfare or public assistance. In each of these areas the Federal Government has played an important role. We have developed a Federal tax policy—that hasn't been working too well lately but has been designed to encourage personal savings.

We have encouraged the purchase of private health insurance through tax deductions and exclusions for employer-paid coverage.

We have developed a system of social insurance; we call it medicare.

And finally, we have developed a welfare system called medicaid.

In the course of developing Federal policy in each of these areas, we have slowly come to the realization that our financing decisions also affect the way health care services are delivered. Only recently have we recognized that our tax policy, our medicare policy, and our medicaid policy all tend to insulate the individual patient from the cost of care and discourage price competition among health care providers.

We have recognized that our financial decisions affect the delivery system, and we have begun to make changes. The DIG system is one example of payment reform that brings about delivery system reform. Medicare waivers are another example. And what we have come to realize is that financing decisions are inextricably tied to the way services are delivered.

In thinking about long-term care, we must address the same four financing sources: personal savings, private insurance, social insurance, and public assistance.

The fact is, when it comes to Federal policy on long-term care we focused only on public assistance. We are just beginning to look at ways to stimulate personal savings and private insurance, and we have yet to examine the issue of whether we should create a social insurance program for long-term care.

No one disputes that long-term care is a vitally important policy issue. In fiscal year 1982 public dollars contributed to over half of the $40 billion spent on long-term care services, and almost 90 percent of these payments went to institutional care. Demographic trends indicate that demands for these services may as much as triple by the year 2050, when the baby boom generation retires.

Our first task, then, is to examine ways in which we can encourage individuals to protect themselves against the cost of long-term care services.

For example, tax law changes might include the development of inheritance and estate tax policies that do not penalize families and individuals contributing to long-term care services. Or we might provide tax deductions for families who provide care or contribute money for long-term care. Reverse equity mortgages are also a possibility, and there is the whole issue of private insurance for long-term care and what measures the Federal Government might take to stimulate its development.

In the social insurance area, there is continuing discussion about whether medicare should be expanded to cover long-term care services. As an acute medical care program, medicare does not pay for long-term care services; but many people feel that role should be expanded.

The last Federal function, public assistance or welfare, is the function most people tend to look at first. But let me point out to you that if we are successful in formulating effective Federal policy on personal savings, private insurance, and social insurance, the demand for an expanded welfare program should be much less.

We cannot, however, overlook the fact that our principal involvement at the national level is presently through the medicaid program.

The first issue we must address is what responsibility there is for the Federal Government or State government and local government in providing long-term care services, particularly for the indigent. What is the financial responsibility and what is the program management responsibility?

Second, we need to examine how that program is structured. We now know that how we pay for services affects how those services are delivered. Medicaid is an institutionally based program, because that's where services are paid for. Do you want to hospitalize everyone? Set your payment system to do it. If you want to SNF them, you can do that, too. We can force all the other third-party payers into this sort of institutional line. But that is not what this Senator believes to be the national responsibility with regard to America's elderly and its elderly poor.

In considering proposals to restructure how we pay for long-term care services under medicaid, there are lessons from medicare that should be kept in mind.

We have learned from medicare that new benefits rarely reduce program costs; they more often add to total costs. Consequently, if we move to cover long-term care services in the home in an effort to reduce nursing home expenditures, we are going to have to be careful to assure that we don't simply increase overall expenditures rather than reduce them. We must be careful not to undermine the informal support system that presently exists in the long-term care area. It is estimated that between 60 and 80 percent of long-term care is currently provided by friends and family, and it ill behooves the National Government to change that support.

It is easy to see why public policy on long-term care is so perplexing. How can we shift from a medical model of long-term care to a more humane and less restrictive home and community based model without increasing costs and decreasing the involvement of the family?

Fortunately, we are not short on ideas. The Omnibus Reconciliation Act of 1981 allows States to experiment with the development and implementation of home and community-based alternatives to institutional care. Other activities designed to stimulate the development of cost-effective alternatives, include the long-term care channeling program, the Administration on Aging's model project program, and the prepaid capitation demonstration projects.

A number of bills have been introduced in the Senate to address the long-term care issue. Three of the authors are with us today, and I look forward to working with them as we sort through these important concerns.

The health care principles that I advocate—things like competition, consumer choice, patient responsibility, access to information, and self-help—all of these have a place in the long-term care debate.

We must look to the private sector for innovation and cost-effect methods of service delivery.

Today's hearing is only the first in a series of hearings that will be held on long-term care. Our witnesses today will provide an overview of the problem and the issues surrounding our long-term care system, and will review current efforts to address these issues at Federal, State, and local levels.

The hearing on November 14 will focus on proposed legislation to improve the delivery of long-term care services.

A third hearing will be scheduled to look specifically at the developmentally disabled population and their service needs relating to long-term care.

I look forward to hearing the testimony today and to working with all of you who are so vitally interested in this area.

Senator Packwood?

Mr. Chairman, I am very pleased that the Health Subcommittee of the Senate Finance Committee is holding these hearings on the issue of long-term care and services to keep senior citizens at home.

I believe it is important for public policy to be directed at helping people stay at home rather than directed at forcing them to live in an institution.

Senior citizens want to maintain a sense of independence and closeness with their families, and their families want to keep them at home; but unfortunately, existing Federal policy has undermined home health care. Medicare has focused almost exclusively on short-term hospital care; while the medicare program includes some health services, the eligibility requirements raise substantial barriers to many families' and seniors' efforts to stay at home. Only 2 percent of all of medicare's expenditures go for home health services.

The major public program covering long-term care is medicaid, and it is clearly directed at nursing home care. About 40 percent of Federal and State medicaid funds go for nursing home care, and medicaid is the source of 90 percent of all public funds spent on long-term care.

It is important to note how interested the States are in developing alternatives to nursing home care. As part of the 1981 Omnibus Budget Reconciliation Act, States are able to apply for a waiver of medicaid requirements to allow them to develop a wide range of home and community-based services. Thirty-eight States have been granted these waivers, and 8 have waiver applications pending at the Department of Health and Human Services.

I am proud to say that my home State of Oregon was the first to get a medicaid waiver to develop home and community-based care. Oregonians have long recognized the value and the importance of helping keep seniors in their own homes and out of a nursing home, unless absolutely necessary. Oregon's Project Independence is a State-funded program to provide homemaker, housekeeper, personal care, and transportation services to allow Oregon seniors to remain at home. In place since 1976, the program has proved singularly effective in achieving its goal, and along the way it has saved the State a substantial amount of money. In fact, the head of Oregon State's senior services division has said that the Oregon Project Independence and the State's medicaid waiver are saving the State $1 million a month. Just think what that could mean to the Federal Government, if all of the programs in all of the States were implemented nationwide.

Mr. Chairman, I ask unanimous consent that a recent article from the Salem, Oregon "Statesman Journal" be placed in the record at this point.

Senator DURENBERGER. Without objection, it is so ordered.

[The article follows:]

NURSING HOMES' PROFILE CHANGES

(By Sue Hill)

An 85-year-old Salem woman who lived in a nursing home for six years is now living in the family-like setting of an adult foster home.

The change has wrought wonders, according to state officials responsible for the move.

She regained her strength enough to walk unaided. She began making her own bed, taking her own baths and dressing herself.

Mabel is one of 1,515 elderly persons who have been moved out of nursing homes in Oregon into less institutional settings during the past seven months.

Some went into foster homes where meals and lodgings are provided for up to five people. Others returned to their own homes, with part-time assistance from outside housekeepers, visiting nurses and the meals-on-wheels program.

It is all part of a state strategy reversing a decade-long social trend that left many elderly people in nursing homes when they really didn't need such an expensive level of care.

In some cases, elderly people went into nursing homes to recuperate from broken bones or illness. Once healed, they were left there and forgotten.

In other cases, frail elderly people without much money found themselves whipsawed by a federal funding quirk that would pay $1,000 a month to keep them in a nursing home but wouldn't pay $400 a month for part-time housekeeper services to allow them to live at home.

Oregon led the country in attacking that funding quirk and was the first state to get federal blessing to abolish it.

Dick Ladd, head of the state Senior Services Division, is fond of describing new situation this way: Money follows need instead of the reverse.

The state has established new standards to determine the needs of elderly people before they enter nursing homes. As a result of that early intervention, about 1,870 people have been diverted from nursing home placement since February.

The shifts have not only produced what state officials describe as humanitarian results, but have also saved the state millions of dollars.

About half of all nursing home patients in the state are on welfare, and many now paying their own way are expected to exhaust their savings eventually.

Ladd said the new policy saves about $1 million a month in taxpayer dollars.

The Oregon example, he said, has produced a flurry of calls from other states interested in emulating the new policy.

"We're way out ahead of everyone else," he said.

There are an estimated 331,900 persons 65 years or older living in Oregon. About 13,300 of them are in nursing homes.

The new policy has dramatically reduced the need for new nursing home construction in the state.

Senator PACKWOOD. Mr. Chairman, I am going to read just a few sentences from that article. This is from the Salem, Oregon's "Statesman Journal" of October 17, 1983:

> An 85-year old Salem woman who lived in a nursing home for six years is now living in the family-like setting of an adult foster home. The change has wrought wonders, according to state officials responsible for the move. She has regained her strength enough to walk unaided. She began making her own bed, taking her own baths, and dressing herself. Mabel is one of 1,515 elderly persons who have been moved out of nursing homes in Oregon into less institutional settings during the past seven months.
>
> Dick Ladd, head of the State senior services division is fond of describing the new situation this way: "Money follows need, instead of the reverse."
>
> The shifts have not only produced what state officials describe as humanitarian results but have also saved the State millions of dollars. Ladd said, "The new policy saves the state about a million dollars a month."

Mr. Chairman, I cannot emphasize too strongly what Senator Heinz, Senator Bradley, and I have been saying: Home health care will save money. It will save the Federal Government money; it will save the States money. This is not an add-on to medicare or an add-on to medicaid. It is an alternative method of care that is infinitely cheaper—infinitely cheaper—and more humanitarian at the same time.

For those who are going to oppose these bills, I would like them somehow, some way, to indicate why and how they think it is going to be less expensive to continue the present medicaid programs and the present medicare programs than to shift into a system of care that is humanitarian and that is more inexpensive than what we now have.

Mr. Chairman, I ask that the remainder of my statement be placed in the record.

Senator DURENBERGER. Without objection, it is so ordered.

In order of appearance, Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

First I want to commend you for holding these hearings. I think it would be hard to overstate the difficulty that the Congress has had, for the decade that I have served in it, in coming to grips with the question of long-term care.

I will start by making a few general observations:

If we think we have a problem today, it's a problem that is going to be infinitely bigger tomorrow. People over age 75, who are those most in need of some kind of long-term care, be that in their homes, in the community, or in some form of institutional care, are an enormously fast-growing segment of our population. People over 85, those most likely to require long-term care, are growing as a group much faster than any other age group.

A look at public housing projects will give you one concrete example of how this problem, is in a sense, no longer "tiptoeing" round us, but "trampling" upon us. Public housing projects have traditionally been available for the benefit of families, families with children, that is to say younger people. But shortly, they will be occupied, in the majority, by senior citizens. And, because those over age 65, over 75, and in particular the over-85 group will continue to increase, it is not too far-fetched to say that in about 10 years our public housing projects may in effect become nursing homes, or something very close to them.

Another observation I would make is that we have, because of the medicare and medicaid division with which we are familiar, a grave difficulty explaining to people why if you get cancer, you can get medical coverage for treatment, even if it is over a substantial number of years, because cancer under medicare is considered a treatable and even curable disease. Those bills will be paid for largely by medicare.

On the other hand, if you are unfortunate enough to have Alzheimer's disease, which is every bit as implacable—indeed, I would judge it to be more so—than cancer, you can get no help at all from the medicare program, and you will probably be forced to pauperize yourself so that you can qualify for medicaid.

If you happen to have a spouse, that means your spouse has to be pauperized as well.

These program quirks are not easy to explain to people. And we had better start looking at ways not just to explain but to deal with that issue.

Finally, I want to add to what my friend Bob Packwood has said about home health care. Just as we know that there is a good deal of unnecessary hospitalization that takes place, so there is a good deal of unnecessary and extremely costly institutionalization that takes place. And indeed some of the hospitalization takes place because of the phenomenon I described before: If someone says you are acutely ill, even if you are not, you will get some bills paid under medicare even if you most need long-term home and community-based services. Medicaid, particularly prior to the waiver authority that so many States have sought, really only paid for nursing home care of one kind of another. There was and continues to be excessive use of institutional services.

Senator Packwood has introduced a very important bill, cosponsored by Senator Bradley and myself, the Senior Citizens Independent Community Care Act, S. 1244. I have introduced a bill, S. 1301, that would provide tax credits to families that make a strong effort to care for people in their homes. And finally, I and a number of my colleagues present here have introduced a third bill, S. 1614, the Health Care Coordination Act, which tries to get at some of the problems of the dually eligible under medicare and medicaid, and make it less costly to give people more appropriate care.

I would hope, Mr. Chairman, as we conduct this hearing that we will elicit comments on specific legislative proposals such as those that Senator Packwood and myself and others have introduced.

I hope our witnesses will help us address some of the more difficult issues of how we can change our policy in a major way so that we don't have to go through another decade of saying to people, "Listen, you are really better off if you have cancer than if you have Alzheimers." I don't want to ever have to say that to someone, but financially it is true.

So I commend you again, Mr. Chairman, on these hearings. I hope they will bear fruit. Thank you.

Senator DURENBERGER. Before calling on Senator Bradley, I would only say that we have specifically designed the November 14 hearing for participants to comment with specificity on all of the proposed long-term care bills. I would guess, in response to questions, any of the witnesses today would be capable of replying to this legislation; but what we are trying to do today is to get the larger overview that all of you have expressed concern about.

Senator Bradley?

Senator BRADLEY. Mr. Chairman, I won't make a speech—I will simply say that when Senator Packwood and I introduced our original home health care bill back in 1980, we did so because we believed that it was possible to provide quality care in the home at a cost lower than most anyone thought.

Since that time we have altered our bill in various ways to make it even more effective, both in terms of cost and in terms of services. We hope that the hearing today, that focuses on the general issue of home health care and the hearing on November 14, that will focus on our specific proposals will assist the committee and the Senate to understand the conviction that is behind the bill, to look at some of the numbers, and to help us find a workable way to deliver home health care to senior citizens in their homes.

Senator DURENBERGER. Thank you.

Senator Baucus?

Senator BAUCUS. Mr. Chairman, I just want to thank your for holding these hearings of Senators Packwood, Heinz, and Bradley, and others who have good ideas that I think are worth discussing and coordinating.

Senator DURENBERGER. Thank you very much.

If there are no other comments, we will call our first witness, Dr. William Scanlon, principal research associate of the Urban Institute in Washington, D.C.

Dr. Scanlon, we welcome you to the hearing. Your testimony in full will be made part of the record, and you may proceed to summarize it.

STATEMENT OF WILLIAM J. SCANLON, PH.D., PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, D.C.

Dr. SCANLON. Thank you, Mr. Chairman and members of the subcommittee.

I will try to provide you a quick summary of my written testimony.

I think it is very important, that we are taking time to consider the state of long-term care in our country, for the policy responsibility for long-term care has been very diffused. It has largely been left to the States, but also, sometimes within States, to localities.

As a result, how members of the long-term care population are served and at what cost varies considerably. It is important that we stop to examine that variation, to see if it is acceptable from a national perspective.

In my prepared testimony I have provided some background information on the nature of long-term care and the size of the current and future long-term care population. To a great extent you gentlemen have already referred to a number of the facts that are in that testimony. In the interests of time I will not discuss them now, but instead will turn to the public sector involvement in long-term care.

Long-term care is a legitimate concern for the public sector, because it is the one genuine catastrophy for which insurance is extremely scarce. Moreover, the need arises often when one can least afford it. While the long-term care population is not exclusively elderly, two-thirds are, and the probability of needing long-term care increases dramatically with age. At the same time, one's income and economic resources are declining with age.

How we deal with long-term care as a nation has largely been delegated to the States through the medicaid program. While the Federal medicaid statute does provide sufficient flexibility that States could offer more than nursing home care, States have opted to restrict coverage largely to nursing home care. Furthermore, they have attempted to restrict the amount of nursing home care that is provided by limiting the number of beds that are available—through either certificate-of-need regulations or by paying lower medicaid nursing home rates to keep the supply of beds down. The result of these policies is a shortage of nursing home beds for medicaid eligibles seeking care, and the shortage is most acute for persons who are heavy-care patients, who represent the greatest costs to facilities.

This focus on nursing homes on the part of State medicaid programs has been criticized as inefficient in that it creates an institutional bias whereby persons who could be cared for at home more cheaply enter nursing homes because that is the only form of subsidized care.

Some have argued that broadened coverage of in-home and community services would allow those persons to remain at home and be served more cheaply, and that the savings from excessive nursing home care could then be used to serve a broader population at the same cost.

I would say, though, that the experience of various demonstration projects disputes that premise. While there are individuals for whom it is cheaper to serve outside of a nursing home, it is difficult to limit a program solely to those individuals. In particular, it is difficult to limit a program to individuals who would have entered a nursing home. The experience of the demonstrations is that a large segment of the population served, while very needy, would not have entered a nursing home without the services that are made available. This is largely because of the heroic efforts made by family and friends to provide needed services to keep people from being institutionalized.

The result of broadening the population is that total costs increase. Better targeting and incentives to providers such as capitation payments might lower costs of in-home and community care. But nursing home use and costs may still not be reduced, because of the existing bed shortage. I think some research that we have done illustrates strongly the extent of the bed shortage. In the 10 States with the highest number of nursing home beds per elderly population, we found that 90 percent of people who are over 75, dependent in all their activities of daily living and unmarried, were in nursing homes. When we looked at the 10 states with the lowest number of beds, we found only 50 percent of that same group were in nursing homes.

Given the difficulties of designing an in-home and community service program that will not increase costs, State policies limiting coverage to nursing home care may be very rational, as cost containment is one of their primary goals. It is a form of triaging, in the sense of trying to serve the neediest when resources are limited. It does, however, leave a large number of persons in the community who must be cared for by families. And whether or not that burden, which can be quite heavy, should be left entirely as the responsibility of families is the issue that public policy faces today.

Thank you very much.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Dr. William J. Scanlon follows:]

Statement of William J. Scanlon, Ph.D.

Mr. Chairman and Members of the Subcommittee:

I am pleased to give you my views on the current status of long term care in our country and the important issues which will confront us in the future. I am an economist in the Health Policy Center of The Urban Institute and have been involved in research on various aspects of long-term care for the past eight years. The opinions I express are my own and not those of The Urban Institute or its sponsors.

Long-term care is a growing national concern. Yet responsibility for policy on long-term care is diffused. This hearing represents an important beginning to develop a more coherent national policy on long-term care than currently exists. I wish to offer my views on why long-term care is a public policy issue; the current state of long-term care policies; and objectives and choices improved public policy would entail. As an introduction, I would like to provide some background on the nature and dimensions of long-term care need

What makes someone part of the long-term care population is not a particular diagnosis or condition, but the need for supportive services over an extended period. People with mental or physical conditions, present at birth or acquired much later, the result of congenital conditions, disease, or even trauma, can all be part of the long-term care population. Supportive services for this population cover a broad range. More likely than not the services are nonmedical rather than medical and unskilled rather than skilled. Most prominent among them are personal care (assistance with eating, toileting, transferring, bathing or dressing), mobility assistance around the house or outside, household assistance (meal preparation, cleaning, shopping) and supervision.

The most complete enumeration of the long-term care population was done by a Department of Health and Human Services Task Force in 1980. The Task

Force estimated the core of the long-term care population at 6 million in 1977. The total consisted of 3.6 million people living in the community and needing assistance with personal care or mobility; 1.8 million people in long-term care institutions including nursing homes, residential care facilities, and long-stay hospitals; and 0.6 million people living in board and care homes. Beyond this core are important additional populations needing long-term care, but not assistance with mobility or personal care. About 1 million people, not included above, live in the community who need help with household tasks. Other omitted groups are some mentally ill and the developmentally disabled living in the community, needing only supervision or other support services. The size of these last two groups is not known. In sum, the long-term care population likely numbered about 8 million persons in 1977.

Taken alone, future demographic projections imply considerable increases in the need and demand for long-term care services. The greying of America--the increasing proportion of the population that is old or very old--is an oft discussed theme. The U.S. Census Bureau estimates persons over 65 will increase 37 percent by 2000 and 130 percent by 2025. Moreover, among the elderly, the very old cohorts (persons over 75 over 85) will increase the fastest. For example, the number of persons over 85 will increase 124 percent by 2000 and 234 percent by 2025.

While the long-term care population is not exclusively aged, two-thirds are over 65 and the probability of needing various types of assistance increases dramatically with age. The fraction of the population needing personal care assistance rises from less than 1 percent of those under 45 to 32 percent of those over 85. Given the relationship, I have estimated that the Census Bureau's population projections suggest the number of persons over 65 who need personal care will increase from 2.3 million in 1982 to 3.8

million in 2000 and 5.9 million in 2025. These increases represent 60 percent by 2000 and 145 percent by 2025.

At present, the needs of the long-term care population are met largely by institutions and informal sources, that is family and friends. Institutional care receives the most attention because it represents the bulk of purchased services. Expenditures on nursing homes topped $24 billion in 1981 Dollar-wise, they are the fastest growing segment of the U.S. health care industry--their revenues having increased more than fivefold since 1970.

Three-quarters of the long-term care population, however, do not live in institutions. They reside in the community. Services provided these persons are substantial but difficult to measure. As noted, they are served largely by relatives and friends. Seventy-five percent of the long-term care population in the community report they only get assistance from these informal sources. Although no dollars change hands for family-provided care, its provision consumes considerable resources that should not be ignored.

What makes long-term care of great public concern is that it is one catastrophe for which individuals can not obtain insurance and for many persons, the need arises at a point when they are least able to afford it.

Usually financing for catastrophic illness is handled through private insurance which draws on the resources of many to cover the catastrophic costs of a few. This mechanism, however, has not worked for long-term care, for two major reasons. First, insurers are concerned about the potential for adverse selection where only persons more likely to need care will buy the insurance. Second, insurers are concerned about moral hazard, where people with insurance will decide to use more services because they have insurance. Controlling utilization would likely be much more difficult for long-term care than for acute care. Long-term care involves not only professional services but a broad array of support services whose appropriateness is difficult to gauge.

The situation with respect to long-term care insurance is similar to that regarding acute care insurance for the elderly before Medicare. Obtaining adequate coverage at reasonable cost was a major problem only resolved by the introduction of government insurance--Medicare.

The lack of insurance is compounded by the timing of long-term care needs. While families of all ages are likely to have difficulties coping with long-term expenses and obligations, these difficulties are pronounced for the elderly. While their probability of needing long-term care is increasing with age, their economic and social resources are dwindling. Long-term care needs, especially for females, may arise 15-20 years after their own or their spouse's retirement. By that point, savings, other assets, and pensions may be exhausted or will be rapidly exhausted by the cost of services. Turning to informal unpaid care may also be difficult as one's spouse and contemporaries may be deceased or incapable of providing needed care.

While there may be ways to encourage some private long-term care insurance and enhance the private resources available to finance long-term care, a public role in long-term care financing will always be essential. There will be persons who simply can not afford any or certain types of care and there will be persons who can obtain care but only at genuinely catastrophic costs.

How far the public sector goes in resolving these situations is a question of choice. Currently these choices have been delegated to the states through the Medicaid program. Although Medicaid involves substantial federal matching payments and proceeds according to federal rules, long-term care policy under Medicaid is largely determined by the states. For some time, state long-term care policy has been dominated by efforts to keep spending in check. Consistent with this goal, states have been reluctant to cover services outside the nursing home and have restricted the availability of nursing home care, either through certificate-of-need regulation or through low Medicaid nursing home rates. Despite these efforts, nursing home care represents the largest and fastest growing component of State Medicaid budgets.

State efforts to restrict nursing home use has resulted in access problems for Medicaid patients, particularly those requiring intensive and costly care. Indicators of access problems are hospital "backup" or administrative days, and the presence in the community of large numbers of severely impaired persons, who can be said to require nursing home care.

Some recent research I have done with Dr. William Weissert, underscores what limiting nursing home beds can imply. In states with highest bed-to-elderly population ratios, more than 90 percent of persons most in need of care (unmarried persons 75 or older, needing assistance in all activities of daily living) were in nursing homes. Only half that population received care in states with the lowest bed-to-population ratios.

This access problem can be expected to worsen over time. Although the nursing home bed supply has kept pace (barely) with growth of the elderly population in the last decade, recent changes in hospital payment can be expected to increase the competition for available beds. Medicare's new prospective payment system will reward hospitals for reducing length of stay, and there are already reports that hospitals are negotiating with nursing homes to take their patients. Nursing homes may well prefer newly available short-stay, Medicare or private-pay patients to the long-term patient immediately or ultimately covered by Medicaid. Hence Medicaid patients, particularly those needing intensive care, will have an even hard time finding beds.

Limiting Medicaid coverage to nursing homes has been criticized strongly as inefficient. Covering nursing home care and not community or in home services supposedly creates an institutional bias. The argument is that this coverage leads individuals to enter nursing homes who could remain in the community at lower cost if needed services were available and affordable.

I agree that nursing homes are being used inefficiently. What the important issue is, however, is what are the implications of that fact for the redesign of policy. First, eliminating inappropriate placement would not necessarily reduce nursing home use. As I indicated above, these may well be persons in the community who need nurisng home care but cannot gain access. If some less impaired persons failed to enter nursing homes, their places might well be taken by more severely impaired community residents. Second, even if nursing home use could be reduced, there is reason to question whether broader coverage can be provided without increasing total costs. Many have argued that if in home and community services were better covered, persons who would otherwise enter a nursing home would remain at home at lower cost. These cost savings could then be applied to serve more persons at home for the same total amount as previously spent on nursing home care.

Unfortunately, experience in various long-term care demonstrations projects has tended to contradict that premise. Expanding coverage to include community and in home services has increased total costs. The principal reason is that there have been only limited reductions in nursing home use. At best about 20 percent of nursing home use was avoided because of the additional services. (Note that it is not 20 percent of total use, but 20 percent of the use by the types of patients who enroll in a community program. These persons are somewhat marginal nursing home users, so that reducing their use by 20 percent will not have nearly as large an impact on the total use.) In addition, there are large increases in the number of persons being served in the community.

It is possible that this negative outcome is the result of poor targeting. If broad criteria are used to determine eligibility for community and in home services, the population being served will be primarily persons who would never have entered a nursing home. This seems to be the case in the different demonstration projects. Typically, about four-fifths of the control groups, who received no additional coverage, never entered a nursing home. Given the limited reduction in nursing home use, this broad population could only be served at no additional cost if the average cost of service to an individual at home is 3-4 percent of the cost of keeping a person in a nursing home. This translates to about $2 per day per person.

How much improved targeting can contribute to controlling costs has not been determined. The channeling demonstrations sponsored by the Department of Health and Human Services, which are currently underway, represent the most significant effort to date to target services on likely nursing home users. In determining who is eligible for services, the channeling projects require that a person be more impaired or dependent than did previous demonstrations. In addition, they consider the availability of informal sources of care--presumably excluding persons with ample informal supports to avoid substitution of publically purchased care for privately-provided, unpaid care.

Whether the channeling projects will be successful in controlling costs will be determined in the next few years. What may be key to their success is taking the availability of informal care into account in the targeting process. Many people enter nursing homes not because their physical condition absolutely requires it. Instead, they enter because they lack someone to care for them at home. Persons with extreme impairments and great needs remain at home because someone is willing to go to heroic lengths to provide them care. When such care is unavailable, there is no choice but to enter a nursing home.

Providing a limited service package which costs less than nursing home care is not going to satisfy the needs of an extensively impaired person unless they have other sources of support. When a person already has that support, providing additional services is only going to prevent institutionalization if their informal supports would otherwise break down. For example, there may be times when famiy members decide they simply cannot cope with the needs of the dependent person and reluctantly opt for institutionalization. Supplementary services may then make the difference in convincing family members they can hang on.

While targeting services to persons whose informal supports would have collapsed may be the effective cost containment strategy, it is difficult to identify those persons when designing and operating a program. More importantly, whether limiting services to this likely small group is an appropriate policy objective, is an issue. As I said, people may not enter nursing homes because their families make heroic efforts to provide care. Such support, especially when provided by spouses, may never break down. A major question for policy is whether the burden of such family provided care can be ignored even though reducing it is likely to increase public costs.

Given the difficulty of designing a program with coverage beyond nursing home care that does not cost more, the states may be rational in limiting Medicaid coverage largely to nursing homes. While the result may be some persons who do not "belong" in nursing homes being there, the cost of this sort of inefficiency is less than the cost of expanding service coverage.

Moreover, while there may be inappropriate nursing home utilization at present, other methods, besides broader service coverage, have not been sufficiently tried to determine how they might reduce inappropriate utilization. Prominent among these are more extensive utilization review in the form of preadmission screening and case-mix reimbursement. Preadmission screening attempts to divert potential inappropriate users to existing community services. Case-mix reimbursement attempts to alter the incentives of nursing homes in terms of which patients they wish to serve. If successful, case-mix reimbursement would lead nursing homes to prefer heavy care patients, who currently have access problems, and to avoid very light care patients who could manage in the community.

These arguments lead to the conclusion that states have been rational in focusing coverage on nursing home care, if their objective is for the public sector to spend no more or even less on long-term care. With preadmission screening and case-mix reimbursement, concentrating on nursing home coverage is in essence a triaging strategy of trying to serve the neediest when limited resources are available.

No matter how rational, if states pursue this strategy triaging leaves the less-but-still impaired population unserved or a burden on families. It is a question of social choice as to whether these consequences are unacceptable and should be remedied by increasing the public sector role.

The long-term care marketplace: An overview

by William J. Scanlon, Ph.D.
and Judith Feder, Ph.D.

Long-term care is the fastest growing segment of the U.S. healthcare industry. Revenues of the most visible long-term care providers—nursing homes—topped $24 billion in 1981, more than five times their 1970 level. But nursing homes may represent just the tip of the iceberg. Services provided outside the nursing home are substantial but difficult to measure, particularly since most these services are delivered by relatives and friends. Although no dollars change hands for family-provided care, its users represent a potentially sizable market.

In view of the current size of the long-term care industry and the demands that a growing elderly population will place on it, we believe that a detailed examination of the long-term care marketplace is in order. This series presents that examination, exploring various issues affecting long-term care use, provision and financing.

To begin the series, this article provides an overview of the long-term care marketplace, identifying the long-term care population, examining how population and policy changes have affected the use and nature of long-term care services up to now, and exploring how future population and socio-economic changes are likely to influence the long-term care market. Though broad in scope and brief in description, this article aims to establish a foundation for the more detailed discussions of specific issues that the rest of the series will provide.

Identifying the long-term care population

What makes someone part of the long-term care population is not a particular diagnosis or condition, but the need for supportive services over an extended period. People with mental or physical conditions, present at birth or acquired much later, the result of congenital conditions, disease, or even trauma, can all be part of the long-term population. Supportive services for this population cover a broad range that "addresses the health, social and personal care needs of individuals who for one reason or another have never developed or have lost some capacity for self care."[1] More likely than not, the services are nonmedical rather than medical, and unskilled rather than skilled. Most prominent among them are personal care (assistance with eating, toileting, transferring, bathing, or dressing), mobility assistance around the house or outside, household assistance (meal preparation, cleaning, shopping) and supervision.

Service needs may differ with underlying condition—chronic physical illness, mental illness, or development disability. For example, some mentally ill persons re quire supervision and monitoring not needed by physically ill persons, while the mentally retarded and developmentally disabled populations often require educational services to reach their potential.

Counting the long-term care population is difficult. Individual surveys identify needs for assistance with some activities but not others. Other service needs have never been measured systematically or thoroughly.

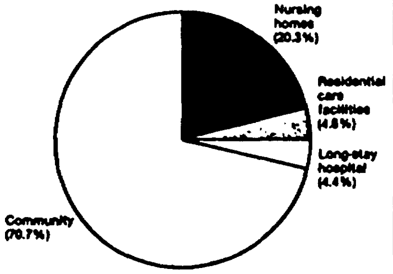
The most complete enumeration of the long-term care population was done by a Department of Health and Human Services Task Force in 1980.[2] The task force estimated the core of the long-term care population at six million in 1977. The total consisted of 3.6 million people living in the community and needing assistance with personal care or mobility; 1.8 million people in long-term care institutions including nursing homes, residential care facilities, and long-stay hospitals; and 0.6 million people living in board and care homes. Beyond this core are important additional populations needing long-term care, but not assistance with mobility or personal care. About one

This is the first article in a year-long series on "Long-Term Care: Challenges and opportunities" which will address this increasingly important area for the financial manager. The series has been developed by a panel of long-term care authorities, under the direction of HFMA's Walker Unger and Thomas Fox, of Pierson, Ball and Dowd, Washington, D.C.

million people, not included in the earlier figures, live in the community and need help with household tasks.[c] Other omitted groups are the mentally ill and the developmentally disabled living in the community, needing supervision or support services. The total number of mentally ill living in the community is estimated to be 0.8 million, while the number of developmentally disabled in both the community and institutions is estimated at 2.8 million.[d] A portion of these people are not counted in the core. In sum, the long-term care population appeared to number about eight million persons in 1977. The distribution of this population by place of residence is illustrated in Exhibit 1.

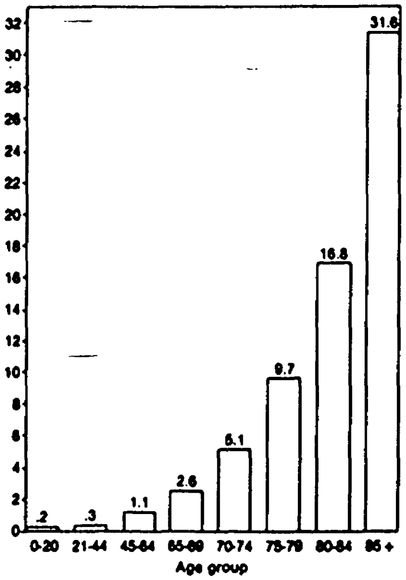
The long-term care population is not restricted to the elderly. About one-third of impaired persons in the community and nursing homes are under 65.[e] Indeed, almost half of community residents needing personal care, mobility, or household activity services are under age 65.[f] However, the common association of aging with long-term care is not a misconception. Service needs increase dramatically with age. Exhibit 2 illustrates this relationship for personal care needs. Only after age 45 do more than 1 percent of the population need care. The proportion rises to 32 percent for persons over 85. About 20 percent of the

Exhibit 1: LTC population by place of residence, 1977



Source: Institutional data are from Office of the Assistant Secretary for Planning and Evaluation, "Working Papers on Long-Term Care," Department of Health and Human Services, October 1981. Community data are from The Urban Institute, *Project to Analyze Existing Long-Term Data — Final Report*, Vol. II, Department of Health and Human Services Contract No. 100-80-0158, July 1983. Due to incomplete data on the community long-term care population in 1977, data from 1979 have been used to adjust the 1977 estimates.

Exhibit 2: Percent of United States population needing personal care,[1] 1977



[1] Persons needing personal care are those requiring assistance with activities of daily living — bathing, dressing, transferring, toileting and eating.

Source: Tabulated from data on persons needing personal care in the National Nursing Home Survey and the Health Interview Survey collected by the National Center for Health Statistics and from data on population from the U.S. Bureau of Census.

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a. Meltzer, J., Farrow, F. and Richman, H. eds *Policy Options in Long-Term Care*. Chicago, Illinois. University of Chicago Press, 1981.

b. Office of the Assistant Secretary for Planning and Evaluation, "Working Papers on Long-Term Care," Department of Health and Human Services, October 1981.

c. Weissert, W., "Size and Characteristics of the Non-Institutional Long-Term Care Population" in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol. II, Department of Health and Human Services Contract No. 100-80-0158, July 1983. The estimate of persons needing help with household tasks is from a 1979 survey and has been adjusted to be consistent with the 1979 data.

d. Goldman, H., Gattozzi, A., and Taube, C., "Defining and Counting the Chronically Mentally Ill," *Hospital and Community Psychiatry*, Vol. 37, No 1, January 1981. The portions of these populations that are institutionalized or who need services such as personal care, mobility assistance or household help have been counted in the previous estimates. Only that unknown fraction needing other kinds of services are additions to the long-term care population

e. Weissert, W. and Scanlon W., "Estimating the Long-Term Care Population. National Prevalence Rates and Selected Characteristics" in *Project to Analyze Existing Long Term Care Data, Final Report*, Volume II, Department of Health and Human Services Contract No 100-80-0158, July 1983 The age distribution of patients in residential facilities and long stay hospitals is unavailable. These groups tend to be younger.

f. Weissert, W., *op. cit.*

total long-term care population are in nursing homes, and 86 percent of nursing home residents are elderly.

Clearly, long-term care can be received in a variety of settings. Nursing homes are the settings that offer the most complete array of services, ranging from simple monitoring to skilled nursing. The almost 80 percent of the long-term care population who do not reside in nursing homes live in a variety of other settings, some of which, like the nursing home, include services as an integral part of the setting, while others include little or no service, but can bring in providers from outside. A matrix relating long-term care services and settings is presented in Exhibit 3. It shows which services are generally inherent to each setting (indicated by an X) and which services can be delivered only if a provider is obtained from outside the setting (indicated by a blank).

The matrix focuses on "formal" or purchased services and ignores the potential for "informal" services, delivered by friends or relatives at no charge. An impaired person living independently with a spouse (in the bottom row of the matrix) could receive a broad array of services, including extensive personal care from that spouse, and never need or want to purchase care.

Surveys indicate that most of the long-term care received by impaired persons living outside nursing homes is delivered by family and friends. Among impaired elderly, less than 10 percent of care recipients got their care from formal or hired providers, and only 18 percent received care from formal providers as well as from friends or relatives.[9]

How well does the mix of formal and informal services currently available satisfy the needs of the impaired population? According to the 1979 Health Interview Survey, people in the community with the most severe impairments were most likely to receive service.[8] Ninety-seven percent of persons needing help in eating as well as other aspects of personal care reported receiving the help they needed most or all of the time. However, one-fourth of persons needing help toileting, one-third of persons needing help dressing, half the persons needing help bathing, and 70 percent of persons needing help getting around reported receiving less help than they needed.[1]

These findings suggest a gap in the provision of service to impaired persons in the community. But they also indicate that families and friends are making a substantial effort to deliver needed care.

Despite the importance of families as providers of long-term care, information is lacking to properly assess the burden that providing care imposes, the circumstances that enable or lead people to rely on their families, and the resources or social costs family-provided care involves. Because information on this informal care is so limited, the remainder of this article focuses on the formal market for long-term care—specifically, its evolution in response to public policy and its likely future development in response to socio-economic and policy changes.

Financing long-term care

Even within the formal long-term care sector, data limitations force a narrow focus. As Exhibit 3 shows, formal services are delivered in a broad array of settings where they are financed by both private and public sources. But the mix of public and private financing for all services cannot be identified. Information is lacking on private spending for long-term care outside the nursing home. The popular perception, based on where users say they get services, is that it is small. But that conclusion is difficult to docu-

Exhibit 3: Array of possible housing settings for the elderly and services inherent in each setting

	Services									
Settings	Shelter	Monitoring	Meal preparation	Housekeeping and chore services	Shopping and errands	Personal care intermittent	Personal care continuous	Rehabilitation	Skilled nursing	24-hour skilled nursing
Nursing Homes										
• Skilled nursing	X	X	X	X	X	X	X	X	X	X
• Intermediate care	X	X	X	X	X	X	X	X	X	
Personal care and other homes										
• Personal care	X	X	X	X	X	X	X			
• Domiciliary care	X	X	X	X	X	X				
Caretaker environment										
• Foster home	X	X	X	X	X	X				
• With relatives	X	X	X	X	X	X				
Congregate housing	X	X	X							
Independent housing										
• Self and spouse	X									
• Self	X									

Key: X = Service inherent in a setting.
Blank = Service not inherent but may be obtained from outside providers.
Source: W. Scanlon, E. DiFederico, and M. Stassen, Long-Term Care: *Current Experience and a Framework for Analysis*, The Urban Institute, February 1979.

ment. Although organizations provide in-home services, they may not provide most privately purchased care. Individuals may be important suppliers of many long-term care services that require little or no special training, like housework, shopping, meal preparation, and personal care. With the large number of potential providers, information on the industry providing care in the community is difficult to collect.

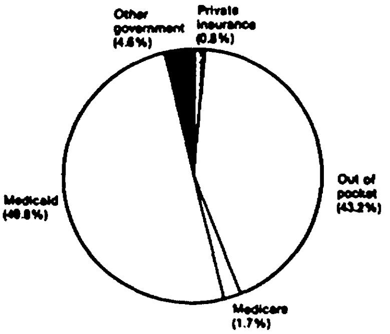
Data on financing for nursing home care are more readily available (See Exhibit 4). In 1981, $24.1 billion was spent on nursing homes. More than $10 billion (43 percent) came directly from patients and $13.6 billion (56 percent) came from public sources.[j] Ninety percent of these public payments came from Medicaid—the Federal-state grant program designed to finance health care for the poor. Private insurance plays almost no role in financing nursing home care.

Exhibit 5 shows public spending on in-home and community care is small relative to public spending on nursing homes. In 1980, only 26.5 percent of government spending went to long-term care outside the nursing home, including in-home services, adult day care, foster care, and care in boarding facilities that provide supervision and sometimes some service to persons unable to care for themselves. Included in this estimate are Medicare home health expenditures ($640 million in 1980) which are not truly long-term care but rather short-term skilled nursing or rehabilitative care.

Public programs' emphasis on nursing home care has resulted more from state choice than from Federal policy. Through Medicaid, the Federal government has offered states matching funds for in-home as well as nursing home care. Until recently, however, most states were reluctant to use Medicaid for that purpose, for fear that its entitlement approach would subsidize far greater use than states were willing or able to support.[k] As a result, most states that provided in-home services did so through grant programs that limited service provision to amounts budgeted and did not offer entitlement to the general population.

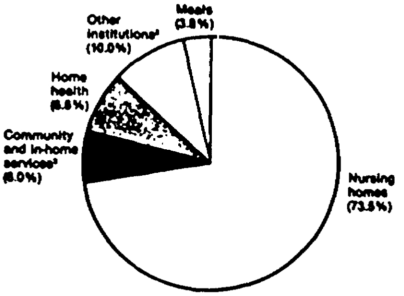
Federal subsidies for nursing home care began in earnest in 1956, under the Old Age Assistance program, and expanded to all states (except Arizona) with the enactment of Medicaid (Title XIX of the Social Security Act) in 1965. The Medicaid program initially covered nursing home care only in skilled nursing facilities (SNFs), but was later extended to cover intermediate care facilities (ICFs).[l] Although coverage of intermediate care facilities is optional, all state Medicaid programs include it.

Exhibit 4: Nursing home expenditures, 1981



Source. D. Waldo and R. Gibson, "National Health Expenditures, 1981," *Health Care Financing Review*, Vol. 4, No. 1, September 1982.

Exhibit 5: Public expenditures on long-term care,[1] 1980



Does not add to 100 percent due to rounding.

Source: Joel Cohen, "Public Program Financing Long-Term Care," National Governors' Association, 1983.

[1] Includes Federal and joint Federal-state programs only.

[2] Includes intermediate care facilities for the mentally retarded and other non-medical institutions.

[3] Includes personal care, homemaker, chore, home management, day care, foster care, and miscellaneous social services.

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[g] Soldo, B., "The Elderly Home Care Population: National Prevalence Rates, Select Characteristics and Alternative Sources of Assistance" in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol. III, Department of Health and Human Services Contract No. 100-80-0158, July 1983.

[h] Weissert, W., *op. cit.*

[i] Persons are classified according to their most severe impairment and typically suffer all lesser degrees of impairment as well. Needing assistance in eating therefore implies a need for assistance in all other elements of personal care. Ranked from most to least severe, impairments in personal care include the need for assistance in eating, toileting, bathing, dressing, and mobility.

[j] Waldo, D. and Gibson, R., "National Health Expenditures, 1981," *Health Care Financing Review*, Vol. 4, No. 1, September 1982.

[k] In the Omnibus Reconciliation Act of 1981 (Section 2176), Congress authorized waivers from various Medicaid requirements for states developing noninstitutional services, reducing the risks associated with coverage. For further discussion, see below.

Federal subsidies supported a dramatic expansion of the nursing home industry. In 1950, about 300,000 persons used nursing home care. By 1960, nursing home users numbered 470,000 and by 1980, over 1,400,000 (See Exhibit 6).[m] This expansion was sufficient not only to support a response to the growth and aging of the elderly population, but also to allow more elderly at any given age to receive nursing home care. The proportion of the population 65 and over living in long-term care institutions rose from 3.64 percent in 1960 to 4.78 percent in 1970.[n] Thirty-five percent of the increase reflects the aging of the elderly population, that is, an increase in the proportion of the very old who are more likely to use institutions. The remaining 65 percent, however, reflects increased use, holding the age distribution constant. The proportion of persons over 65 in institutions would have had to increase from 3.64 percent to 3.99 percent between 1960 and 1970 to keep pace with population change and allow behavior to remain constant. The increase from 3.99 percent to 4.78 percent reflects a change in behavior as a larger fraction of people at each age enter institutions.

Although most states used Federal funds to support nursing home growth, they supported very different amounts of care, both before and after Medicaid's adoption. In 1967, as the Medicaid program began, the nursing home bed supply ranged from 11.9 beds per thousand elderly in West Virginia to 81.6 beds per thousand elderly in Iowa. During the next 13 years, the annual rate of growth varied considerably. In some states, bed growth did not keep up with growth in the elderly population. Other states dramatically increased their bed-to-population ratios. The considerable variation meant that, despite the increased Federal role associated with Medicaid and a general expansion of the bed supply, per capita elderly supply levels continued to vary substantially across states. In 1980, levels ranged from 21.4 beds per thousand elderly in Florida to 95 beds per thousand elderly in South Dakota.

Profound changes in the industry's structure have accompanied the growth of the nursing home industry. Changes include an increasingly sophisticated medical orientation in nursing home care, a shift away from government-owned to proprietary homes,

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[l] In 1967, Congress amended Title XI of the Social Security Act to provide Federal matching for payments to ICFs on the same terms as any Medicaid covered services. In 1971, ICF coverage was transferred to Medicaid. For earlier history, see J.B. Silvers and Bruce Spitz, "The Nursing Home: Capital Formation and Funding," *Healthcare Financial Management*, April 1981, pp. 32-49.

[m] A portion of this increase represented a substitution among institutional types rather than real growth. The population in mental hospitals declined dramatically in the period from 750,000 to 400,000. However, much of this decline involved returning patients to the community because of improved treatment and new philosophies regarding treatment in the least restrictive environment.

[n] Scanlon, W. and Sulvetta M., "The Supply of Institutional Long-Term Care: Descriptive Analysis of Its Growth and Current State," in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol. V., Department of Health and Human Services Contract No. 100-80-0158, July 1983. Comparable data on institutional use by age from the 1980 census are not yet available. Other data suggest utilization rates have increased much less during the 1970s. In addition, the increases are concentrated in the early part of the decade, as bed growth in recent years has simply kept pace with the growth of the elderly population.

Exhibit 6: Number of persons and percent of U.S. population residing in long-term care institutions as reported by census of population

	1950		1960		1970		1980	
	Persons	Percent of population	Persons	Percent of population	Persons	Percent of population	Persons	Percent of population
All Ages								
All LTC institutions	1,161,974	0.76	1,406,266	0.78	1,670,167	0.82	1,916,213	0.85
Nursing homes	296,783	0.20	469,717	0.26	927,514	0.46	1,426,371	0.63
Mental institutions¹	747,817	0.50	804,773	0.44	635,882	0.31	394,450	0.17
TB and chronic disease hospitals	96,376	0.06	107,485	0.06	84,032	0.04	68,606	0.03
Homes of physically handicapped, blind and deaf	20,999	0.01	24,291	0.01	22,739	0.01	26,786	0.01
65 and over								
All LTC institutions	378,516	3.05	607,917	3.64	949,837	4.78	N/A	N/A
Nursing homes	217,536	1.77	387,953	2.32	785,807	3.96	N/A	N/A
Mental institutions	145,530	1.19	182,602	1.09	123,770	0.82	N/A	N/A
TB and chronic disease hospitals	15,449	0.13	37,362	0.22	40,260	0.20	N/A	N/A
Homes of physically handicapped, blind and deaf	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Source: U.S. Bureau of the Census, U.S. Census of Population: 1950. Vol. IV, *Special Reports*, Part 2, Chapter C, Institutional Population. U.S. Government Printing Office, Washington, D.C., 1953.

U.S. Bureau of the Census, U.S. Census of Population: 1960. *Subject Reports*. Final Report PC (2)-8A: Inmates of Institutions, U.S. Government Printing Office, Washington, D.C., 1963.

U.S. Bureau of the Census, U.S. Census of Population: 1970. *Subject Reports*. Final Report PC(2)-4E. Persons in Institutions and Other Group Quarters, U.S. Government Printing Office, Washington, D.C., 1973.

1980 figures are unpublished. Bureau of the Census, preliminary estimates.

¹Includes mental hospitals, facilities for mentally impaired and residential treatment centers.

and, more recently, a growing concentration of ownership in multi-facility chains.

The more sophisticated medical orientation in nursing home care reflects Medicaid requirements for covered care and state as well as Federal efforts to enforce structural and staffing standards. Both skilled and intermediate levels of Medicaid-covered care required more nursing involvement than small boarding institutions had previously offered. Medicaid also required states to comply with (1) the 1967 Life Safety Code Standards for the design and outfitting of buildings and (2) state licensure requirements regarding nursing home construction and staffing. During the 1970s, many states went well beyond Federal minimum requirements in specifying the level and kind of staffing required per patient for different levels of care.

Both structural and staffing standards caused many small nursing homes to go out of business during the 1970s. More than 6,000, or 28 percent of homes operating in 1971, closed by 1976. In the same period, 4,800 homes opened. The new homes were more than twice as large as the homes they replaced, and the average size of a nursing home increased from 54 5 to 68.9 beds.[o]

Government programs' expansion also brought a shift from government to proprietary ownership. Between 1950 and 1980, government-owned homes' share of patients fell from almost 40 percent to about 8.4 percent, and proprietaries' share rose from 37 percent to 70 percent.[p] Although that ownership distribution remained stable during the 1970s, another change is now in progress—concentration of ownership in multi-facility chains. Between 1980 and 1982, the major investor-owned chains increased their beds by 64 percent, resulting in their ownership of 16 percent of all nursing home beds.[q] This growth in concentration partly reflects the attractiveness of nursing homes as an investment, leading chains to expand. However, it also results from public policy—specifically, Certificate-Of-Need regulation, which prohibits or restricts growth of nursing home beds in many states. With these restrictions, chains expand by purchasing existing facilities rather than building new ones and thereby acquire a larger share of the nursing home stock.

Despite expansion of the nursing home industry and nursing home use, there appears to be a shortage of nursing home beds relative to the demand for nursing home care by publicly supported patients. The reason for access problems is that the total costs of nursing home care for people eligible for Medicaid support would exceed what states are willing or able to pay. For years, nursing home care has accounted for more than one-third of Medicaid spending. Since Medicaid's adoption, national nursing home expenditures have increased quite rapidly, growing from $2.1 billion in 1965 to $24.2 billion in 1981.[r] For most of that period, Medicaid spending on nursing homes increased over 20 percent per year, more than twice as fast as total state and local spending.[s] Even before the 1980s recession, states were taking steps to reduce long-term care's share of state budgets.[t]

Most states have limited their long-term care expenditures by limiting what they pay for nursing home care and by using Certificate-Of-Need to control the number of nursing home beds. A shortage of nursing home beds creates a particular problem for Medicaid patients needing costly care. Because Medicaid pays less than private patients for nursing home care and, in most states, does not sufficiently vary its rates with the cost of different patients' care, nursing homes prefer private-pay to Medicaid patients and Medicaid patients needing little care to those with expensive care needs.

While understandable, this economic discrimination poses a serious access problem for patients most in need of care. Research indicates that where bed supplies are most limited (the result of low Medicaid rates or Certificate-Of-Need regulation), smaller proportions of the most impaired population actually reside in nursing homes. In states with the highest bed-to-elderly population ratios, more than 90 percent of persons most in need of care (unmarried persons 75 or older, needing assistance in all activities of daily living) were in nursing homes. Only half that population received care in states with the lowest bed-to-population ratios.[u]

This access problem can be expected to worsen. Although the nursing home bed supply has kept pace with growth of the elderly population in the last decade, recent changes in hospital payment can be expected to increase the competition for available beds. Medicare's new prospective payment system will reward hospitals for reducing length of stay, and hospitals are therefore making special efforts to get nursing homes to take their patients.[v] Nursing homes may well prefer newly available short-stay, private-pay or Medicare patients to the long-term patient immediately or ultimately covered by Medicaid. Hence Medicaid patients, particularly those needing intensive care, may have an even harder time finding beds.

As noted at the outset, until recently most states have not supported much long-term care outside the nursing home. Although the Federal Medicaid program offered to match noninstitutional and institutional spending alike, states took advantage of the latter

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[o] Ibid

[p] Ibid and Al Sirrocco, "An Overview of the 1980 National Master Facility Inventory Survey of Nursing and Related Care Homes," National Center for Health Statistics, August 1983

[q] La Violette, S. "Nursing Home Chains Scramble for More Private Paying Patients," *Modern Health Care*, May 1983, pp 130-138

[r] Waldo and Gibson, *op cit*

[s] Bovbjerg, R and Holahan, J., *Medicaid in the Reagan Era Federal Policy and State Choices*, Urban Institute Press, 1982.

[t] Feder, J. and Scanlon, W., "Regulating the Bed Supply in Nursing Homes," *Milbank Memorial Fund Quarterly/Health and Society*, 58 1, Winter 1980, pp 54-88

[u] Weissert, W and Scanlon, W., "Determinants of Institutionalization of the Aged," in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol III, Department of Health and Human Services Contract No 100-80-0158, July 1983

far more than the former. For many years, only New York and Oklahoma offered noninstitutional Medicaid long-term care on a large scale.[v]

States' reluctance to offer these benefits reflected concern about costs. Although the availability of noninstitutional services could prevent nursing home use for some, demonstrations involving subsidized in-home and community services suggest that these savings will be offset by the costs of service to a larger total number of users.[x] The result is likely to be greater, not less, state spending.

With these risks, most states offered noninstitutional services on a non-entitlement basis, using either their own money or Federal block grants (under Title XX of the Social Security Act or The Older Americans Act). Most states controlled these programs tightly, keeping expenditures small. California was an exception, allowing its in-home service program to expand dramatically and incur sizable costs for the state.[y]

Recently, states have shown greater interest in Medicaid-financed noninstitutional care. In part, this interest reflects concern about the limited availability of service and an unsatisfied need for care. But increased state Medicaid activity also reflects a change in Federal fiscal incentives and Medicaid rules. The Federal government has cut back its grants to the states under Title XX.

At the same time, changes in Federal law allow targeted Medicaid coverage for these services—that is, a focus on specific geographic areas or narrowly defined populations. Since Medicaid no longer poses the risk of full-scale entitlement and continues to offer a generous Federal match, many states are seeking authorization for noninstitutional long-term care benefits.

It is too early to tell whether these benefits will simply replace services previously financed by other means or actively expand noninstitutional care. Although states may resist expansion, advocacy groups for the elderly can be expected to promote it. Their case will be strengthened by evidence that nursing home care is becoming increasingly hard to obtain.

Taken alone, future demographic and social projections imply considerable increases in the need and demand for formal long-term care services.[z] The graying of America—the increasing proportion of the population that is old or very old—is an often-discussed theme. The U.S. Census Bureau estimates 31.8 million persons or 12.7 percent of the population will be 65 and over in 1990, compared to 25.5 million or 11.2 percent in 1980. Moreover, among the elderly, the very old cohorts (persons 75 and over or 85 and over) will increase the fastest (See Exhibit 7).

These demographic projections alone have led to estimates that 2.5 to 3 million beds will be needed in 1990, to maintain current use patterns.[aa] To reach this level would require growth rates of about 3 percent pe year. Although that rate about equals the growth rates of the late 1970s, many states have considered past growth excessive and have used their Certificate-Of-Need programs to bring it to a halt. Furthermore, higher capital costs may be discouraging investment. Maintaining the 3 percent growth rate will require some shifts in public policy.

An even greater expansion of beds may be needed to accommodate other developments. The availability of informal care in the home may decline with the increasing participation and attachment of women to the labor force. Daughters and daughters-in-law have traditionally been the second most important source of informal care, following the patient's own spouse. As the proportion of women who are firmly established in careers increases, their ability and willingness to provide such care presumably declines. A larger share of dependent persons than in the past may therefore have to seek services from formal providers.

Medical developments could also increase the ex-

Exhibit 7: Number of persons in U.S. population in selected age groups, 1980-2000

(Numbers in thousands)

	1980	1990*	2000*	Average annual growth rate
Persons				
65 and over	25,544	31,799	35,036	1.58%
75-84	7,140	10,284	12,207	2.66%
85 and over	2,264	3,461	5,136	4.09%
Total population	226,504	249,731	267,990	1.61%

*These are projections based on an assumption of reductions in mortality rates such that life expectancy at birth will increase to 79.6 years by the year 2050. Current life expectancy is 74.6 years. Alternative projections involving even more improvement in mortality rates (life expectancy in 2050 of 83.3 years) result in estimates of 32,112,000 persons over 65 in 1990 and 36,404,000 in 2000. Projections based on less improvement in mortality (life expectancy in 2050 of 76.7 years) forecast 31,[illegible],000 persons over 65 in 1990 and 33,[illegible],000 in 2000.

Source: U.S. Department of Commerce, Bureau of the Census, "General Population Characteristics: United States Summary" *1980 Census of Population, Characteristics of the Population*, No. PC80-1-B1, May 1983 and U.S. Department of Commerce, Bureau of the Census, "Projections of the Population of the United States: 1982 to 2050 (Advance Reports)" *Population Estimates and Projections; Current Population Reports*, Series P-25, No. 922, October 1982.

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[v] Kovener, R.R. and Palmer, M.C., "Implementing the Medicare Prospective Pricing System," *Healthcare Financial Management*, September 1983, pp. 74-78.

[w] Cohen, J., "Public Programs Financing Long-Term Care," National Governors Association, 1983.

[x] U.S. General Accounting Office, "The Elderly Should Benefit From Expanded Home Health Care But Increasing These Services Will Not Insure Cost Reductions," Report to the chairman of the Committee on Labor and Human Resources, U.S. Senate, GAO/IPE-83-1, Dec. 7, 1982.

[y] James Bluck, "In-Home Services in California," in Judith Feder and Daniel Nichols, eds., "In-Home Services for Long-Term Care in Five States," Working Paper 1298-11, Washington, D.C., The Urban Institute, September 1981.

[z] For a similar view of the future, see Laurence F. Lane, "The Nursing Home: Weighing Investment Decisions," *Healthcare Financial Management*, May 1981, pp. 30-45.

pected demand for long-term care, if they reduce mortality but not morbidity rates. In fact, the improvements in mortality that have occurred in the recent past have contributed significantly to the size of the current long-term care population, since comparable advances in treatment of age-related conditions and dependencies have not occurred. Better treatment and prevention of some chronic conditions could reverse this trend, particularly if they affected the incidence of senility, arthritis, or osteoporosis.

Although demographic, social, and medical developments may increase the demand for formal services, future elderly will be better off economically than their predecessors and better able to purchase the care they need. Increases in the Social Security taxable wage base, higher contribution rates, and greater real earnings will result in post-retirement benefit payments replacing a larger fraction of pre-retirement earnings.[bb] More workers will be covered by private pensions, further improving the elderly's income. In 1979, about 40 percent of families with individuals aged 65 to 69 received private pension benefits. The proportions are projected to rise to 80 percent in 2004.[cc] Benefit levels for covered persons will also rise. Better public and private retirement benefits going to more people will put larger proportions of future elderly in higher income categories.[dd]

Finally, future elderly are likely to enter retirement with greater savings and other assets. Unlike the current elderly, they will have had little or none of their worklives affected by the Depression or World War II. Many will also have gained substantially from the real estate inflation of the 1970s, which increased the values of owner-occupied housing, most families' most significant asset.

Shifts in residential patterns, already occurring, increase the likelihood that the market will respond to the future elderly's demands. Life care communities and condominium apartments are relatively new kinds of residences which provide or facilitate the delivery of long-term care. Life care communities make a commitment to satisfying the long-term care needs of residents as they arise. Condominiums could increase the resources of the elderly and make it easier and cheaper to serve them. Elderly who sell their single-family homes to buy a condominium may use only a portion of their equity. The remainder becomes a more liquid asset available for service purchase. A condominium building with a concentration of elderly also provides the potential for more efficient service delivery. Delivering in-home services is almost always more costly than providing the same service in a nursing home because of the travel costs between patients' homes.

Concentrating potential patients within a single building or small area could drastically reduce the travel costs and make the marketing of in-home services more viable. Concentration would also make it practical and economically feasible to offer services that are needed frequently and take little time to deliver (like help in toileting and transferring), since service personnel could be located (and fully occupied) within the building. High transportation costs now often make these services too costly to provide.

Despite increases in average resources and changes in living environments, many elderly will remain unable to afford long-term care. Future income improvements will be uneven. In 2000, at least 20 percent will have no private pensions and many pensioners will receive very limited benefits. Women, in particular, will remain disadvantaged, since most pensions do not extend to survivors. Some elderly will enter retirement with limited savings and Social Security benefits reflecting a lifetime of moderate to low income. Moreover, having more resources at retirement age may not mean much when one needs formal long-term care. The typical formal long-term care user, a widow of age 80, will first need long-term care 15-20 years after her spouse's retirement. By that time, the incremental resources available at retirement may have been exhausted.

An important public sector role will therefore remain—subsidizing people unable to afford needed services. The nature and extent of the public role cannot be easily foreseen. Even with private resources meeting the needs of a larger share of the dependent population, the total projected increase in that population likely implies a greater demand for public subsidies. But responding to that demand will run counter to strong desires to constrain government programs. It is not easy to predict the outcome of this conflict, which will depend on the relative political influence of elderly users and nonelderly taxpayers, on the strength of the economy, and on the availability of Federal aid to states with particularly large elderly populations.

Our current long-term care system is largely a creature of government policy. But in contrast to many European countries, governments in the U.S. do not provide much care directly or exercise direct control over who gets what services. Instead, Federal and state governments subsidize individuals' purchases of care in the private market. Through these subsidies and the terms on which they are offered, our governments determine the overall size of the long-term care industry, the mix of services it will provide, and the kinds of persons who will receive care.

The current structure of subsidies and related incentives appear to have some serious gaps. Some people seem to receive less service than they need, and many people receive needed services only by imposing sizable burdens on their families. The formal provision of noninstitutional services appears to be quite limited and even the provision of institutional

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aa. Office of the Assistant Secretary for Planning and Evaluation, op. cit. and Valiante, John D., "Forecasting Capital Requirements: Potential Trends in Capital Investments During the 1980's," *Healthcare Financial Management*, August 1982, pp. 52-58.

bb. Zedlewski, S.R., "Microsimulation of the Private Pension System: Four Projections to the Year 2020," in *Brookings Conference on Retirement and Aging, Fall 1982*, Washington, D.C., The Brookings Institution, forthcoming.

cc. Employee Benefit Research Institute, *Retirement Income Opportunities in an Aging America: Income Levels and Adequacy*, Washington, D.C., 1982.

dd. Zedlewski, op. cit.

services appears inadequate in some places.

Pressure to resolve these inadequacies will rise with the growth in the elderly population, and public policymakers will be forced to respond. Notwithstanding the expected increasing importance of private purchase of long-term care, governments' responses—the decisions they make about how much to spend and the terms on which to spend it—will shape the long-term care industry in the years to come. □

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At press time

Long-term care: Challenges and opportunities

Healthcare Financial Management begins a year-long series of articles on long-term care in this issue. The series will describe and analyze the financing and delivery of long-term care services in both institutional and noninstitutional settings. It will explore a host of management, financing, marketing, accounting, legal and regulatory issues facing the long-term care field. The series will cover current arrangements, future directions and opportunities for investment.

Why long-term care? First, it is the fastest-growing segment of the healthcare marketplace in the United States. Second, the new Medicare prospective rate-setting system heightens the interest of acute care providers in finding suitable substitutes for inpatient hospital services. Third, population projections suggest there will be substantial increases in the number of people requiring long-term care.

The logo for this series is based on demographic projections. Over the course of the next seven decades, there will be a phenomenal increase in the number of elderly persons, the primary users of long-term care services. Currently, there are 2.6 million Americans 85 and older, the group which creates the largest demand for these services. There are 27.4 million Americans 65 and older, and this age group is expected to grow to 67 million by 2050.

The older age cohort (85 and older) is expected to expand to 5.1 million Americans in the year 2000 and to 16 million in the year 2050. This 640 percent increase in growth by the year 2050 is represented in the logo by the rapidly rising top line. The 65 and older group, while reflecting larger numbers of people, will show a far smaller rate of growth, represented by the bottom line.

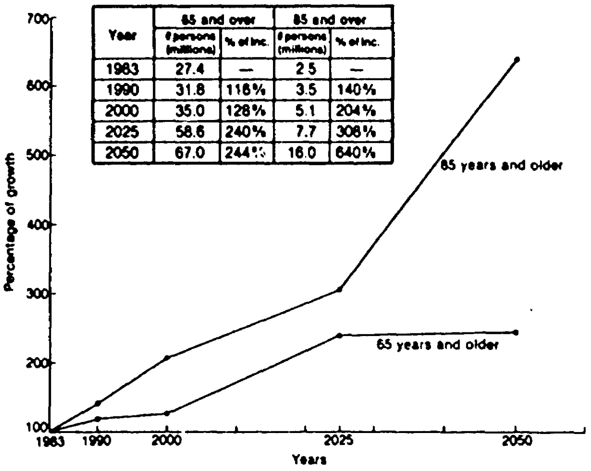
As a percentage of the total population, this age segment (85 and older) would rise from 1.0 percent currently to 1.9 percent in 2000 and 5.2 percent in 2050. The magnitude of this increase creates substantial challenges and opportunities for healthcare providers.

This series was developed by Contributing Editor Walter J. Unger after extensive consultation with authorities in the long-term care field. He is most recently known to *HFM* readers for his role in the development of its series on tax-exempt hospital revenue bonds and its 1981-82 series on capital management in healthcare organizations. He also was the coordinating editor of *HFM's* preferred provider organization series. In addition, Unger serves as HFMA's director of special studies in the Washington, D.C., office. His co-editor for this series is Thomas C. Fox, the partner in charge of the health law practice of Pierson, Ball and Dowd, Washington, D.C.. The firm serves as legal counsel to the American Health Care Association, the largest trade association in the long term care field. Fox has chaired eight annual national seminars on long-term care and the law for the National Health Lawyers Association. He currently serves as president of that organization.

An editorial advisory board of 16 outstanding individuals has also played a key role in the development of this series. Over the course of the past nine months, this board has been deeply involved in the series' design and implementation and has reviewed and critiqued the manuscripts that will appear in this series. This distinguished panel of advisors appears on page 42. *HFM's* long-term care series will run throughout 1984. Reader reactions to this series are invited. ☐

The Editors

1983-2050 percentage increase in selected U.S. population age groups



Year	65 and over		85 and over	
	# persons (millions)	% of inc.	# persons (millions)	% of inc.
1983	27.4	—	2.5	—
1990	31.8	116%	3.5	140%
2000	35.0	128%	5.1	204%
2025	58.6	240%	7.7	308%
2050	67.0	244%	16.0	640%

The long-term care marketplace: An overview

by William J. Scanlon, Ph.D.
and Judith Feder, Ph.D.

Long-term care is the fastest growing segment of the U.S. healthcare industry. Revenues of the most visible long-term care providers—nursing homes—topped $24 billion in 1981, more than five times their 1970 level. But nursing homes may represent just the tip of the iceberg. Services provided outside the nursing home are substantial but difficult to measure, particularly since most these services are delivered by relatives and friends. Although no dollars change hands for family-provided care, its users represent a potentially sizable market.

In view of the current size of the long-term care industry and the demands that a growing elderly population will place on it, we believe that a detailed examination of the long-term care marketplace is in order. This series presents that examination, exploring various issues affecting long-term care use, provision and financing.

To begin the series, this article provides an overview of the long-term care marketplace, identifying the long-term care population, examining how population and policy changes have affected the use and nature of long-term care services up to now, and exploring how future population and socio-economic changes are likely to influence the long-term care market. Though broad in scope and brief in description, this article aims to establish a foundation for the more detailed discussions of specific issues that the rest of the series will provide.

This is the first article in a year-long series on "Long-Term Care: Challenges and opportunities" which will address this increasingly important area for the financial manager. The series has been developed by a panel of long-term care authorities, under the direction of HFMA's Walter Unger and Thomas Fox, of Pierson, Ball and Dowd, Washington, D.C.

Identifying the long-term care population

What makes someone part of the long-term care population is not a particular diagnosis or condition, but the need for supportive services over an extended period. People with mental or physical conditions, present at birth or acquired much later, the result of congenital conditions, disease, or even trauma, can all be part of the long-term population. Supportive services for this population cover a broad range that "addresses the health, social and personal care needs of individuals who for one reason or another have never developed or have lost some capacity for self care."[a] More likely than not, the services are nonmedical rather than medical, and unskilled rather than skilled. Most prominent among them are personal care (assistance with eating, toileting, transferring, bathing, or dressing), mobility assistance around the house or outside, household assistance (meal preparation, cleaning, shopping) and supervision.

Service needs may differ with underlying condition—chronic physical illness, mental illness, or development disability. For example, some mentally ill persons re quire supervision and monitoring not needed by physically ill persons, while the mentally retarded and developmentally disabled populations often require educational services to reach their potential.

Counting the long-term care population is difficult. Individual surveys identify needs for assistance with some activities but not others. Other service needs have never been measured systematically or thoroughly.

The most complete enumeration of the long-term care population was done by a Department of Health and Human Services Task Force in 1980.[b] The task force estimated the core of the long-term care population at six million in 1977. The total consisted of 3.6 million people living in the community and needing assistance with personal care or mobility; 1.8 million people in long-term care institutions including nursing homes, residential care facilities, and long-stay hospitals; and 0.6 million people living in board and care homes. Beyond this core are important additional populations needing long-term care, but not assistance with mobility or personal care. About one million people, not included in the earlier figures, live in the community and need help with household tasks[c] Other omitted groups are the mentally ill and the developmentally disabled living in the community, needing supervision or support services. The total number of mentally ill living in the community is estimated to be 0.8 million, while the number of developmentally disabled in both the community and institutions is estimated at 2 8 million.[d] A portion of these people are not counted in the core. In sum, the long-term care population appeared to number about eight million persons in 1977. The distribution of this population by place of residence is illustrated in Exhibit 1.

The long-term care population is not restricted to the elderly. About one-third of impaired persons in the community and nursing homes are under 65.[e] Indeed, almost half of community residents needing personal care, mobility, or household activity services are under age 65.[f] However, the common association of aging with long-term care is not a misconception. Service needs increase dramatically with age. Exhibit 2 illustrates this relationship for personal care needs. Only after age 45 do more than 1 percent of the population need care. The proportion rises to 32 percent for persons over 85. About 20 percent of the

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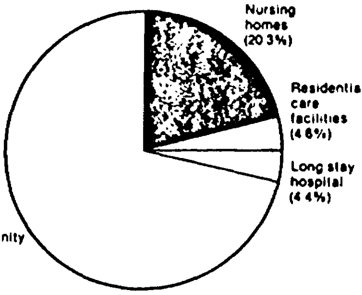
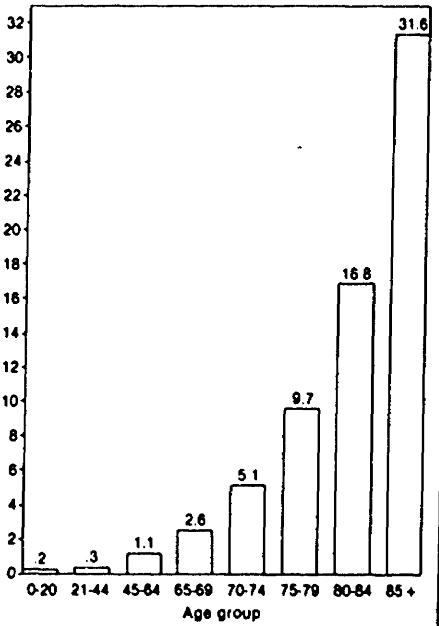
Exhibit 1: LTC population by place of residence, 1977



Source: Institutional data are from Office of the Assistant Secretary for Planning and Evaluation, "Working Papers on Long-Term Care," Department of Health and Human Services, October 1981. Community data are from The Urban Institute, *Project to Analyze Existing Long-Term Data — Final Report*, Vol. II, Department of Health and Human Services Contract No. 100-80-0158, July 1983 Due to incomplete data on the community long-term care population in 1977, data from 1979 have been used to adjust the 1977 estimates.

Exhibit 2: Percent of United States population needing personal care,[1] 1977



[1] Persons needing personal care are those requiring assistance with activities of daily living — bathing, dressing, transferring, toileting and eating

Source Tabulated from data on persons needing personal care in the National Nursing Home Survey and the Health Interview Survey collected by the National Center for Health Statistics and from data on population from the U.S. Bureau of Census.

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a Meltzer, J., Farrow, F. and Richman, H eds *Policy Options in Long-Term Care*, Chicago, Illinois: University of Chicago Press, 1981

b Office of the Assistant Secretary for Planning and Evaluation, "Working Papers on Long-Term Care," Department of Health and Human Services, October 1981.

c. Weissert, W., "Size and Characteristics of the Non-Institutional Long-Term Care Population" in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol II, Department of Health and Human Services Contract No 100-80-0158, July 1983. The estimate of persons needing help with household tasks is from a 1979 survey and has been adjusted to be consistent with the 1979 data.

d Goldman, H., Gattonzi, A., and Taube, C., "Defining and Counting the Chronically Mentally Ill," *Hospital and Community Psychiatry*, Vol. 37, No 1, January 1981 The portions of these populations that are institutionalized or who need services such as personal care, mobility assistance or household help have been counted in the previous estimates Only that unknown fraction needing other kinds of services are additions to the long-term care population.

e Weissert, W and Scanlon W., "Estimating the Long-Term Care Population National Prevalence Rates and Selected Characteristics" in *Project to Analyze Existing Long-Term Care Data, Final Report*, Volume II, Department of Health and Human Services Contract No. 100-80-0158, July 1983. The age distribution of patients in residential facilities and long stay hospitals is unavailable. These groups tend to be younger.

f Weissert, W., *op. cit*

Long-term care

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total long-term care population are in nursing homes, and 86 percent of nursing home residents are elderly.

Clearly, long-term care can be received in a variety of settings. Nursing homes are the settings that offer the most complete array of services, ranging from simple monitoring to skilled nursing. The almost 80 percent of the long-term care population who do not reside in nursing homes live in a variety of other settings, some of which, like the nursing home, include services as an integral part of the setting, while others include little or no service, but can bring in providers from outside. A matrix relating long-term care services and settings is presented in **Exhibit 3.** It shows which services are generally inherent to each setting (indicated by an X) and which services can be delivered only if a provider is obtained from outside the setting (indicated by a blank).

The matrix focuses on "formal" or purchased services and ignores the potential for "informal" services, delivered by friends or relatives at no charge. An impaired person living independently with a spouse (in the bottom row of the matrix) could receive a broad array of services, including extensive personal care from that spouse, and never need or want to purchase care.

Surveys indicate that most of the long-term care received by impaired persons living outside nursing homes is delivered by family and friends. Among impaired elderly, less than 10 percent of care recipients got their care from formal or hired providers, and only 16 percent received care from formal providers as well as from friends or relatives.[g]

How well does the mix of formal and informal services currently available satisfy the needs of the impaired population? According to the 1979 Health Interview Survey, people in the community with the most severe impairments were most likely to receive service.[h] Ninety-seven percent of persons needing help in eating as well as other aspects of personal care reported receiving the help they needed most or all of the time. However, one-fourth of persons needing help toileting, one-third of persons needing help dressing, half the persons needing help bathing, and 70 percent of persons needing help getting around reported receiving less help than they needed.[i]

These findings suggest a gap in the provision of service to impaired persons in the community. But they also indicate that families and friends are making a substantial effort to deliver needed care.

Despite the importance of families as providers of long-term care, information is lacking to properly assess the burden that providing care imposes, the circumstances that enable or lead people to rely on their families, and the resources or social costs family-provided care involves. Because information on this informal care is so limited, the remainder of this article focuses on the formal market for long-term care—specifically, its evolution in response to public policy and its likely future development in response to socio-economic and policy changes.

Financing long-term care

Even within the formal long-term care sector, data limitations force a narrow focus. As **Exhibit 3** shows, formal services are delivered in a broad array of settings where they are financed by both private and public sources. But the mix of public and private financing for all services cannot be identified. Informa-

Exhibit 3: Array of possible housing settings for the elderly and services inherent in each setting

	Services									
Settings	Shelter	Monitoring	Meal preparation	Housekeeping and chore services	Shopping and errands	Personal care intermittent	Personal care continuous	Rehabilitation	Skilled nursing	24-hour skilled nursing
Nursing Homes										
• Skilled nursing	X	X	X	X	X	X	X	X	X	X
• Intermediate care	X	X	X	X	X	X	X	X	X	
Personal care and other homes										
• Personal care	X	X	X	X	X	X	X			
• Domiciliary care	X	X	X	X	X	X				
Caretaker environment										
• Foster home	X	X	X	X	X	X				
• With relatives	X	X	X	X	X	X				
Congregate housing	X	X	X							
Independent housing										
• Self and spouse	X									
• Self	X									

Key. X = Service inherent in a setting

Blank = Service not inherent but may be obtained from outside providers.

Source W. Scanlon, E. DiFederico, and M. Stassen, *Long-Term Care: Current Experience and a Framework for Analysis*, The Urban Institute, February 1979 tion is lacking on private spending for long-term care outside the nursing home. The popular perception, based on where users say they get services, is that it is small. But that conclusion is difficult to document. Although organizations provide in-home services, they may not provide most privately purchased care. Individuals may be important suppliers of many long-term care services that require little or no special training, like housework, shopping, meal preparation, and personal care. With the large number of potential providers, information on the industry providing care in the community is difficult to collect.

Data on financing for nursing home care are more readily available (See Exhibit 4). In 1981, $24.1 billion was spent on nursing homes. More than $10 billion (43 percent) came directly from patients and $13.6 billion (56 percent) came from public sources.[j] Ninety percent of these public payments came from Medicaid—the Federal-state grant program designed to finance health care for the poor. Private insurance plays almost no role in financing nursing home care.

Exhibit 5 shows public spending on in-home and community care is small relative to public spending on nursing homes. In 1980, only 26.5 percent of government spending went to long-term care outside the nursing home, including in-home services, adult day care, foster care, and care in boarding facilities that provide supervision and sometimes some service to persons unable to care for themselves. Included in this estimate are Medicare home health expenditures ($640 million in 1980) which are not truly long-term care but rather short-term skilled nursing or rehabilitative care.

Public programs' emphasis on nursing home care has resulted more from state choice than from Federal policy. Through Medicaid, the Federal government has offered states matching funds for in-home as well as nursing home care. Until recently, however, most states were reluctant to use Medicaid for that purpose, for fear that its entitlement approach would subsidize far greater use than states were willing or able to support.[k] As a result, most states that provided in-home services did so through grant programs that limited service provision to amounts budgeted and did not offer entitlement to the general population.

Federal subsidies for nursing home care began in earnest in 1956, under the Old Age Assistance program, and expanded to all states (except Arizona) with the enactment of Medicaid (Title XIX of the So-

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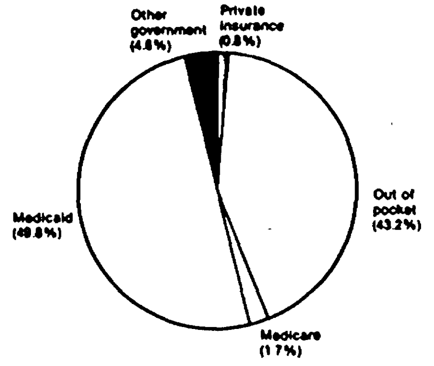
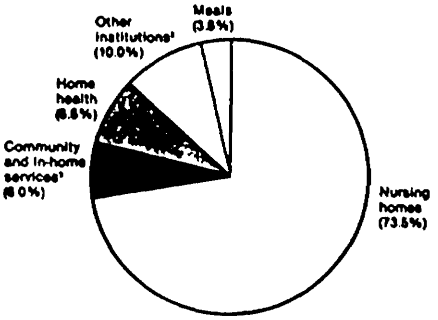
Exhibit 4: Nursing home expenditures, 1981



Source. D. Waldo and R. Gibson, "National Health Expenditures, 1981," *Health Care Financing Review*, Vol. 4, No. 1, September 1982.

Exhibit 5: Public expenditures on long-term care,[1] 1980



Does not add to 100 percent due to rounding.

Source: Joel Cohen, "Public Program Financing Long-Term Care," National Governors' Association, 1983

[1] Includes Federal and joint Federal-state programs only.

[2] Includes intermediate care facilities for the mentally retarded and other non-medical institutions.

[3] Includes personal care, homemaker, chore, home management, day care, foster care, and miscellaneous social services.

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g Soldo, B., "The Elderly Home Care Population: National Prevalence Rates, Select Characteristics and Alternative Sources of Assistance" in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol III, Department of Health and Human Services Contract No 100-80-0158, July 1983

h Weissert, W., *op cit*

i. Persons are classified according to their most severe impairment and typically suffer all lesser degrees of impairment as well. Needing assistance in eating therefore implies a need for assistance in all other elements of personal care. Ranked from most to least severe, impairments in personal care include the need for assistance in eating, toileting, bathing, dressing, and mobility

j Waldo, D. and Gibson, R., "National Health Expenditures, 1981," *Health Care Financing Review*, Vol. 4, No. 1, September 1982

k In the Omnibus Reconciliation Act of 1981 (Section 2176), Congress authorized waivers from various Medicaid requirements for states developing noninstitutional services, reducing the risks associated with coverage. For further discussion, see below.

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cial Security Act) in 1965. The Medicaid program initially covered nursing home care only in skilled nursing facilities (SNFs), but was later extended to cover intermediate care facilities (ICFs).[l] Although coverage of intermediate care facilities is optional, all state Medicaid programs include it.

Federal subsidies supported a dramatic expansion of the nursing home industry. In 1950, about 300,000 persons used nursing home care. By 1960, nursing home users numbered 470,000 and by 1980, over 1,400,000 (See Exhibit 6).[m] This expansion was sufficient not only to support a response to the growth and aging of the elderly population, but also to allow more elderly at any given age to receive nursing home care. The proportion of the population 65 and over living in long-term care institutions rose from 3.64 percent in 1960 to 4.78 percent in 1970.[n] Thirty-five percent of the increase reflects the aging of the elderly population, that is, an increase in the proportion of the very old who are more likely to use institutions. The remaining 65 percent, however, reflects increased use, holding the age distribution constant. The proportion of persons over 65 in institutions would have had to increase from 3.64 percent to 3.99 percent between 1960 and 1970 to keep pace with population change and allow behavior to remain constant. The increase from 3.99 percent to 4.78 percent reflects a change in behavior as a larger fraction of people at each age enter institutions.

Although most states used Federal funds to support nursing home growth, they supported very different amounts of care, both before and after Medicaid's adoption. In 1967, as the Medicaid program began, the nursing home bed supply ranged from 11.9 beds per thousand elderly in West Virginia to 81.8 beds per thousand elderly in Iowa. During the next 13 years, the annual rate of growth varied considerably. In some states, bed growth did not keep up with growth in the elderly population. Other states dramatically increased their bed-to-population ratios. The considerable variation meant that, despite the in-

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[l] In 1967, Congress amended Title XI of the Social Security Act to provide Federal matching for payments to ICFs on the same terms as any Medicaid covered services. In 1971, ICF coverage was transferred to Medicaid. For earlier history, see J.B. Silvers and Bruce Spitz, "The Nursing Home Capital Formation and Funding," *Healthcare Financial Management*, April 1981, pp. 32-49.

[m] A portion of this increase represented a substitution among institutional types rather than real growth. The population in mental hospitals declined dramatically in the period from 750,000 to 400,000. However, much of this decline involved returning patients to the community because of improved treatment and new philosophies regarding treatment in the least restrictive environment.

[n] Scanlon, W. and Sulvetta M., "The Supply of Institutional Long-Term Care: Descriptive Analysis of Its Growth and Current State," in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol. V., Department of Health and Human Services Contract No. 100-80-0158, July 1983. Comparable data on institutional use by age from the 1980 census are not yet available. Other data suggest utilization rates have increased much less during the 1970s. In addition, the increases are concentrated in the early part of the decade, as bed growth in recent years has simply kept pace with the growth of the elderly population.

Exhibit 6: Number of persons and percent of U.S. population residing in long-term care institutions as reported by census of population

	1950		1960		1970		1980	
	Persons	Percent of population	Persons	Percent of population	Persons	Percent of population	Persons	Percent of population
All Ages								
All LTC institutions	1,161,974	0.76	1,406,268	0.78	1,670,187	0.82	1,916,213	0.86
Nursing homes	296,783	0.20	469,717	0.26	927,514	0.46	1,426,371	0.63
Mental institutions[1]	747,817	0.50	804,773	0.44	635,882	0.31	394,450	0.17
TB and chronic disease hospitals	96,375	0.06	107,485	0.06	84,032	0.04	68,606	0.03
Homes of physically handicapped, blind and deaf	20,999	0.01	24,291	0.01	22,739	0.01	26,786	0.01
65 and over								
All LTC institutions	378,515	3.06	607,517	3.64	949,837	4.78	N/A	N/A
Nursing homes	217,636	1.77	387,953	2.32	795,807	3.96	N/A	N/A
Mental institutions	145,530	1.19	182,602	1.09	123,770	0.62	N/A	N/A
TB and chronic disease hospitals	15,449	0.13	37,362	0.22	40,260	0.20	N/A	N/A
Homes of physically handicapped, blind and deaf	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Source: U.S. Bureau of the Census, U.S. Census of Population: 1950. Vol. IV, *Special Reports*, Part 2, Chapter C, Institutional Population. U.S. Government Printing Office, Washington, D.C., 1953.

U.S. Bureau of the Census, U.S. Census of Population: 1960. *Subject Reports*: Final Report PC (2)-8A. Inmates of Institutions, U.S. Government Printing Office, Washington, D.C., 1963.

U.S. Bureau of the Census, U.S. Census of Population: 1970. *Subject Reports*. Final Report PC(2)-4E: Persons in Institutions and Other Group Quarters, U.S. Government Printing Office, Washington, D.C., 1973.

1980 figures are unpublished. Bureau of the Census, preliminary estimates.

[1] Includes mental hospitals, facilities for mentally impaired and residential treatment centers.

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creased Federal role associated with Medicaid and a general expansion of the bed supply, per capita elderly supply levels continued to vary substantially across states. In 1980, levels ranged from 21.4 beds per thousand elderly in Florida to 95 beds per thousand elderly in South Dakota.

Profound changes in the industry's structure have accompanied the growth of the nursing home industry. Changes include an increasingly sophisticated medical orientation in nursing home care, a shift away from government-owned to proprietary homes, and, more recently, a growing concentration of ownership in multi-facility chains.

The more sophisticated medical orientation in nursing home care reflects Medicaid requirements for covered care and state as well as Federal efforts to enforce structural and staffing standards. Both skilled and intermediate levels of Medicaid-covered care required more nursing involvement than small boarding institutions had previously offered. Medicaid also required states to comply with (1) the 1967 Life Safety Code Standards for the design and outfitting of buildings and (2) state licensure requirements regarding nursing home construction and staffing. During the 1970s, many states went well beyond Federal minimum requirements in specifying the level and kind of staffing required per patient for different levels of care.

Both structural and staffing standards caused many small nursing homes to go out of business during the 1970s. More than 6,000, or 28 percent of homes operating in 1971, closed by 1976. In the same period, 4,800 homes opened. The new homes were more than twice as large as the homes they replaced, and the average size of a nursing home increased from 54.5 to 68.9 beds.[o]

Government programs' expansion also brought a shift from government to proprietary ownership. Between 1950 and 1980, government-owned homes' share of patients fell from almost 40 percent to about 8.4 percent, and proprietaries' share rose from 37 percent to 70 percent.[p] Although that ownership distribution remained stable during the 1970s, another change is now in progress—concentration of ownership in multi-facility chains. Between 1980 and 1982, the major investor-owned chains increased their beds by 64 percent, resulting in their ownership of 16 percent of all nursing home beds.[q] This growth in concentration partly reflects the attractiveness of nursing homes as an investment, leading chains to expand. However, it also results from public policy—specifically, Certificate-Of-Need regulation, which prohibits or restricts growth of nursing home beds in many states. With these restrictions, chains expand by purchasing existing facilities rather than building new ones and thereby acquire a larger share of the nursing home stock.

Despite expansion of the nursing home industry and nursing home use, there appears to be a shortage of nursing home beds relative to the demand for nursing home care by publicly supported patients. The reason for access problems is that the total costs of nursing home care for people eligible for Medicaid support would exceed what states are willing or able to pay. For years, nursing home care has accounted for more than one-third of Medicaid spending. Since Medicaid's adoption, national nursing home expenditures have increased quite rapidly, growing from $2.1 billion in 1965 to $24.2 billion in 1981.[r] For most of that period, Medicaid spending on nursing homes increased over 20 percent per year, more than twice as fast as total state and local spending [s] Even before the 1980s recession, states were taking steps to reduce long-term care's share of state budgets.[t]

Most states have limited their long-term care expenditures by limiting what they pay for nursing home care and by using Certificate-Of-Need to control the number of nursing home beds. A shortage of nursing home beds creates a particular problem for Medicaid patients needing costly care. Because Medicaid pays less than private patients for nursing home care and, in most states, does not sufficiently vary its rates with the cost of different patients' care, nursing homes prefer private-pay to Medicaid patients and Medicaid patients needing little care to those with expensive care needs.

While understandable, this economic discrimination poses a serious access problem for patients most in need of care. Research indicates that where bed supplies are most limited (the result of low Medicaid rates or Certificate-Of-Need regulation), smaller proportions of the most impaired population actually reside in nursing homes. In states with the highest bed-to-elderly population ratios, more than 90 percent of persons most in need of care (unmarried persons 75 or older, needing assistance in all activities of daily living) were in nursing homes. Only half that population received care in states with the lowest bed-to-population ratios.[u]

This access problem can be expected to worsen. Although the nursing home bed supply has kept pace with growth of the elderly population in the last de-

Continued on page 30

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o. Ibid.

p. Ibid. and Al Sirrocco, "An Overview of the 1980 National Master Facility Inventory Survey of Nursing and Related Care Homes," National Center for Health Statistics, August 1983.

q. La Violette, S. "Nursing Home Chains Scramble for More Private Paying Patients," *Modern Health Care*, May 1983, pp 130-138.

r. Waldo and Gibson, *op. cit.*

s. Bovbjerg, R. and Holahan, J., *Medicaid in the Reagan Era: Federal Policy and State Choices*, Urban Institute Press, 1982.

t. Feder, J and Scanlon, W., "Regulating the Bed Supply in Nursing Homes," *Milbank Memorial Fund Quarterly/Health and Society*, 58:1, Winter 1980, pp. 54-88.

u. Weissert, W and Scanlon, W., "Determinants of Institutionalization of the Aged," in *Project to Analyze Existing Long-Term Care Data, Final Report*, Vol. III, Department of Health and Human Services Contract No. 100-80-0158, July 1983.

Senator DURENBERGER. Senator Packwood?

Senator PACKWOOD. No questions, Mr. Chairman.

Senator DURENBERGER. Senator Heinz?

Senator HEINZ. No questions.

Senator DURENBERGER. Let me ask you, Dr. Scanlon, a very general question: Do you think we are at the point where we have enough of the answers at hand to launch long-term-care efforts on the Federal side in some major new direction?

Dr. SCANLON. No; Senator, I do not. I think that there are a number of questions which remain to be answered.

We have learned considerably from the demonstrations I cited in my introductory remarks. However, there are major efforts currently underway—the channeling demonstrations, and the State programs under the 2176 waivers. I think in terms of designing a new program, that we need to draw on these experiences to try to meet objectives that we set for that program.

In any new program we are going to have some objectives with respect to cost and some objectives with respect to the population that we are going to serve, and I think we need to discover what mechanisms work best in trying to achieve those objectives.

Senator DURENBERGER. On page 6 of your written testimony you indicate that experience from various long-term care demonstrations has "increased the total cost of long-term care because community care services have been increased." You also indicate that there has been limited reduction in pursuing the use of community-based services. How then do you explain the expanded activity on the part of States to develop systems in which the type and the range of community-based care has actually increased?

Dr. SCANLON. I think that it is a reflection of the need that exists in the community for long-term care and the States recognition that they are not serving that need.

A survey of the State programs under 2176 that the National Governors Association has produced has indicated that these programs tend to be rather small and that the States are being very cautious about the extent to which they provide in-home and community services. It is not that everyone does not recognize the need for these services; it is a question of being financially liable for these services after the program has been implemented. And I think the States feel too fiscally pressed to open up a very large program.

Senator DURENBERGER. If one of our fiscal options was just to make incremental changes in current policy, would you recommend that we continue the approach as through 2176 in assisting States to alter their own care systems?

Dr. SCANLON. I think the option of using the States as the mechanism whereby a program is implemented is a very good one. The States have both a strong sense of fiscal responsibility and because of concern about the impact on their budgets and because they are much closer to the problem a better sense of how a program should be operated.

Second, I think that we learn from the diversity of what States do. Through the medicaid program we have a tremendous variety of approaches to both payment and coverage of service, utilization review, and other policies, which make a big difference in terms of the way a program operates. If we were to legislate a national program, we would be choosing one option for all of those kinds of areas, and therefore we would not know whether or not there were better alternatives available.

Senator DURENBERGER. Thank you very much, Dr. Scanlon.

Are there any other questions?

Senator PACKWOOD. I want to ask him just one question: How do you account for the success which Oregon has had which runs counter to your statement that increased home run utilization will be by people who would not go into a nursing home?

Our program has been going since 1975, and when we got the waiver we consolidated medicaid with it. But it appears to be working.

Dr. SCANLON. I think there are a number of possibilities. I am not that familiar with the Oregon experience; however, there is the question of whether or not better targeting of services to people who would have entered a nursing home will actually reduce costs. You may be more successful at that.

The example you cited from the newspaper article is a case of a person who is in a somewhat less intensive institutional environment than a nursing home. I think that is an important means of trying to save nursing home costs—keeping people in less restrictive yet supported or quasi-institutional environments.

It is not possible for many people to survive at home alone, with services being delivered from the outside. It is critical that they have someone else in their home or in their building to provide services on an as-needed basis. As needs may arise many times during the course of a day, the notion of keeping people alone in the home and in the community is not viable. However, keeping people in different types of congregate environments where one can receive services that are constantly available in that environment while one only needs those service intermittently may be a very cost effective and a very humane way of providing services. It is different than a nursing home, but it is still somewhat of an institution.

Senator PACKWOOD. Well, in this project in Oregon people have literally been taken out of nursing homes, moved into adult foster care or back home. I will read you just the end of one paragraph and the next paragraph:

"As the result of these waivers, additional adult foster homes were established." I am reading from the testimony of Mr. Robert Zeigen, who will testify for the State of Oregon later.

> We now find substitute living situations are being increasingly used by private paying persons who formerly would have entered a nursing facility. We estimate that our Medicaid costs have been reduced by approximately $1 million each month as the result of these actions, while we have been able to serve an increased number of persons at risk of institutionalization. This is greatly facilitated by the availability of Oregon Project Independence to serve persons not eligible for Medicaid. In the process, the Medicaid nursing facility caseload has been reduced by 5.6 percent.

Dr. SCANLON. I think that the key is that these may be alternative living arrangements that are not the same as trying to serve a person in their own home. And to the extent that foster care and sort of group living exist——

Senator PACKWOOD. Some of them are foster care.

Dr. SCANLON. Some of them are, I know. That helps very much in terms of reducing the average cost of the program.

The notion of serving a very heavy-care patient in the community, with services being delivered to their home——

Senator PACKWOOD. But I don't think we are talking about serving a patient who needs heavy care, in the sense you use it. That person is going to be in a nursing home or maybe in a hospital.

Dr. SCANLON. But there are many people who need heavy care who live in the community and live with their spouse. One of the things that we have found in our research, in looking at the determinants of institutionalization, is that, just as many people who are as dependent as the nursing home population, living at home. But the difference is that they are often living with their spouse. A spouse is willing to make the heroic effort to keep that person at home.

I think if when we decide to serve only people that have lesser needs because it is not too costly, we have to recognize that we are not going to be serving that heavy care population that lives in the community, and we are going to be asking their spouses or families to be the ones that provide all their care.

Senator DURENBERGER. Any other questions?

[No response.]

Senator DURENBERGER. Dr. Scanlon, thank you very much.

Dr. SCANLON. Thank you.

Senator DURENBERGER. We appreciate your testimony a great deal.

Senator DURENBERGER. Our next witness will be Ms. Eleanor Chelimsky, Director, Institute for Program Evaluation of the U.S. General Accounting Office in Washington, D.C.

We welcome you and your testimony, and your associates. GAO always comes with associates. Your statement in full will be made part of the record, and you may summarize that statement now.

STATEMENT OF ELEANOR CHELIMSKY, DIRECTOR, INSTITUTE FOR PROGRAM EVALUATION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C.

Ms. CHELIMSKY. Thank you so much, Mr. Chairman.

Good afternoon, Mr. Chairman, members of the subcommittee. It is a pleasure for us to be here and talk about the work we have been doing at GAO in the area of long-term care. We have been doing it for some years now.

Let me begin by introducing all of these associates that you noticed already: Janet Shikles, Tom Dowdal, Susan Van Gelder. All of them have been working in this area for some years now.

Well, in order to heed the subcommittee's time constraints and the need for brevity, I am presenting only the highlights of the short statement you have. Since that already is a ministatement, I guess this qualifies as a miniministatement. So if it is at all possible, I hope that, as you said, the larger one will be in the record.

Based on our work in this area, we think it is clear there are currently many growing pressures to expand community-based long-term care, and I think we have heard about some of them already today.

These pressures, we think, stem principally from four factors—although of course there are other factors. There is a large increase in public demand; there is a change from acute to chronic disease as our major health care problem; we have efforts to reduce Government expenditure in other areas, which creates a bulge in this area; and of course there is a desire to improve the wellbeing and the independence of the elderly.

Two recent GAO reports that we have done may be useful to you in your deliberations on long-term health services. The first is on home health care. In that study, we found that people who received expanded home health services lived longer and were more satisfied with their lives than those who didn't receive those services. That is obviously a major achievement.

However, we found that such expansion would increase the numbers of people eligible for and receiving publicly supported care. We also found that costs for providing home health care were not offset by reduced nursing home and hospital use.

What that means is that we should probably not be expecting home health care to reduce overall health care costs. There are several reasons why this is true.

We have heard one or two of these already before. More disabled elderly in the community will become eligible for these services than were before; families could substitute these publicly subsidized services for their own informal support. Whenever persons are diverted from nursing home beds and then are replaced by others in need of nursing home care, savings are not going to be realized. Finally, because home health care services are provided in individual homes—this of course was what Dr. Scanlon and Senator Packwood were just discussing—the cost of such care will often be higher than it is in nursing homes where many individuals can be served at the same time and obviously we can get economies of scale.

But regardless of these findings on costs, we think demand for community-based long-term care services will continue to grow because people prefer a wide range of optional services.

So, given this demand pressure, given the potential costliness of expanding home care, and given constraints on the supply of health services, which I think we are always going to have, it is absolutely clear we need to develop the most efficient means possible for providing these services.

The second GAO report I want to mention is our study of medicaid and nursing homes, which is just out today. In that report we conclude that nursing home bed supply doesn't seem to be keeping pace with the increase in the aged population most likely to use nursing home care—that's the population 75 to 85 that you were talking about, Senator Heinz.

Also, the variation in supply across States results in having some elderly in some States unable to gain access to nursing homes, while people in other States appear to use them unnecessarily.

Our study notes two conflicting trends in the data on nursing homes. The first involves an increasingly dependent nursing home population and an increase in the number who may need to enter those homes in the next decade.

Let me just parenthetically note that it was the excellent detailed data base on all medicaid nursing home residents from the chairman's home State of Minnesota which allowed us to examine and measure changes in physical dependency over time. We were glad to have that data base.

Well, as I was saying, we found that the nursing home population is getting larger and more dependent; but the second trend we identified runs precisely counter to the first: That is, some States are attempting to keep their medicaid costs down by limiting the bed supply for which the demand is increasing. Not only that, but bed supply may be further constrained by the recent changes in hospital reimbursement. The problem is that medicare's new diagnosis-related group payment system—that's the DRG we have been talking about—with its built-in incentive to reduce lengths of stay in hospitals, may encourage those hospitals to place more patients in nursing homes and in home health care, as they try to discharge patients earlier than they have in the past. So that's a new hurdle for disabled or chronically ill elderly in trying to find a nursing home.

To sum up quickly, then, let me emphasize several factors that I have mentioned that I think have great significance for long-term care policy:

First, most elderly and their families prefer to avoid institutional care and would rather receive a range of services in the community.

Second, there is a growing elderly population with an increasing likelihood of disability and dependency, who will need long-term care services.

Third, many elderly who will need beds in nursing homes may not be able to find them because of the States' efforts to limit supply and because of the new medicare hospital policy.

Finally, a whole new group of individuals may be seeking expanded home health services as the result of the changes in medicare's hospital reimbursement system.

So with this kind of swelling demand and shrinking supply, it seems obvious that we need to identify how these services should be organized and reimbursed to assure maximum efficiency and effectiveness. Unfortunately, to do that we need data, and what we found is that basic program data on long-term care services are just grossly inadequate.

Data on the care needs of the persons who are served and not served in long-term care settings, and data on the cost of these services, are generally outdated, unreliable, unavailable.

So until we have a better understanding of the current delivery and reimbursement of long-term care services, it is going to be difficult to translate the findings of long-term care research projects into effective national policy.

Now, there is a great deal of diversity and innovation in what the individual States are already doing, and the development of data on their experiences could yield very useful information. We need knowledge in four areas:

First, the characteristics of the persons who are most in need of long-term care;

Second, the types of services that long-term care should encompass and who should provide them;

Third, the methods of payment that will provide services most efficiently; and

Finally, the mechanisms that will allow the maximum informal support from families and friends.

These four areas must be addressed, it seems to us, if we are eventually to develop a system that is not only adequate and efficient but also appropriate and equitable.

Thank you. I will be happy to answer any questions.

[Ms. Chelimsky's prepared statement follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE

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STATEMENT OF

ELEANOR CHELIMSKY

DIRECTOR, INSTITUTE FOR PROGRAM EVALUATION

ON

LONG-TERM CARE

BEFORE THE

SUBCOMMITTEE ON HEALTH

UNITED STATES SENATE

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

We are pleased to be here to talk about GAO's work in long-term care over the past several years (see Appendix). As you noted in your announcement for this hearing, "one of the most difficult social issues facing our Nation is to determine how best to provide for the long-term needs of our frail elderly and disabled populations." Currently there is no coordinated national policy that promotes both adequate and efficient long-term care services.

The elderly and their families often encounter numerous difficulties when they look for long-term care services. As we determined from one study (GAO, 1979), they are likely to find that

--there is a lack of information about the services available,

--community services essential to remaining at home may not exist,

--there is often a lack of coordination among public and private community service providers,

--eligibility for services varies across institutions and across states, and

--professionals may tend to recommend nursing home placement not because it is appropriate but because they do not have the expertise or time to arrange for community care.

Community-based long-term care is often expensive and may be unaffordable to many. The elderly in need of services often find that the only source of help they can receive is nursing home care subsidized by Medicaid.

Because of these problems, there is considerable interest in the government's liberalizing eligibility and the coverage of services to insure the expansion of community-based home health care. Revisions to the present system are also being proposed in response to

--an increase in health care demand stemming from the growth in the size of the elderly population and reduction in the ability of families to provide care to aged parents and grandparents,

--the new dominance of chronic disease as the major health care problem among the elderly,

--efforts to reduce high government expenditures for nursing homes and hospital care, and

--a desire to increase the independence and improve the physical and mental well-being of the elderly.

Some recent GAO reports (GAO, 1982 and 1983) may be of use as you consider what changes are needed in the payment and provision of long-term care services to the chronically ill elderly. Let me briefly describe our findings from two studies--one on home health care and the other on nursing home care.

HOME HEALTH CARE STUDY

Our study of home health care (GAO, 1982) found that an expansion of community-based benefits would provide valuable services to the nation's elderly. We found evidence that individuals who received expanded home health care services lived longer than those who did not receive these services. Those who received them also reported feeling more satisfied with their lives. However, we found that such expansion would increase the numbers of people eligible for and receiving publicly supported care. And, as eligibility and services expanded, this would necessarily mean growth in the nation's overall health bill. Nonetheless, we had expected to find that some of the increased home health care costs could be offset if there were savings from reduced nursing home and hospital use.

But in our review of home health projects, which offer a wide array of community-based care to the chronically ill elderly, we found that home health care services have not conclusively reduced either institutionalization or total service costs. While one might intuitively expect that providing home health care services to people in their own homes would be less expensive than providing nursing home care, there are several reasons why an expansion of home health care may not reduce overall health care costs:

1. Two to three times as many chronically ill elderly live in the community as live in nursing homes. Making home health care services more widely available might mean that some people living in the community who are eligible for the additional services might use them because they are as disabled as some nursing home residents. The additional services would probably be beneficial to them but would also increase overall health care costs because more persons would be served.
2. Most of the long-term care given to the elderly today is provided informally by relatives. With broader coverage and eligibility for a wider range of home health care services, families might substitute publicly subsidized services to reduce their own burden.
3. The unmet demand for nursing home beds is substantial in some geographical areas of the country. This means that while some individuals may not enter nursing

homes, savings may not be realized in the short term if the chronically disabled elderly who are waiting in hospital beds or in the community for nursing home care are placed in beds made newly available by expanded home health care.

4. Finally, because home health care services are provided in individual homes, it is difficult for the price of such care to be competitive when extensive services are provided in nursing homes where many individuals can be served at the same time.

While these findings indicate both that home health care is beneficial and that costs are likely to increase, perhaps the important issue here is that community-based long-term care services <u>will continue to grow</u>. This is because most individuals and their families prefer to avoid institutions and desire instead a wide range of options in long-term care in addition to nursing home services. The increasing number of initiatives and programs in long-term care at the state level are in part a response to this public preference for obtaining needed services outside institutions. Given this pressure and the potential costliness of expanding home care, attention to developing efficient means of providing these services is essential.

NURSING HOME STUDY

Besides the pressure from popular support for expanded community-based long-term care services, constraints on the availability of nursing home beds may add to the pressure to increase services. These constraints were identified in another GAO report, available today, in which we reviewed nursing home care across the states (GAO, 1983). The government spends more on nursing home care than on any other long-term health care service. Because Medicare and private insurance pay for only a negligible portion of this care, Medicaid, a state administered and federally supported program, has become the primary payer. National estimates of its coverage range from 48 to 75 percent of all nursing home residents.

In our study of trends in nursing home services over the last several years, we concluded that nursing home bed supply may not have kept pace with the increase in the population most likely to use nursing home care. Available estimates of the growth in elderly population cohorts show that the number of persons age 65 and older grew 2.4 percent a year in the middle to late 1970's and bed supply grew 2.9 percent. However, the biggest users of nursing home care, those age 85 and older, grew an estimated 4.5 percent a year. These data suggest that bed supply did not increase fast enough to serve the same proportion of elderly who have been served in the past. We also found that the availability of nursing home services varies widely from state to state. Some elderly are unable to gain access to nursing homes, and others appear to use them unnecessarily.

We found two conflicting trends in the available data on nursing homes. The first trend, based on data from two national surveys and a detailed data base on all Minnesota Medicaid nursing home residents, involves a growing intensity of services. The elderly who now reside in nursing homes are becoming increasingly disabled and dependent, and the number who may need to enter them in the next decade is likely to increase. Unless major breakthroughs in the treatment of chronic diseases occur, extended life expectancies, with greater likelihood of chronic disabling diseases, and a reduced number of family members able to provide informal care will lead to a net increase in the population most likely to need intensive nursing home services. Further, if community-based services postpone or prevent placement in nursing homes for some elderly, nursing home residents are likely to be more dependent and have costlier care needs than in the past.

The second trend, conflicting sharply with the first, involves the effort by most states to keep their Medicaid costs down, despite high nursing home occupancy rates and growing demand for services. The states are making this effort because Medicaid expenditures for nursing home care constitute a large component of the states' Medicaid budgets and have increased at high rates in the past. Virtually all the states have had problems financing this service and their efforts to reduce costs tend to focus on ways of limiting nursing home reimbursement or the supply of beds or both.

While the states are attempting to cut their costs by limiting the availability of nursing home services, recent changes in Medicare's hospital reimbursement system may sharpen this conflict. Medicare's new diagnosis-related group (DRG) payment system for hospital care, with its built-in incentive to reduce lengths of stay in hospitals, may place greater pressures on the use of a limited nursing home bed supply. Hospitals may attempt to place more patients in nursing homes and in home health care as they try to discharge patients earlier than they have in the past. However, nursing home beds may not be available to meet this new demand, which would, in turn, increase the need to expand community-based services.

CONCLUSION

To sum up, I have drawn attention to several factors that have clear significance for long-term care policy. First, and perhaps paramount, most elderly and their families prefer to avoid institutional care and would rather receive a range of services in the community. Second, there is a growing elderly population, with an increasing likelihood of disabilities, who will be in need of long-term care services. Third, many individuals like those who have appropriately used nursing home services in the past may not be able to find nursing home beds, because of the states' efforts to limit the supply of beds and because of the effect of Medicare's DRG system on expanding the demand for nursing home services. These individuals may need to rely on an expanded array of home health services. Fourth, and finally, a new group of individuals may be seeking expanded home health care services as a result of the changes in Medicare's hospital reimbursement system.

An expansion in the availability and use of community-based services is likely to increase public health expenditures. This is probable because of reasons I have already mentioned, including the following: (1) more individuals are likely to use these services, (2) many of these services would now be paid out of public funds whereas historically they were provided by the family, and (3) providing expanded community-based services will not necessarily result in institutional savings.

With the expected expansion of both demand and costs for long-term care and the concern that many persons who are in need of long-term care may have difficulty in obtaining the services that they need, it is imperative to identify how these services should be organized and reimbursed to insure maximum efficiency and effectiveness. Our studies have found that basic program data on long-term care services are inadequate. Data on the care needs of the persons who are served and not served in long-term care settings and on the costs of these services are generally outdated, unreliable, or unavailable. Until we have a better understanding of the current delivery and reimbursement of long-term care services, it will be difficult to translate the findings of current long-term care research projects into effective national policy.

While demonstration projects are important in testing untried alternatives, we should recognize that there is great variety in what the individual states are already doing under Medicaid and other state programs. For example, there is a need to evaluate the several state preadmission screening programs that have been in operation for several years as well as alternative methods of reimbursement for the care of the very dependent elderly in nursing homes. The development of data on and an analysis of their experiences could yield considerably useful information.

We believe that the analysis of long-term care experiments should focus specifically on four areas: (1) the characteristics of the persons who are most in need of long-term care, (2) the types of services that long-term care should encompass and who should provide them, (3) the methods of payment that will provide services the most efficiently, and (4) the mechanisms that will allow the maximum of informal support from families and friends. In the evaluation of new proposals for providing long-term care, these four areas must be addressed if we are to derive the kind of information that we need in order to develop a system that is adequate, efficient, appropriate, and equitable.

MAJOR GAO REPORTS ON LONG-TERM CARE

Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for Medicaid and the Elderly, GAO/IPE-84-1, October 21, 1983.

Federal Funding of Long-Term Care for the Elderly, GAO/HRD-83-60, June 15, 1983.

The Elderly Should Benefit from Expanded Home Health Care but Increasing These Services Will Not Insure Cost Reductions, GAO/IPE-83-1, December 7, 1982.

Audit of Medicaid Costs Reported by Autumn Hills Convalescent Centers, Inc., Houston, Texas, GAO/HRD-83-9, October 14, 1982.

Assessment of the Use of Tax Credits for Families Who Provide Health Care to Disabled Elderly Residents, GAO/IPE-82-7, August 27, 1982.

Preliminary Findings on Patient Characteristics and State Medicaid Expenditures for Nursing Home Care, GAO/IPE-82-4, July 15, 1982.

The Status of the Department of Health and Human Services' Compliance with Requirements to Establish a Data Collection Plan for the Medicaid Home and Community Care Waiver, GAO/IPE-82-3, May 4, 1982.

Improved Knowledge Base Would Be Helpful in Reaching Policy Decisions on Providing Long-Term, In-Home Services for the Elderly, HRD-82-4, October 26, 1981.

Medicare Home Health Services: A Difficult Program to Control, HRD-81-155, September 25, 1981.

Evaluation of the Health Care Financing Administration's Proposed Home Health Care Cost Limits, HRD-80-85, May 8, 1980.

Entering a Nursing Home--Costly Implications for Medicaid and the Elderly, PAD-80-12, November 26, 1979.

Home Health: The Need for a National Policy to Better Provide for the Elderly, HRD-78-19, December 30, 1977.

The Well-Being of Older People in Cleveland, Ohio, HRD-77-70, April 19, 1977.

Senator DURENBERGER. Thank you very much. That was an excellent statement.

Senator Packwood?

Senator PACKWOOD. No questions.

As usual, I find the GAO reports very good.

Senator DURENBERGER. Senator Heinz?

Senator HEINZ. Mr. Chairman, one question:

Ms. Chelimksy, you have mentioned an "urgent demand" on pages 6 and 7 of your statement "for more and better information." And indeed, it comes as something—only something—of a mild shock that you are in such bad straits when it comes to having the additional information you need to help us.

I said earlier that Senator Bradley, Senator Packwood, and I, and some other members of this committee have introduced a bill, S. 1614, that establishes up to 20 State programs, the Health Care Coordination Act. In that bill we have included very substantial data reporting requirements for this reason.

Ms. CHELIMSKY. Yes, I saw that.

Senator HEINZ. It is financed in good part by capitated medicare payments. Now, I am not asking you to speak directly about the bill, per se; but I am asking you if such a bill and such information gathering as we provide in that bill seems to embody the right kind of principal components to help guide us in the choices we must make in the future.

Ms. CHELIMSKY. Yes, I think it does. I was very happy when I saw the kinds of questions you were asking, the kinds of data you were thinking of collecting, the kinds of monitoring that you are planning to do. It seems to me exemplary, and I think we will know a lot more based on some of these efforts that you are doing now than we presently do. I certainly hope so.

Senator HEINZ. Well, just to follow up on that, in your statement, where you indicate on page 9 and then on page 10 specifically the kinds of knowledge we need, is it your view that we catch most of those categories?

Ms. CHELIMSKY. We think there is always going to be a problem in looking at the question of who needs what services. There is a problem of utilization and need. You can't equate the two. Because people are in nursing homes doesn't necessarily mean that they need to be there.

Senator HEINZ. Yes.

Ms. CHELIMSKY. That problem permeates the whole data question. You simply cannot make any determination about who is being served, whether it is appropriate, whether it is reasonable. It is a major problem, and I don't think there is much we can do about that now.

For the other data requirements that we mentioned earlier, I think it does very well.

Senator HEINZ. Thank you very much.

Thank you, Mr. Chairman.

Senator DURENBERGER. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Ms. Chelimsky, I think you have done a good job in documenting lots of areas of need here. It is a near staggering problem.

Ms. CHELIMSKY. Yes.

Senator BAUCUS. And certainly on in future years, for reasons you have indicated. I also think it is important to find more information; but from our point of view it is probably more important if we could find some dollars for some of this.

Unfortunately, right now we are going in the other direction in this committee, to find ways to use these deficits. To some degree in our country, some of the chickens have come home to roost. We are now in a position where we are trying to figure out how to pay less now so we are not paying more later. But I only say that so we are not kidding ourselves. On the one hand, two very significant problems collide here.

Ms. CHELIMSKY. Yes.

Senator BAUCUS. I just hope that we all keep that in mind as we try to solve this.

I think Alzheimer's disease, for example, should probably be covered by medicare, especially since some other illnesses are covered. Alzheimer's is not now covered. So it behooves us to put on our thinking caps. That was not your charge, I understand that, for this purpose, but we must put on our thinking caps so we can find some way to imaginatively figure out how to solve some of this.

You have made a very important first step here, and I want to thank you.

Ms. CHELIMSKY. Thank you, Senator.

Senator DURENBERGER. Ms. Chelimsky, I think your 1982 report on home health care suggests that targeting services to specific populations, specifically to those less impaired, could help us contain costs. Could you tell us briefly how you think targeting ought to be done, and are assessment instruments adequate out there for identifying persons to whom services should be targeted?

Ms. CHELIMSKY. I don't think we know how to do targeting yet. That's one of the things we hope to learn from some of the channeling projects that are going on. We understand that we need to have a mix of services, that we need to have a spectrum of options available to people; but I think we need to learn an awful lot more about which populations can most benefit from which types of services.

We also need to look at how we pay and provide for those services. I don't think we have looked at all of those yet, and I certainly don't think we have done it systematically.

Senator DURENBERGER. Did you find any States that were good at targeting, that might give us some preliminary clues? Add on to that, for example, how many States use preadmission screening programs.

Ms. CHELIMSKY. That is one of the things that hasn't been looked at enough. I note that preadmission screening is going to be a critical component of some of the legislation, and I am concerned about what the effects of that are likely to be.

My own sense is that a large part of the problem of cost comes from the level of dependency. If in fact preadmission screening is effective, what is likely to happen in my view is that you are going to see the level of dependency, and therefore the cost of serving people with high levels of dependency, increase. It is almost a counterintuitive finding.

Senator DURENBERGER. Yes.

Ms. CHELIMSKY. And I am troubled about the fact that we really don't have systematic findings on that question yet.

Senator DURENBERGER. Do you have any thoughts on the feasibility of prepaid capitation payments for acute and long-term care services under medicare? Or prepaid capitation for acute and long-term services for persons eligible for medicare or medicaid?

Ms. CHELIMSKY. Well, I guess I am concerned about costs, and so it does seem to me important to do something on capitation.

Perhaps I should pass this to you, Tom. Would you like to speak to this?

Mr. DOWDAL. I don't know whether today we have the information we need to set a capitation rate for long-term care for the population as a whole, or even for particular at-risk populations of people, because the programs don't cover the same things. In order to get them all, to figure out what you would need to set the rate at, you would have to bring in all of the data from the various programs, all of which have different payment mechanisms, reimbursement systems, and things. In trying to put that all together to come up with a good rate, it is extremely difficult. I don't know whether we could do that at this time.

The idea of capitation, of course, is generally one that we favor. It does give incentives to minimize costs, if you set the capitition rate at the proper level.

Senator DURENBERGER. I think you indicated in your testimony that the report coming out today tells us what we have all suspected, and that is that in a bunch of our States people can't get into nursing homes who need it, and in a lot of other States people are in there who don't need it.

What is the problem in the former category? Is it the rate of payment that is set, which doesn't provide an adequate incentive to invest in homes? Is it the certificate-of-need regulations? I take it your report must deal in some way with why, in those States where there is more demand than supply.

Ms. CHELIMSKY. Yes. I think this is a very complex issue. It has to do with many particular stakeholder interests, in many cases.

There is the fact that nursing homes prefer to take private patients, very often. There is the fact that they prefer to take less costly patients. What I mean by 'less costly' is people with less dependency who require less intensive support and help. So what so very often occurs is that you have people who may not have the kinds of needs that others do who are occupying the beds. With the bed supply being reduced, or at least not being increased at the same rate that the most needy population is growing, that creates this kind of problem of not being able to find those beds.

Senator DURENBERGER. Senator Bradley, do you have questions?

Senator BRADLEY. Yes, Mr. Chairman. Thank you.

It seems from your report that you haven't seen any real evidence that it can be delivered in a cost-efficient way. Is that what you basically said?

Ms. CHELIMSKY. It seems to me more that you have a whole set of forces driving the kind of situation that we have. You have an enormous demand.

Every time in history where Federal dollars are going to be replacing private dollars, we have had an iceberg sort of thing, the zooming effect has been just very big, of newly eligible people pushing up costs. And given also the replacement of different types of funding, some of which is informal in the case of families, as was mentioned earlier, it is just extremely difficult to look at the size of these forces anc estimate exactly how this is going to affect us in terms of cost.

The problem here, I think, is also that we don't know how to do this in an appropriate way, and that's what I think your question was getting at.

I wanted to mention the first, because it seems to me that's an overarching problem that we are facing, which is really a little bit different than the question of how to do it cost-effectively. But that's true, too.

We don't really have good triage mechanisms for deciding who should be in a nursing home, who should go to home health care, who should be in a hospital. That's a problem.

It is very difficult, also, to determine costs based on a selected population that has perhaps lower intensivity of dependency needs and therefore costs less, and so it is a selection problem as well.

Senator **BRADLEY**. But I don't take your words of caution as a rejection or disapproval of the concept or the need. Is that correct?

Ms. **CHELIMSKY**. That is absolutely right. We think we need more experimentation. We think we need to learn an awful lot more, and I think we need to go a little bit slowly until we know better what these forces that we are releasing are likely to mean.

Senator **BRADLEY**. So you think that programs like the channeling grant programs to the States are very helpful in generating this kind of information?

Ms. **CHELIMSKY**. Yes, we expect to learn a great deal from them.

Senator **BRADLEY**. Do you think that any program that as adopted should be a narrowly targeted program in duration, geographic area, and population?

Ms. **CHELIMSKY**. I am not sure about the "narrowly targeted." I would be worrying about the generalizability afterwards. It seems to me that a small generalizable program would be ideal, in other words, one that would be designed so that one could have a sense that it would be representative and some sense that if we moved this out it would have approximately the same kinds of effects. That would be the ideal.

The most important thing now is that we learn something.

Senator **BRADLEY**. If you were looking at two population groups of senior citizens, though, one disabled and one healthy, wouldn't you say that you would gain different information from the two groups, and that you might look at those two programs as separate entities?

Ms. **CHELIMSKY**. Oh, yes, I certainly would. But I think it depends on what you are trying to learn. Are you trying to learn, you know, what is the effect of a particular kind of institutionalization or noninstitutionalization on a particular kind of population group? Or are you looking at something else? Are you looking purely at a question of costs—what is it going to cost to maintain somebody who is sick versus someone healthy? Depending on the question, you would design your study and your comparison groups, differently.

Senator **Bradley**. Well, I think you are looking at quality and cost, basically.

Ms. **Chelimsky**. Yes.

Senator **Bradley**. From your work, what do you suggest to be the best assurance of testing quality?

What technique, what screening process, what assessment process?

Ms. **Chelimsky**. I am not sure that I know how to answer that. We have seen some very good work in some of the demonstrations in the case-assessment efforts that were made, and they were extremely costly. So you ran into this tradeoff, again, of having excellent quality, marvelously targeted to people, very appropriate, with actually good results in terms of increased longevity. And the costs were so great that the programs didn't go ahead. You are always going to have that problem—quality is expensive. If you are looking for it alone, life is very simple; if you are trying to get a program where at the same time you are asking for quality and for it not to cost a lot, you know, the problem has been the same in all of our programs.

Senator **Bradley**. But what would be the criteria to assess quality, other than longevity? That's a fairly obvious one.

Mr. **Dowdal**. Senator, are you thinking of a quality assurance kind of thing, to put in with the program?

Senator **Bradley**. Right.

Mr. **Dowdal**. I don't know if we have ever identified one that we could absolutely say that would be the kind that you would want to do, that would really assure quality, that the right people get it.

Senator **Bradley**. So your study doesn't help us make judgments about whether it is possible to deliver quality care in the home?

Mr. **Dowdal**. I am sure quality care can be delivered at the home, but I don't think we are in a position where we can recommend a particular mechanism that will assure that quality is delivered at home. Most of the ones we have looked at we have found problems with.

Senator **Bradley**. But you can say that if a program is targeted to a particular population, either a general population or a disabled population or another kind of clearly definable population, that any demonstration project would be worth more?

Ms. **Chelimsky**. I think a demonstration project is useful in terms of what it is trying to do. I think if you learn from a demonstration what it is that you are setting out to learn, and in your case clearly you are asking what is quality care for somebody?—well, you can find that in many ways. Quality could be a question of longevity; it could be a question of satisfaction; it could be a question of independence.

For instance, if independence were the criterion, you would automatically be ruling out institutionalization. So you would have already answered your question by keeping somebody at home.

So the question of what somebody is looking for depends on what the medical problem is, what kind of solution you need to find, what kind of help you need to have, what your living conditions are, what your socioeconomic situation is. I think the question has to be posed in a way that you can get an answer.

Senator BRADLEY. What you are saying is you need a kind of individualized approach?

Ms. CHELIMSKY. I don't think so. I am saying that the demonstration needs to have an objective that can be answered in the way that the demonstration is implemented. I think that that's the thing that you need to do.

Senator DURENBERGER. Can I draw this to some kind of conclusion and ask you my "acid rain" question? [Laughter.]

I mean, we think we have a problem and so we bring in the terrestrial scientists, and they look at the land, and then we bring in the aquatic scientists and the biologists, and they look at the water and so forth. Then finally we get around to deciding that it must be coming from overhead, so we get into this linear relationships between emissions and what comes down.

Is the problem here that we aren't asking the right questions of the system? We haven't designed the right kind of demonstration? Is there something else that we should be setting up in this sort of experimental demonstration mode that we aren't doing?

I answered Bill's question as "get the system to price competition and consumer choice" and that satisfies me to a degree on quality; but is there another set of questions that we ought to be moving out there with and financing in the answer?

Ms. CHELIMSKY. I am very modest about this. I would be very happy if I knew that we were looking at questions that would tell us how we could get a system that would allow people to have options, that would not enormously increase the costs that we are going to have, that would take care of the increasing dependency that we see coming, and the demographics of large increases of people between 75 to 85.

So I feel very modest about what would be a wonderful thing to achieve. I am not thinking about perfect quality of medical care at this point, although obviously that would be a great thing to have.

Senator DURENBERGER. Tom, is there an add-on to that?

Mr. DOWDAL. I was going to say, in response to your question, that in the demonstration programs that we have looked at, generally we found that the way they have been designed would not give you the final answer that they were supposed to be providing. So more care in the design of the projects would probably be helpful to get the answers that you are looking for. There are a number of our reports that deal with that specific issue.

Ms. CHELIMSKY. Yes, I would agree with that.

Senator DURENBERGER. Are there other questions from my colleagues?

[No response.]

Senator DURENBERGER. If not, I thank you very much for your work, your efforts, and your testimony.

Our next witness is Ms. Patrice Feinstein, Associate Administrator for Policy in the Health Care Financing Administration, U.S. Department of Health and Human Services.

Ms. Feinstein, your statement will be made a part of the record, and you may now proceed to summarize it.

STATEMENT OF PATRICE HIRCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Ms. FEINSTEIN. Mr. Chairman, it is a pleasure to be here to address this committee again, this time on the subject of health care and particularly long-term care.

We have a few charts a little later in my presentation.

With me today are Larry Oday on my right, Director of the Bureau of Eligibility, Reimbursement, and Coverage; and Linda Hamm, Director of the Division of Long-Term Care Experimentation.

Long-term care is difficult to define because we know it is not simply a medical or health-care problem. Long-term care entails the combination of health and social services, housing, income support, and assistance from relatives and friends.

We also know that long-term care needs generally increase with age, which leads us to expect increasing demand for this care as the American population ages.

How to best meet this demand within the limits of a financially endangered medicare program and a medicaid program that already strains many State budgets is a challenge that must be approached with extreme caution.

A review of the demographic trends indicates dramatic potential for the growth of long-term care. Currently there are 26 million people over age 65, about 11 percent of the population. By the year 2030, the baby boom generation will increase this proportion to 18 percent—or 59 million persons. In other words, by the year 2030, 1 in 5 persons will be elderly—twice the proportion today.

In addition, the aging of the aged has significantly increased the demand for long-term care in the last decade and will continue to do so in the next century.

More than 20 percent of those over age 85 are in nursing homes, and those receiving home health care receive five times more services than the younger elderly. However, the aged are only one segment of the long-term care population. The adult disabled constitute a significant element of the population with long-term care needs. Other groups requiring some measure of long-term care include the mentally retarded, the developmentally disabled, and the adult chronically mentally ill.

Finally, the terminally ill, who require care for an extended period of time, also must be included in the long-term care population.

Before I describe some of our initiatives and potential policy options for meeting the increased demand for long-term care, I would like to summarize what medicare and medicaid currently provide.

The Health Care Financing Administration is the primary source of funding for long-term care services in the United States. The medicaid program is the principal payor, with total Federal and State payments in 1983 of approximately $16 billion for institutional care and about $550 million for home health services.

During the same fiscal year, the medicare program will spend about $520 million for skilled care and $1.5 billion for home health care.

The medicare program does not offer long-term care for the chronically ill and disabled because of its emphasis on acute care and postacute treatment of illness and injury. For fiscal year 1982, program outlays for skilled nursing facility services were 1 percent of total program costs, and the rate of increase has been about 7 percent each year for the past 5 years.

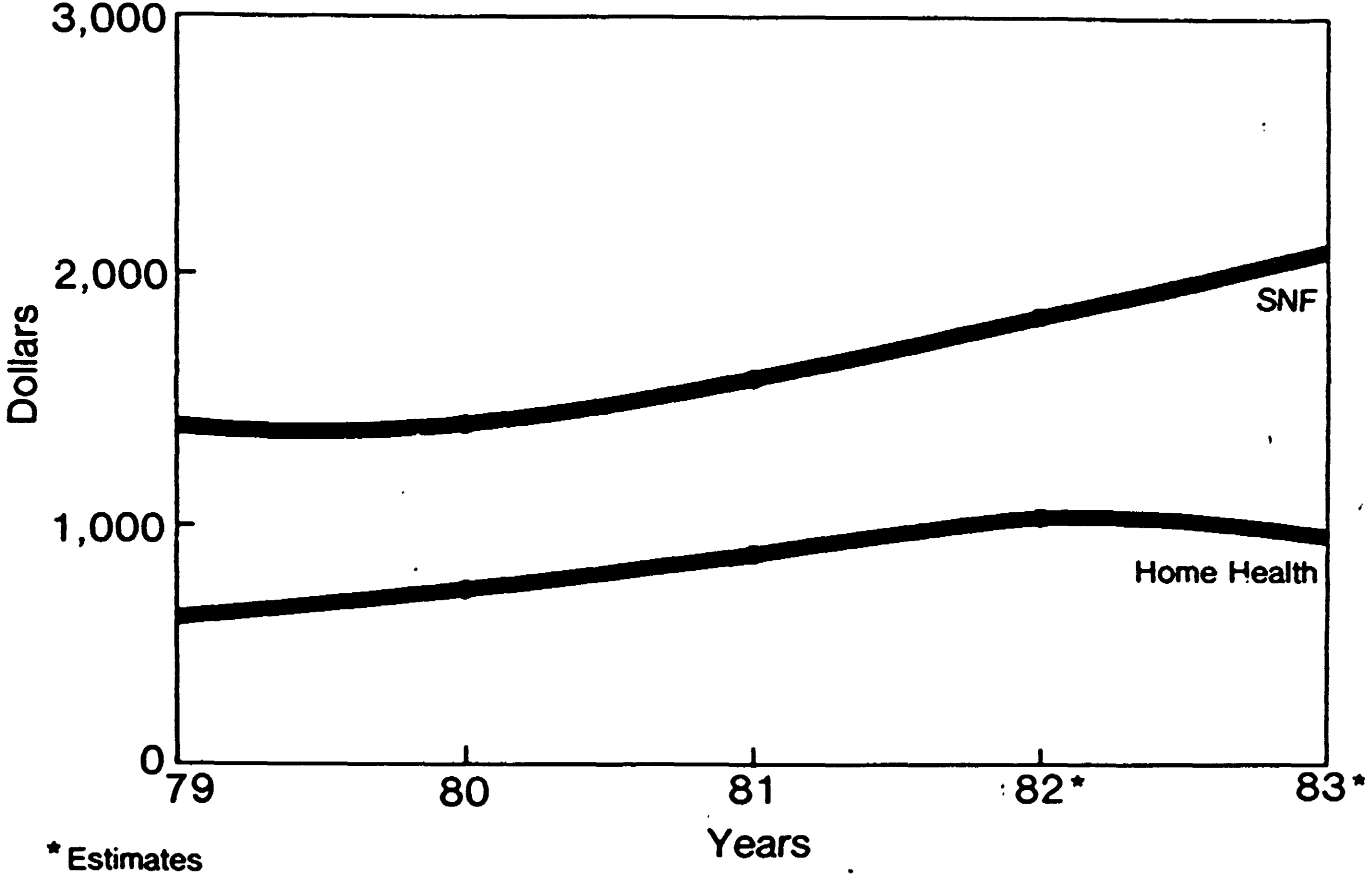
Let's take a look at the charts for a moment, on Medicare home health, and SNF expenditures.

Expenditures for home health care appear to be under control if you look at per recipient costs on chart A. However, chart B. shows an enormous increase in overall home health expenditures, due to increased usage and volume because more people are getting more services.

S Hunt

CHART A

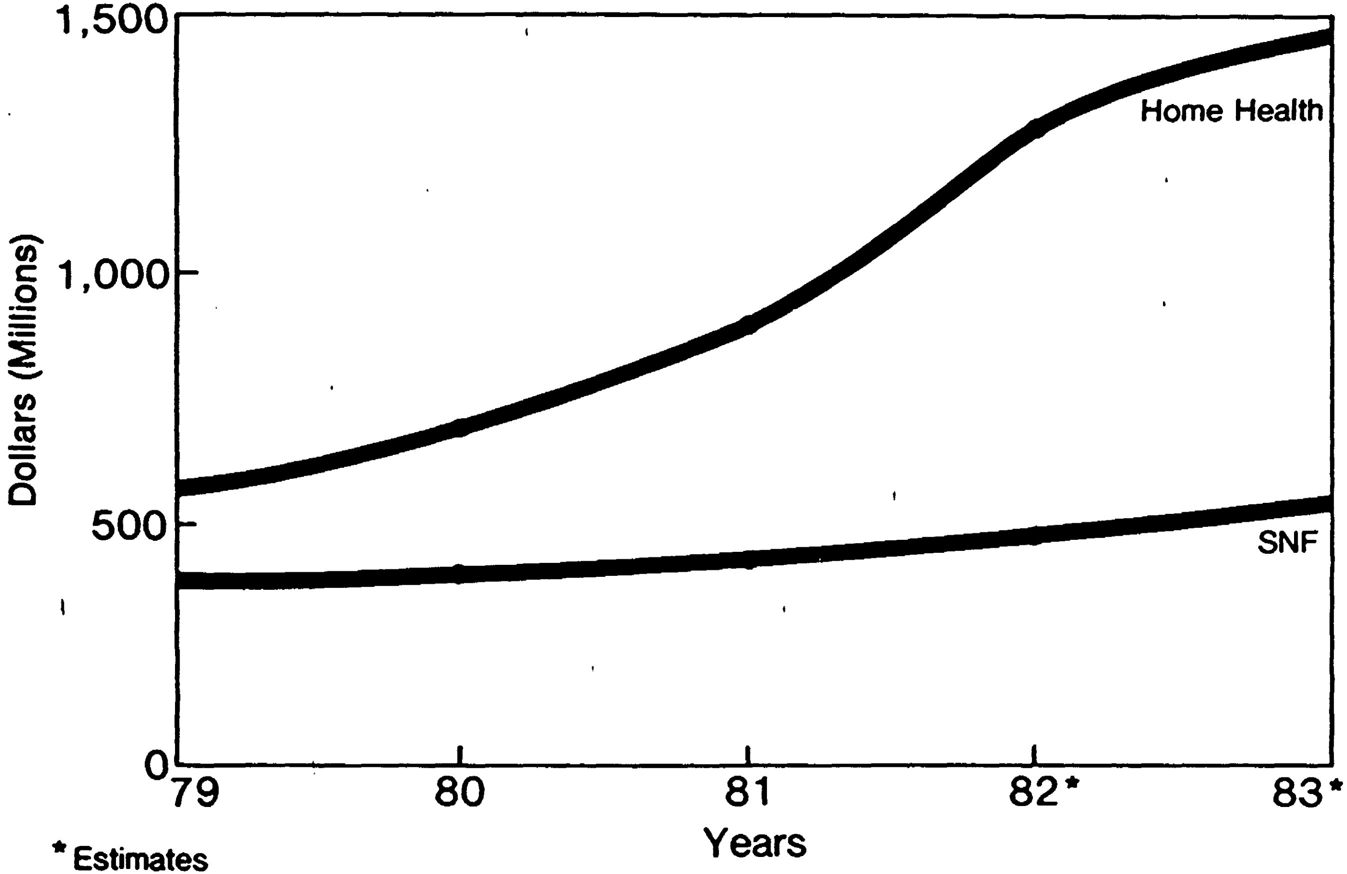
Medicare Expenditures Per Recipient for Long Term Care Services



* Estimates

CHART 8

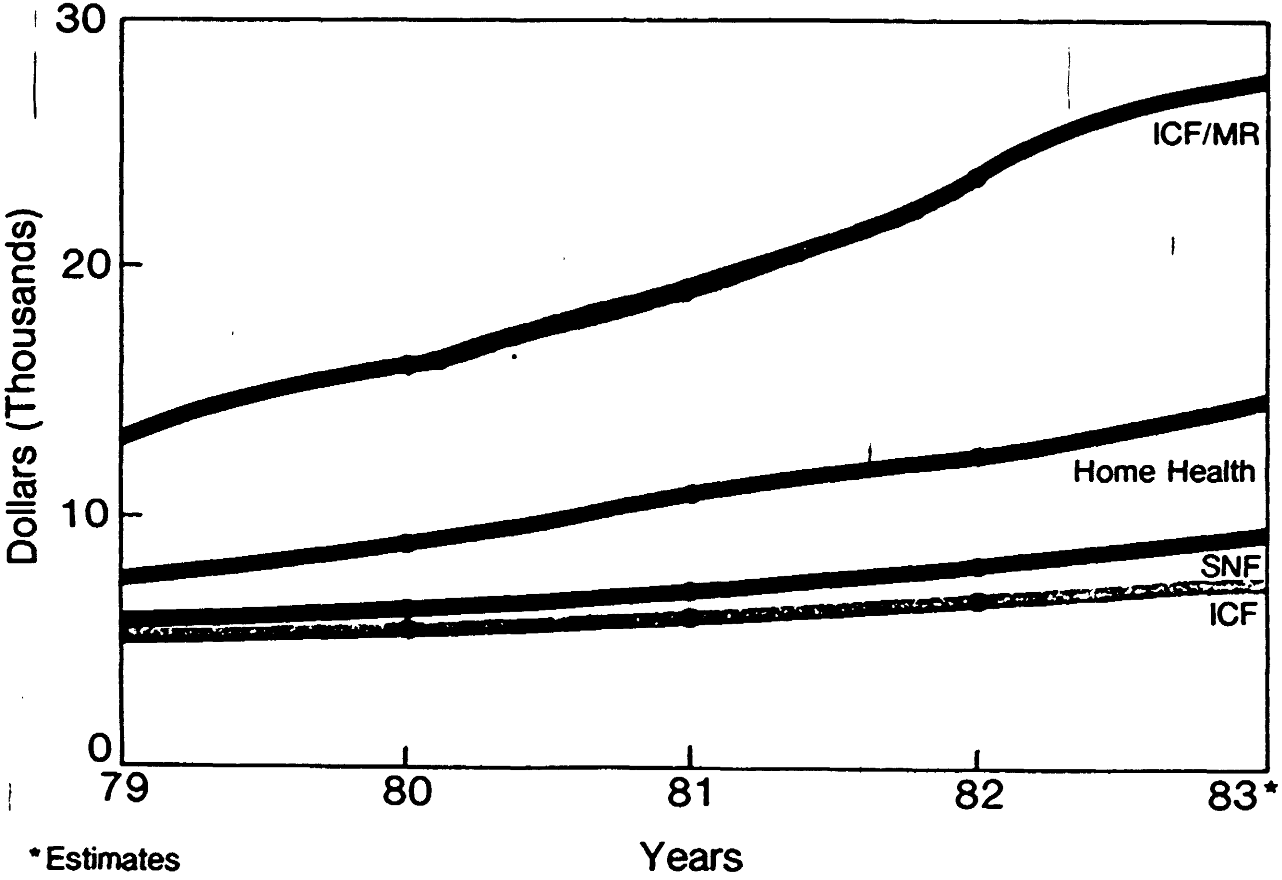
Medicare Expenditures for Long Term Care Services



* Estimates

CHART C

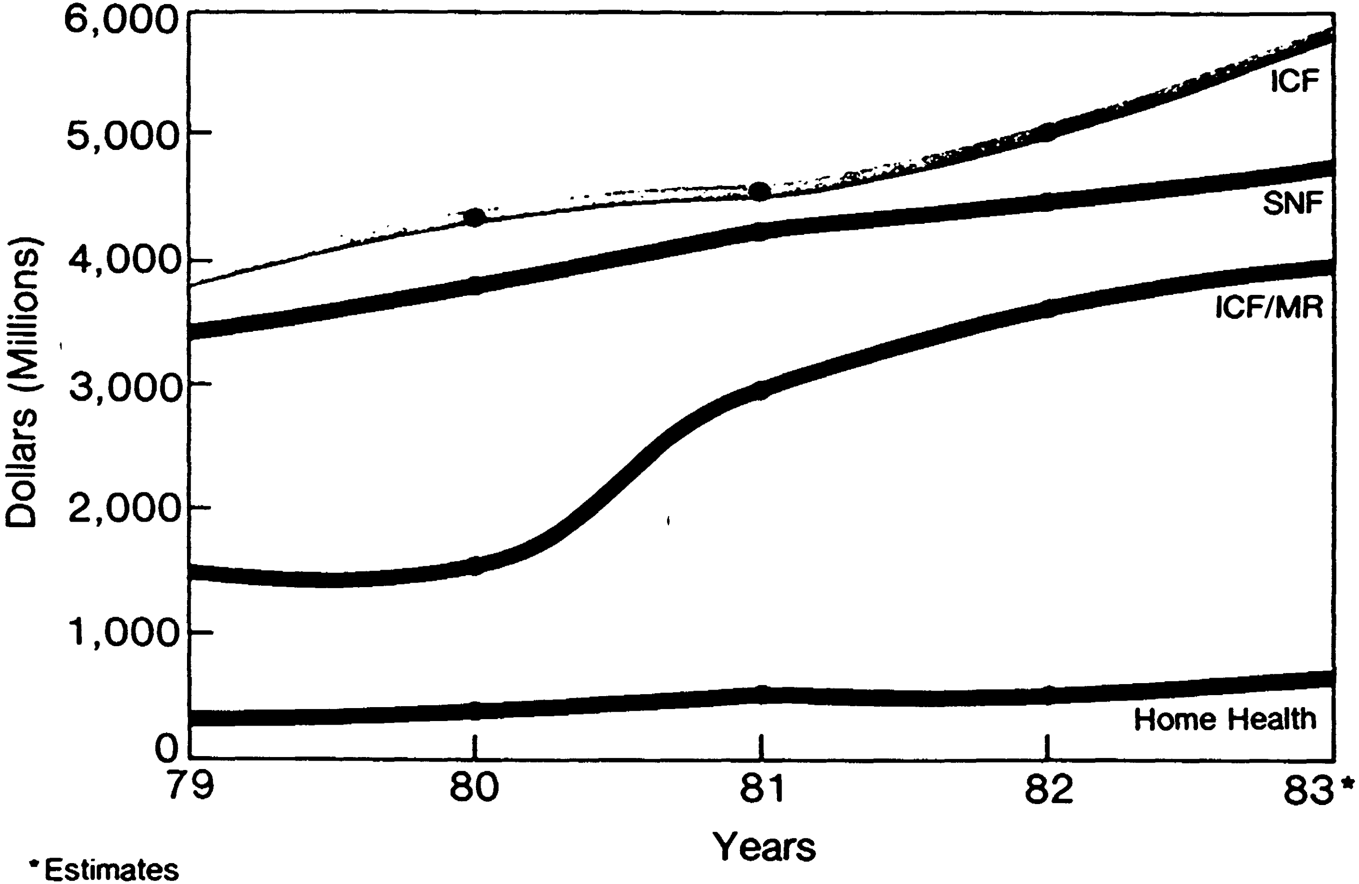
Medicaid Expenditures per Recipient for Long Term Care Services



*Estimates

CHART D

Medicaid Expenditures for Long Term Care Services



*Estimates

From 1981 to 1982, the number of vists per thousand enrollees increased by 14 percent. During the same period, the number of visits per user also increased by 9 percent, in a 1-year period. This causes us some concern.

On the SNF side, SNF expenditures and expenditures per recipient indicate a relatively stable situation, with the SNF benefit being used as originally intended.

Noninstitutional long-term care, or home health care, under medicare has grown dramatically. As I said, home health expenditures increased at an average annual rate of over 30 percent, and in addition the number of visits per capita has been going up at a rapid rate.

While the medicare program supports a continually increasing amount of long-term care, the major portion of publicly funded care is the medicaid program. In fiscal year 1982 almost half of all medicaid expenditures went to long-term care. We estimate that long-term care costs will continue this growth to consume up to 65 percent of medicaid expenditures by 1990.

The primary component driving these expenditures upward is the cost of institutional care, largely in the ICF/MR category.

There are currently 8,000 SNF's in the Nation, of which 30 percent do not participate in medicare but provide care only to medicaid patients. In addition, there are over 11,000 intermediate care facilities, and 2,000 intermediate care facilities for the mentally retarded.

Payments to these institutions have increased at an average annual rate of nearly 15 percent over the last 5 years. Spiralling costs in long-term care institutional care have led to a general perception that much of this care could be provided more effectively in the home and community settings, or that expanded home care could prevent or delay institutionalization.

Looking at the medicaid expenditures, I think charts C and D illustrate a modest growth pattern for home health, SNF, and ICF expenditures, which have remained relatively constant in terms of their growth.

At issue here is what is happening with the intermediate care facilities for the mentally retarded, where the cost per recipient and overall ICF/MR costs are increasing rapidly.

The desire to provide better and more individually responsive yet lower cost substitute care resulted in the enactment of the medicaid waiver authority to implement programs of home and community-based services.

Unfortunately, we are not convinced that our home health outlays will continue to be significantly lower cost substitutes for institutional care. For example, looking at comparable routine costs for home health and SNF services, we project that each home visit in 1984 will cost an average of about $46 a day compared to the average cost of $51 a day for SNF care.

While it is difficult to compare the cost of home visits provided on an intermittent basis to the per diem cost of inpatient care, the comparison clearly illustrates that home health care may not have the potential cost savings that many anticipate.

The medicaid authority to implement the Omnibus Reconciliation Act waivers program has been well received by the States.

Under these programs, States can provide a comprehensive array of medical-social services, including case management, homemaker, home health aides, personal care, and the like.

As of October 1, 38 States have been approved to operate 51 programs of home and community-based care, and an additional 38 applications are under review.

Only 10 of the programs are targeted to provide services on a statewide basis. Thirty-one programs are targeting benefits specifically to the aged and disabled, and 26 are specifically for the mentally retarded.

The most popular services offered in these waivers are case management, respite care, and adult day care.

Clearly, Congress and the States are beginning to shift their focus in long-term care to the community setting; however, the cost-effectiveness of community alternatives to institutionalization have not yet been conclusively proven. Recognizing that the growing long-term care population—especially the group at risk of institutionalization—will continue to drive up expenditures, HCFA is conducting a broad array of research and demonstration activities to find better ways to manage and coordinate the delivery of various long-term care services. I would like to highlight a few of those for you.

HCFA has initiated a number of community-based care projects to test whether the provision and management of an appropriate mix of in-home health and social services directed at individual client needs will reduce institutional care costs without sacrificing quality.

Findings from several earlier demonstrations have been mixed. Some projects have shown significant reductions in mortality and higher levels of self-maintenance and satisfaction. However, other studies conducted by HCFA indicate an expansion of home health services can be more costly than nursing home care, if there is a lack of targeting—that is, the individuals served are not truly at risk of institutionalization.

Senator PACKWOOD. Can I interrupt there, Mr. Chairman?

Senator DURENBERGER. Yes.

Senator PACKWOOD. In a nutshell, are you saying this: If you can substitute home health care for institutionalization, it is clearly cheaper if you can make a 1-for-1 trade? Is that a given?

Ms. FEINSTEIN. If one looks only at medicare outlays and the difference between the cost of a routine day-of-care in a SNF versus the cost of one uncomplicated home health visit, yes. But I don't think you can simply add up the two columns that narrowly and determine whether or not it is cost-effective.

Senator PACKWOOD. But you are assuming that everybody at home needs a visit every day. That is your presumption on that comparison, isn't it?

Ms. FEINSTEIN. No. I am simply stating that what medicare will pay for an average home health visit—and there are many different kinds of home health visits that make it not average—is almost the same as what medicare pays for the routine part of a SNF day of care.

Senator PACKWOOD. Well, in other words—then I won't interrupt you more—you are saying that you are not even convinced that on a 1-to-1 basis home health care is any cheaper than institutionalization?

Ms. FEINSTEIN. No, I don't think I am saying that.

Senator DURENBERGER. I read you about halfway through a 19-page statement, which alarms me only because of the length of time we have committed to this hearing. If I am correct on that, could I ask you if there is a way to summarize the balance of your statement?

Ms. FEINSTEIN. All right.

Senator DURENBERGER. It is well-sectioned in here. Perhaps you could highlight some of the main points.

Ms. FEINSTEIN. I will try to be more brief in continuing.

The channeling demonstrations have received a lot of attention, focusing on whether the long-term care needs of the impaired elderly can be met in a cost-effective way through community-based systems.

In five project sites, the financial control model also seeks to limit costs through the use of a fixed budget for demonstration services.

Recognizing the growth of the hospice movement in this country, HCFA implemented a hospice demonstration in 1980.

Relative to prospective payment, we are heavily involved in developing prospective payment systems for both skilled nursing facilities and home health agencies.

I think it is important that we focus some of our efforts on family support and look at the types of services that are provided by family, friends and volunteers. We have some projects going on that are studying the role of informal care-givers.

One very interesting study is in Washington State, where HCFA is offering paid respite care, family training in how to provide care, and a combination of respite care and family training.

Social HMO demonstrations in several of the States is another area that we are hopeful will be very promising. The demonstrations are offering fixed annual prepaid capitation amounts for both acute care and long-term care.

I think before we consider any changes in the long-term care benefits we need to carefully weigh the costs, especially given the precarious nature of the trust funds.

Our research and demonstration activities have yielded some positive findings: Community-based care can be effective if targeted to appropriate individuals, and strengthening informal care can preclude the necessity of providing formal care. But there is still a lot we don't know, Mr. Chairman. We would be happy to shed some light on some of the problems of getting there.

Senator DURENBERGER. Thank you. This way we are going to make everybody buy a copy of your report, to find out what you didn't say. [Laughter.]

[Ms. Feinstein's prepared statement follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

PATRICE HIRSCH FEINSTEIN

ASSOCIATE ADMINISTRATOR FOR POLICY

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

NOVEMBER 3, 1983

I AM PLEASED TO HAVE THIS OPPORTUNITY TO DISCUSS WITH YOU THE GENERAL ISSUES SURROUNDING LONG-TERM CARE AND THEIR IMPLICATIONS FOR THE MEDICARE AND MEDICAID PROGRAMS AND OTHER DEPARTMENT INITIATIVES IN THIS AREA. WITH ME TODAY ARE LARRY ODAY, DIRECTOR OF THE BUREAU OF ELIGIBILITY, REIMBURSEMENT AND POLICY AND LINDA HAMM, DIRECTOR OF THE DIVISION OF LONG-TERM CARE EXPERIMENTATION.

LONG-TERM CARE IS DIFFICULT TO DEFINE BECAUSE WE KNOW IT IS NOT SIMPLY A MEDICAL OR HEALTH CARE PROBLEM. LONG-TERM CARE ENTAILS A COMBINATION OF HEALTH AND SOCIAL SERVICES, HOUSING, INCOME SUPPORT AND ASSISTANCE FROM RELATIVES AND FRIENDS. WE ALSO KNOW THAT LONG-TERM CARE NEEDS GENERALLY INCREASE WITH AGE WHICH LEADS US TO EXPECT INCREASED DEMAND FOR THIS CARE AS THE AMERICAN POPULATION AGES IN THE COMING DECADES. HOW TO BEST MEET THIS DEMAND WITHIN THE LIMITS OF A FINANCIALLY ENDANGERED MEDICARE PROGRAM AND A MEDICAID PROGRAM THAT ALREADY STRAINS MANY STATE BUDGETS IS A CHALLENGE THAT MUST BE APPROACHED WITH EXTREME CAUTION.

DEMOGRAPHIC TRENDS AND THE DEMAND FOR LONG-TERM CARE

A REVIEW OF DEMOGRAPHIC TRENDS INDICATES DRAMATIC POTENTIAL FOR THE GROWTH OF LONG-TERM CARE. CURRENTLY, THERE ARE 26 MILLION PEOPLE OVER AGE 65, ABOUT 11 PERCENT OF THE POPULATION. BY THE YEAR 2030, THE "BABY BOOM" GENERATION WILL INCREASE THIS PROPORTION TO 18 PERCENT, OR 59 MILLION

PERSONS. IN OTHER WORDS, BY THE YEAR 2030, ONE IN FIVE PERSONS WILL BE ELDERLY, TWICE THE PROPORTION TODAY. IN ADDITION, THE AGING OF THE AGED HAS SIGNIFICANTLY INCREASED THE DEMAND FOR LONG-TERM CARE SERVICES IN THE LAST DECADE AND WILL CONTINUE TO DO SO WELL INTO THE 21ST CENTURY. FOR EXAMPLE, MORE THAN 20 PERCENT OF THOSE OVER AGE 85 ARE IN NURSING HOMES AND THOSE RECEIVING HOME HEALTH CARE RECEIVE FIVE TIMES MORE SERVICES THAN THE YOUNGER ELDERLY.

HOWEVER, THE AGED ARE ONLY ONE SEGMENT OF THE LONG-TERM CARE POPULATION. THE ADULT DISABLED CONSTITUTE A SIGNIFICANT ELEMENT OF THE POPULATION WITH LONG-TERM CARE NEEDS. APPROXIMATELY 12 PERCENT OF THE POPULATION OVER AGE 65 AND 2 PERCENT UNDER AGE 65, OR A TOTAL OF ABOUT 5 MILLION PEOPLE, REQUIRE SOME ASSISTANCE IN PERFORMING THE ACTIVITIES OF DAILY LIVING.1/ OTHER GROUPS REQUIRING SOME MEASURE OF LONG-TERM CARE INCLUDE THE MENTALLY RETARDED, THE DEVELOPMENTALLY DISABLED AND THE ADULT CHRONICALLY MENTALLY ILL. RECENT ESTIMATES SET THE NUMBER OF MENTALLY RETARDED AT 6 MILLION AND THE DEVELOPMENTALLY DISABLED AT ALMOST ONE AND ONE-HALF MILLION.2/ FINALLY, THE TERMINALLY ILL WHO REQUIRE CARE FOR AN EXTENDED PERIOD OF TIME ALSO MUST BE INCLUDED IN THE LONG-TERM CARE POPULATION.

1/ 1979 NATIONAL HEALTH INTERVIEW SURVEY, NATIONAL CENTER FOR HEALTH STATISTICS.

2/ LAVOR, JUDITH, "LONG TERM CARE: A CHALLENGE TO SERVICE SYSTEMS," LONG TERM CARE, PRAEGER, 1979.

LONG-TERM CARE IN THE MEDICARE AND MEDICAID PROGRAMS

BEFORE I DESCRIBE SOME OF OUR INITIATIVES AND POTENTIAL POLICY OPTIONS FOR MEETING THE INCREASING DEMAND FOR LONG-TERM CARE, I WOULD LIKE TO SUMMARIZE WHAT MEDICARE AND MEDICAID ARE CURRENTLY PROVIDING.

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) IS THE PRIMARY SOURCE OF FUNDING FOR LONG-TERM CARE SERVICES IN THE UNITED STATES. THE MEDICAID PROGRAM IS THE PRINCIPAL PAYOR WITH TOTAL FEDERAL AND STATE PAYMENTS IN FY 1983 OF APPROXIMATELY $16 BILLION FOR INSTITUTIONAL CARE AND ABOUT $550 MILLION FOR HOME HEALTH SERVICES. DURING THE SAME FISCAL YEAR, THE MEDICARE PROGRAM WILL SPEND ABOUT $520 MILLION FOR SKILLED NURSING FACILITY SERVICES AND $1.5 BILLION FOR HOME HEALTH CARE.

THE MEDICARE PROGRAM DOES NOT OFFER LONG-TERM CARE FOR THE CHRONICALLY ILL AND DISABLED BECAUSE OF ITS STATUTORY EMPHASIS ON THE ACUTE AND POST-ACUTE TREATMENT OF ILLNESS AND INJURY. FOR FY 1982, PROGRAM OUTLAYS FOR SKILLED NURSING FACILITY SERVICES WERE ONE PERCENT OF TOTAL PROGRAM COSTS AND THE RATE OF INCREASE HAS BEEN ABOUT 7 PERCENT EACH YEAR FOR THE PAST 5 YEARS. SOME SAY THAT THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS MAY INCREASE THE GROWTH OF NURSING HOME EXPENDITURES BECAUSE HOSPITALS MAY DISCHARGE MORE AND PERHAPS SICKER PATIENTS TO NURSING HOMES.

Noninstitutional long-term care or home health care under Medicare has grown dramatically. For the decade ending in 1982, home health expenditures increased at an average annual rate of over 30 percent and the number of visits per capita has been going up at a rapid rate too. In fact, an analysis of home health utilization and reimbursement performed for us by Brandeis University indicates that over half of the increase in home health expenditures was caused by the general growth in Medicare beneficiaries and especially in the proportion of those who receive home health services. The increase in home health charges per visit, caused primarily by inflation, accounted for almost 40 percent of the growth in home health expenditures.

And this growth may increase at an even greater rate due to provisions enacted in the Omnibus Reconciliation Act of 1980 (P.L. 96-499) to permit unlimited home health visits without the requirement for a prior hospital stay or payment of a deductible amount. Enactment of the hospice benefit in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) will also permit terminally ill Medicare patients to receive an expanded variety of medical and social services primarily in their homes.

While the Medicare program supports a continually increasing amount of long-term care, the major portion of publicly

FUNDED LONG-TERM CARE IS PROVIDED UNDER THE MEDICAID PROGRAM. IN FY 1982, ALMOST HALF OF ALL MEDICAID EXPENDITURES WENT TO LONG-TERM CARE, AND WE ESTIMATE THAT LONG-TERM CARE COSTS WILL CONTINUE THIS GROWTH TO CONSUME UP TO 65 PERCENT OF MEDICAID EXPENDITURES BY 1990. THE PRIMARY COMPONENT DRIVING THESE EXPENDITURES UPWARD IS THE COST OF INSTITUTIONAL CARE, THAT IS, PAYMENTS TO SKILLED NURSING FACILITIES (SNFS), INTERMEDIATE CARE FACILITIES (ICFS), INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFS/MR) AND MENTAL HOSPITALS. THERE ARE CURRENTLY 8,000 SNFS IN THE NATION, OF WHICH 30 PERCENT DO NOT PARTICIPATE IN MEDICARE BUT PROVIDE CARE ONLY TO MEDICAID PATIENTS. IN ADDITION, THERE ARE OVER 11,000 ICFS AND 2,000 ICFS/MR. PAYMENTS TO THESE INSTITUTIONS HAVE INCREASED AT AN AVERAGE ANNUAL RATE OF 14.9 PERCENT OVER THE LAST FIVE YEARS, AND MEDICAID PAYS FOR OVER HALF OF ALL NURSING HOME EXPENDITURES IN THE NATION. THE SPIRALING COSTS IN LONG-TERM INSTITUTIONAL CARE HAVE LED TO A GENERAL PERCEPTION THAT MUCH OF THIS CARE COULD BE PROVIDED MORE COST EFFECTIVELY IN HOME AND COMMUNITY SETTINGS, OR THAT EXPANDED HOME CARE COULD PREVENT OR DELAY INSTITUTIONALIZATION.

THE DESIRE TO PROVIDE BETTER, MORE INDIVIDUALLY RESPONSIVE, YET LOWER COST SUBSTITUTE CARE RESULTED IN THE ENACTMENT OF THE MEDICAID WAIVER AUTHORITY TO IMPLEMENT PROGRAMS OF HOME AND COMMUNITY-BASED CARE AND THE MEDICARE HOME

HEALTH AND HOSPICE AMENDMENTS WHICH I MENTIONED EARLIER. UNFORTUNATELY, WE ARE NOT CONVINCED THAT OUR HOME HEALTH OUTLAYS WILL CONTINUE TO BE SIGNIFICANTLY LOWER COST SUBSTITUTES FOR INSTITUTIONAL CARE. FOR EXAMPLE, LOOKING AT COMPARABLE ROUTINE COSTS FOR HOME HEALTH CARE AND SNF SERVICES, WE PROJECT THAT EACH HOME VISIT IN 1984 WILL COST AN AVERAGE OF ABOUT $46 COMPARED TO THE AVERAGE COST OF $51 FOR A SNF DAY OF CARE. WHILE IT IS DIFFICULT TO COMPARE THE COST OF HOME VISITS PROVIDED ON AN INTERMITTENT BASIS TO THE PER DIEM COST OF INPATIENT CARE, THE COMPARISON CLEARLY ILLUSTRATES THAT HOME HEALTH CARE MAY NOT HAVE THE POTENTIAL COST SAVINGS THAT MANY ANTICIPATE.

HOME AND COMMUNITY-BASED CARE WAIVER PROGRAMS

THE MEDICAID WAIVER AUTHORITY TO IMPLEMENT PROGRAMS OF HOME AND COMMUNITY-BASED CARE WAS INCLUDED IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (P.L. 97-35) AND HAS BEEN WELL RECEIVED BY STATES. UNDER THESE PROGRAMS, STATES CAN PROVIDE A COMPREHENSIVE ARRAY OF MEDICAL AND SOCIAL SERVICES INCLUDING CASE MANAGEMENT, HOMEMAKER AND HOME HEALTH AIDES, PERSONAL CARE, ADULT DAY CARE, HABILITATION CARE AND RESPITE CARE TO AVOID MORE COSTLY INSTITUTIONAL CARE.

As of October 1, 38 States have been approved to operate 51 programs of home and community-based care, and an additional 38 applications are under review. Only 10 of the programs are targeted to provide services on a Statewide basis; 31 programs are targeting benefits to the aged and disabled and 26 are for the mentally retarded. The most popular services to be provided are case management, respite care and adult day care. As these programs are still in their initial states, we have no definitive information on the nature of the care provided or on any cost savings.

Our regional offices have conducted twenty assessments of the home and community-based services programs to date, and most preliminary reports are favorable. For example, savings in Rhode Island are estimated to be about $700 per patient per month. Other States are also reporting that the success of their programs have allowed them to drop some ICFs for the mentally retarded from their Medicaid provider roster, in favor of highly targeted community-based services.

RESEARCH AND DEMONSTRATION ACTIVITY

Clearly, Congress and the States are beginning to shift their focus in long-term care to the community setting. However, the cost-effectiveness of community alternatives

TO INSTITUTIONALIZATION HAVE NOT YET BEEN CONCLUSIVELY PROVEN. RECOGNIZING THAT THE GROWING LONG-TERM CARE POPULATION, ESPECIALLY THE GROUP AT RISK OF INSTITUTIONALIZATION, WILL CONTINUE TO DRIVE UP THE EXPENDITURES FOR LONG-TERM CARE, THE HEALTH CARE FINANCING ADMINISTRATION HAS UNDERTAKEN A NUMBER OF RESEARCH AND DEMONSTRATION PROJECTS TO PROVIDE MORE INFORMATION ON ALTERNATIVE WAYS TO PROVIDE NECESSARY LONG-TERM CARE SERVICES IN A COST-EFFECTIVE MANNER.

HCFA IS CONDUCTING A BROAD ARRAY OF RESEARCH AND DEMONSTRATION ACTIVITIES TO FIND BETTER WAYS TO MANAGE AND COORDINATE THE DELIVERY OF VARIOUS LONG-TERM CARE SERVICES AND TO PROVIDE INCENTIVES TO CONTROL COSTS THROUGH ALTERNATIVE REIMBURSEMENT, INCLUDING PROSPECTIVE PAYMENT. I WOULD LIKE TO HIGHLIGHT A FEW MAJOR EFFORTS.

RESEARCH EFFORTS HAVE FOCUSED PRIMARILY ON DETERMINANTS OF UTILIZATION, INCLUDING FAMILY RELATIONSHIPS AND CARE-GIVING; ON COMPONENTS OF COST SUCH AS PATIENT CASE MIX, QUALITY OF CARE AND PROVIDER CHARACTERISTICS; AND ON ASSESSING PROGRAMS OF LONG-TERM CARE, INCLUDING ALTERNATIVE APPROACHES TO PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES.

COMMUNITY-BASED CARE

HCFA HAS INITIATED A NUMBER OF COMMUNITY-BASED CARE PROJECTS TO TEST WHETHER THE PROVISION AND MANAGEMENT OF AN APPROPRIATE MIX OF IN-HOME HEALTH AND SOCIAL SERVICES DIRECTED AT INDIVIDUAL CLIENT NEEDS WILL REDUCE INSTITUTIONAL CARE COSTS WITHOUT SACRIFICING QUALITY OF CARE. FINDINGS FROM SEVERAL EARLIER DEMONSTRATIONS HAVE BEEN MIXED. SOME PROJECTS HAVE SHOWN SIGNIFICANT REDUCTIONS IN MORTALITY AND HIGHER LEVELS OF SELF-MAINTENANCE AND SATISFACTION FOR DEMONSTRATION PARTICIPANTS VERSUS COMPARISON GROUP MEMBERS. HOWEVER, OTHER STUDIES CONDUCTED BY HCFA INDICATE THAT AN EXPANSION OF HOME HEALTH SERVICES CAN BE MORE COSTLY THAN NURSING HOME CARE IF THERE IS A LACK OF TARGETING, THAT IS, THE INDIVIDUALS SERVED ARE NOT TRULY AT RISK OF INSTITUTIONALIZATION. FOR EXAMPLE, THE GEORGIA ALTERNATIVE HEALTH SERVICES DEMONSTRATION FOUND THAT THE EXPANDED SERVICES PROVIDED UNDER THE DEMONSTRATION WERE ADDITIONAL SERVICES REIMBURSED BY MEDICAID, RATHER THAN SUBSTITUTES FOR NURSING HOME CARE. AN EVALUATION OF THE COMMUNITY CARE DEMONSTRATIONS IS NOW BEING PERFORMED UNDER CONTRACT, AND WE WILL RECEIVE A FINAL REPORT IN EARLY 1984.

THE FINDINGS FROM OUR COMMUNITY CARE DEMONSTRATIONS ARE SIMILAR TO THOSE REPORTED BY THE GENERAL ACCOUNTING OFFICE (GAO) IN ITS 1982 REPORT ON EXPANDING HOME HEALTH CARE.

THE GAO FOUND THAT EXPANDED HOME HEALTH SERVICES INCREASED THE LONGEVITY AND SATISFACTION OF CHRONICALLY ILL, ELDERLY PATIENTS. HOWEVER, THESE SERVICES DID NOT REDUCE NURSING HOME OR HOSPITAL USE OR TOTAL SERVICE COSTS. THE GAO RECOMMENDED FURTHER EVALUATION OF THE EFFECTS OF EXPANDED HOME HEALTH CARE ON INDIVIDUALS WHO ARE MOST AT RISK OF INSTITUTIONAL CARE, AND OF HOW HOME CARE SHOULD BE ORGANIZED FOR MAXIMUM EFFICIENCY AND EFFECTIVENESS.

AS A RESULT OF THE FINDINGS FROM THE COMMUNITY-BASED CARE DEMONSTRATIONS, THE DEPARTMENT HAS IMPLEMENTED A MAJOR RESEARCH PROJECT, THE NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION IN TEN PROJECT SITES. THE ADMINISTRATION ON AGING AND HCFA SHARE IN THE FUNDING OF THIS INITIATIVE WHICH IS BEING COORDINATED BY THE OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION. THE DEMONSTRATION BUILDS UPON PREVIOUS EFFORTS BY TARGETING THE POPULATION MOST AT RISK OF INSTITUTIONAL CARE AND BY PROVIDING SUFFICIENT ATTENTION TO MAINTAINING AND STRENGTHENING INFORMAL PROVIDERS OF CARE, PARTICULARLY FAMILY, FRIENDS AND VOLUNTEERS.

THE CHANNELING DEMONSTRATION IS DESIGNED TO DETERMINE WHETHER THE LONG-TERM CARE NEEDS OF ELDERLY IMPAIRED PERSONS CAN BE MET IN A COST EFFECTIVE WAY THROUGH A COMMUNITY-BASED

SYSTEM OF COMPREHENSIVE NEEDS ASSESSMENT, CARE PLANNING AND CASE MANAGEMENT. THE PROJECTS GENERALLY COMBINE INNOVATIVE APPROACHES TO THE ORGANIZATION AND DELIVERY OF SERVICES WITH BROADER SERVICE PACKAGES. IN FIVE PROJECT SITES, A FINANCIAL CONTROL MODEL ALSO SEEKS TO LIMIT COSTS THROUGH THE USE OF A FIXED BUDGET FOR DEMONSTRATION SERVICES. A PLAN OF CARE THEN SPECIFIES THE AMOUNT, SCOPE AND DURATION OF SERVICES WHICH CAN BE PROVIDED TO EACH PATIENT. THE CHANNELING DEMONSTRATION IS SCHEDULED FOR COMPLETION IN JUNE 1985. THE RESULTS WILL BE MADE AVAILABLE BEGINNING IN FEBRUARY 1985, WITH THE FINAL REPORT EXPECTED IN SEPTEMBER 1985.

HOSPICE CARE

RECOGNIZING THE GROWTH OF THE HOSPICE MOVEMENT IN THIS COUNTRY AND THE HUMANE ALTERNATIVE IT OFFERS FOR CARE DURING A TERMINAL ILLNESS, HCFA IMPLEMENTED A HOSPICE DEMONSTRATION IN 1980. THE 26 PARTICIPATING HOSPICES WERE REIMBURSED UNDER THE DEMONSTRATION FOR MANY ITEMS AND SERVICES NOT COVERED UNDER MEDICARE AND MEDICAID INCLUDING OUTPATIENT DRUGS, RESPITE CARE, VISITS BY DIETITIANS AND HOMEMAKERS, COUNSELING, CONTINUOUS HOME CARE, CERTAIN SELF-HELP DEVICES, INPATIENT HOSPICE CARE AND BEREAVEMENT SERVICES TO FAMILY MEMBERS.

RESULTS FROM THE DEMONSTRATION AS WELL AS DATA FROM CONVENTIONAL TREATMENT MODALITIES ARE BEING EVALUATED BY BROWN UNIVERSITY SUPPORTED JOINTLY BY THE ROBERT WOOD JOHNSON FOUNDATION, THE JOHN A. HARTFORD FOUNDATION AND HCFA. WHILE THE FINAL REPORT WILL NOT BE COMPLETED UNTIL THE SPRING OF 1984, PRELIMINARY DATA HAVE BEEN USED TO IMPLEMENT THE MEDICARE HOSPICE BENEFIT, ENACTED IN 1982 AS PART OF TEFRA.

PROSPECTIVE PAYMENT

AS MANDATED BY CONGRESS, WE ARE HEAVILY INVOLVED IN DEVELOPING PROSPECTIVE PAYMENT SYSTEMS FOR BOTH SKILLED NURSING FACILITIES (SNFS) AND HOME HEALTH AGENCIES (HHAS).

TO DEVELOP RECOMMENDATIONS FOR A SNF PROSPECTIVE PAYMENT SYSTEM, WE HAVE LOOKED AT THE RELATIONSHIP BETWEEN PATIENT CASE MIX AND RESOURCE CONSUMPTION IN FREESTANDING AND HOSPITAL-BASED SNFS AND THE DIFFERENCE BETWEEN MEDICARE AND NON-MEDICARE PATIENTS IN THESE FACILITIES. WE HAVE ALSO ANALYZED ALL OF THE MEDICARE SNF COST REPORTS TO IDENTIFY FACTORS THAT MIGHT CAUSE COST VARIATIONS AMONG SNFS. WE HAVE LOOKED AT THE YALE UNIVERSITY STUDY OF "RESOURCE UTILIZATION GROUPS" OR "RUGS" AS A POSSIBLE CLASSIFICATION SYSTEM FOR LONG-TERM CARE PATIENTS. WHILE RUGS MAY NOT BE A USEFUL TOOL FOR MEDICARE PURPOSES BECAUSE THE MEDICARE PATIENT IS VERY DIFFERENT FROM THE TYPICAL LONG-TERM CARE PATIENT AND BECAUSE

SO FEW SNF RESIDENTS ARE MEDICARE PATIENTS, THE RUG SYSTEM MAY HOLD SOME PROMISE FOR FACILITIES THAT CARE FOR THE LONG-STAY MEDICAID PATIENT. IN FACT, A DEMONSTRATION PROJECT IN NEW YORK IS DEVELOPING A STATEWIDE MEDICAID REIMBURSEMENT SYSTEM USING RESOURCE UTILIZATION GROUPS TO DETERMINE THE RELATIVE COST OF CARING FOR VARIOUS NURSING HOME PATIENTS. ULTIMATELY, A RATE WILL BE DEVELOPED FOR EACH NURSING HOME WHICH REFLECTS THE FACILITY'S MIX OF PATIENTS.

FOR HHAS, WE HAVE ISSUED A REQUEST FOR PROPOSALS TO DESIGN A PROSPECTIVE PAYMENT SYSTEM AND CARRY OUT A DEMONSTRATION OF THE SYSTEM. PROPOSALS RECEIVED BY THE END OF OCTOBER ARE CURRENTLY BEING EVALUATED. WE EXPECT TO AWARD A CONTRACT IN JANUARY 1984. DURING THE DEVELOPMENT STAGE OF THE CONTRACT, SEVERAL DIFFERENT PAYMENT APPROACHES WILL BE EVALUATED, INCLUDING CAPITATION AND CASE MIX.

OTHER STUDIES

IN ADDITION TO THESE MAJOR RESEARCH AND DEMONSTRATION EFFORTS, I WOULD LIKE TO MENTION TWO MORE STUDIES THAT HCFA IS FUNDING TO LOOK AT IMPORTANT ASPECTS OF LONG-TERM CARE. RECOGNIZING THAT OVER THREE-QUARTERS OF LONG-TERM CARE SERVICES PROVIDED TO INDIVIDUALS LIVING AT HOME ARE PROVIDED BY AN INFORMAL NETWORK OF FAMILY, FRIENDS AND VOLUNTEERS, WE ARE EXAMINING THE ROLE OF INFORMAL CARE-GIVERS, THE TYPES OF SERVICES

THEY PROVIDE, FACTORS THAT STRENGTHEN OR WEAKEN THE FAMILY SYSTEMS IN PROVIDING CARE TO THE ELDERLY AND RECOMMENDATIONS TO ENHANCE INFORMAL CARE TO AVOID INSTITUTIONALIZATION. IN A DEMONSTRATION TO TAKE PLACE IN WASHINGTON STATE, HCFA WILL FOCUS ON THREE SUPPORT STRATEGIES: PAID RESPITE CARE, FAMILY TRAINING IN HOW TO PROVIDE CARE AND A COMBINATION OF RESPITE CARE AND FAMILY TRAINING. THE PROVISION OF THESE SERVICES WILL BEGIN IN JANUARY 1984.

IN A ANOTHER AREA, WE ARE WORKING WITH THE ROBERT WOOD JOHNSON FOUNDATION ON A STUDY TO IMPROVE LONG-TERM CARE FOR THE ELDERLY BY HELPING UNIVERSITY SCHOOLS OF NURSING ESTABLISH CLINICAL AFFILIATIONS WITH NURSING HOMES. THE GOALS OF THIS DEMONSTRATION ARE TO EDUCATE MORE NURSES IN GERONTOLOGY, TO MAKE MORE EFFECTIVE USE OF NURSE AND PHYSICIAN SERVICES IN NURSING HOME CARE, TO HELP NURSING HOMES HAVING MAJOR PROBLEMS RECRUITING CLINICAL STAFF AND MAINTAINING ADEQUATE STANDARDS OF CARE AND TO DEVELOP NURSING HOMES AS BRIDGES BETWEEN HOSPITALS AND COMMUNITY-BASED CARE.

THE SOCIAL HEALTH MAINTENANCE ORGANIZATION (HMO) DEMONSTRATION ADDRESSES BOTH ISSUES OF SERVICE COORDINATION AND MANAGEMENT AND ALTERNATIVE REIMBURSEMENT TO CONTROL COSTS. THE SOCIAL HMO PROVIDES A BROAD RANGE OF ACUTE AND LONG-TERM CARE HEALTH AND SOCIAL SERVICES TO VOLUNTARILY ENROLLED ELDERLY

INDIVIDUALS FOR A FIXED ANNUAL PREPAID CAPITATION AMOUNT. A MANAGING PROVIDER COORDINATES AN INTEGRATED SERVICE SYSTEM COVERING ALL BASIC ACUTE HOSPITAL, NURSING HOME, AMBULATORY MEDICAL CARE SERVICES AND PERSONAL CARE SUPPORT SERVICES, INCLUDING HOMEMAKER, HOME HEALTH AND CHORE SERVICES. OTHER SERVICES COULD INCLUDE MEALS, COUNSELING, TRANSPORTATION, INFORMATION AND REFERRAL.

WE BELIEVE THE SOCIAL HMO DEMONSTRATION WILL PROVIDE US WITH IMPORTANT INFORMATION ON THE COST-EFFECTIVENESS OF THIS APPROACH COMPARED TO FEE-FOR-SERVICE CARE. WE WILL ALSO EXAMINE THE QUALITY OF CARE AND THE EFFECT OF AN INTEGRATED CARE SYSTEM ON MEETING THE ACUTE AND LONG-TERM CARE NEEDS OF THE ELDERLY.

ADMINISTRATION ON AGING ACTIVITIES

FINALLY, TITLE III OF THE OLDER AMERICANS ACT, ADMINISTERED BY THE ADMINISTRATION ON AGING (AOA), MANDATES THE DEVELOPMENT OF COMPREHENSIVE AND COORDINATED SERVICE DELIVERY SYSTEMS, INCLUDING A CONTINUUM OF CARE TO SERVE VULNERABLE ELDERLY INDIVIDUALS. THIS ACT ALSO CREATES A LONG-TERM CARE OMBUDSMAN PROGRAM, THE RESPONSIBILITY OF WHICH, AMONG OTHER THINGS, IS TO RESOLVE PROBLEMS RAISED BY RESIDENTS OR FAMILY MEMBERS OF RESIDENTS OF LONG-TERM CARE FACILITIES. THE OMBUDSMAN

PROGRAM ALSO MONITORS THE DEVELOPMENT AND IMPLEMENTATION OF FEDERAL, STATE AND LOCAL LAWS, REGULATIONS AND POLICIES RELATING TO LONG-TERM CARE IN THE STATE. THERE ARE NOW 508 LOCAL OMBUDSMAN PROGRAMS, OVER HALF OF THESE SPONSORED BY AREA AGENCIES ON AGING.

IN ADDITION TO THE AOA'S INVOLVEMENT IN THE NATIONAL CHANNELING DEMONSTRATION PROGRAM MENTIONED EARLIER, THE AOA IS FUNDING THE LONG-TERM CARE GERONTOLOGY CENTER PROGRAM, TO PROVIDE A NATIONAL KNOWLEDGE BASE WHICH WILL ASSIST IN THE DEVELOPMENT OF A CONTINUUM OF CARE FOR VULNERABLE OLDER PERSONS. THE LONG-TERM CARE GERONTOLOGY CENTERS ARE LOCATED IN MAJOR UNIVERSITIES THROUGHOUT THE COUNTRY. THE PROGRAM PLACES A STRONG EMPHASIS ON BRINGING TOGETHER A VARIETY OF DISCIPLINES WITHIN UNIVERSITIES, ESPECIALLY MEDICINE, NURSING, AND SOCIAL WORK.

CONCLUSION

I WOULD LIKE TO EMPHASIZE THAT BEFORE WE CONSIDER ANY CHANGES IN LONG-TERM CARE BENEFITS, WE WOULD NEED TO CAREFULLY WEIGH THE COST, ESPECIALLY GIVEN THE PRECARIOUS NATURE OF THE MEDICARE TRUST FUND. OUR FIRST PRIORITY MUST BE TO DEVELOP SOLUTIONS THAT WILL GUARANTEE THE INTEGRITY OF THE TRUST FUND.

LONG-TERM CARE HAS MANY ASPECTS AND PERMITS MANY APPROACHES TO MEETING A BROAD VARIETY OF NEEDS, BOTH MEDICAL AND SOCIAL. WHILE IT SEEMS CLEAR THAT MEDICARE AND MEDICAID MAY NOT BE ABLE TO AFFORD THE CONTINUING ESCALATION IN THE EXPENDITURES FOR LONG-TERM CARE, IT IS ALSO APPARENT THAT NO PRECISE SOLUTIONS HAVE BEEN IDENTIFIED FOR IMPLEMENTATION.

OUR RESEARCH AND DEMONSTRATION ACTIVITIES HAVE YIELDED SOME POSITIVE FINDINGS. FOR EXAMPLE, COMMUNITY-BASED CARE CAN BE COST-EFFECTIVE IF TARGETED TO APPROPRIATE INDIVIDUALS, AND STRENGTHENING INFORMAL CARE SUPPORTS CAN PRECLUDE THE NECESSITY OF PROVIDING FORMAL CARE. A HUNTER COLLEGE STUDY FOUND THAT THE MOST FREQUENTLY REQUESTED SERVICES TO ASSIST INFORMAL CARE-GIVERS ARE TRANSPORTATION, HOMEMAKERS, INFORMATION AND REFERRAL SERVICES AND RESPITE CARE.

HOWEVER, THERE IS MUCH THAT WE DO NOT KNOW ABOUT PROVIDING COST-EFFECTIVE LONG-TERM CARE. THIS FACT MAY BE ONE REASON FOR THE CAUTION WITH WHICH STATES ARE IMPLEMENTING THEIR MEDICAID PROGRAMS OF HOME AND COMMUNITY-BASED CARE. WHILE 38 STATES ARE APPROVED TO IMPLEMENT 51 PROGRAMS OF COMMUNITY-BASED CARE, THESE PROGRAMS ARE TARGETING SERVICES TO A TOTAL OF ONLY ABOUT 58,000 INDIVIDUALS, WITH THE AVERAGE PROGRAM COVERING FEWER THAN 500. I BELIEVE STATES ARE BEING APPROPRIATELY CAUTIOUS BECAUSE THEY KNOW THAT IT IS DIFFICULT TO TARGET COMMUNITY-BASED SERVICES TO THOSE

WHO WOULD OTHERWISE BE INSTITUTIONALIZED. OUR EARLY DEMONSTRATION TAUGHT US THIS LESSON AND THE CHANNELING DEMONSTRATIONS ARE DESIGNED TO PROVIDE US WITH MORE INFORMATION TO TARGET EFFECTIVELY. AFTER ALL, MOST OF US COULD BENEFIT FROM SOME TYPE OF HOME CARE, BUT THE COST OF INDISCRIMINANT ASSISTANCE COULD BE ASTRONOMICAL.

BECAUSE OF THE SURETY OF INCREASED DEMAND AND THE CURRENT INFLATIONARY FEE-FOR-SERVICE ENVIRONMENT, WE MUST BE EXTREMELY CAREFUL WHEN WE CONSIDER RESTRUCTURING CURRENT LONG-TERM CARE BENEFITS. WHILE IT IS CERTAINLY ATTRACTIVE IN THE SHORT TERM, WE REALLY DO NOT KNOW IF EXPANDED HOME AND COMMUNITY-BASED CARE IS THE BEST APPROACH. OTHER ALTERNATIVES NEED CAREFUL CONSIDERATION. FOR EXAMPLE, THERE ARE SOME INDICATIONS THAT A BETTER APPROACH MIGHT BE ALTERNATIVE LIVING SITUATIONS, SUCH AS SHELTERED OR CONGREGATE HOUSING, COMBINED WITH THE PROVISION OF SOME PERSONAL CARE SERVICES.

BECAUSE OF THE IMPORTANCE OF LONG-TERM CARE TO THE NATION'S WELL-BEING AND BECAUSE OF THE MULTIPLICITY OF PUBLIC AND PRIVATE INITIATIVES IN THIS AREA, HCFA IS SPONSORING A WORKING CONFERENCE THIS WINTER. THE CONFERENCE WILL FOCUS ON SEVERAL CONCEPTS WITH POTENTIAL FOR PROVIDING BETTER APPROACHES TO DELIVERING AND FINANCING LONG-TERM CARE. WE HOPE TO DISCUSS A WIDE SPECTRUM OF VIEWS ON SUCH ISSUES AS PRIVATE LONG-TERM CARE INSURANCE, HOME EQUITY CONVERSION, SOCIAL HMOs, STATE TAX INCENTIVES FOR FAMILY CARE, SHELTERED HOUSING, LIFE CARE COMMUNITIES AND VOLUNTEERISM.

THE LONG-TERM CARE CHALLENGE CAN BE MET ONLY THROUGH CONTINUED STUDY, EVALUATION AND REALISTIC APPRAISAL OF ALTERNATIVES AND THEIR POTENTIAL IMPACT ON THE OVERALL HEALTH CARE SYSTEM. TO MOVE TOO SLOWLY MIGHT DEPRIVE SOME INDIVIDUALS OF LONG-TERM CARE ASSISTANCE; HOWEVER, IF WE MOVE TOO QUICKLY, WE MIGHT ENDANGER PROGRAMS UPON WHICH MANY RELY TO MEET THEIR BASIC HEALTH CARE NEEDS. ADOPTING THE BETTER COURSE CANNOT BE DONE WITHOUT THE COOPERATION OF PUBLIC AND PRIVATE SECTORS AND THE WILLINGNESS TO BE FLEXIBLE WHEN CIRCUMSTANCES SO WARRANT. I SHARE YOUR COMMITMENT, MR. CHAIRMAN, TO ASSURING THAT AMERICANS IN THE COMING DECADES WILL NOT LACK NECESSARY CARE AND I KNOW WE WILL CONTINUE TO WORK TOGETHER AND MAKE THAT REALITY.

I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator DURENBERGER. Senator Packwood?

Senator PACKWOOD. Tell me what the middle paragraph on page 7 means. You say, "Our regional offices have conducted 20 assessments of the home and community-based services programs to date, and most preliminary reports are favorable. For example, savings in Rhode Island are estimated to be about $700 per patient per month." Can you elaborate on that?

Ms. FEINSTEIN. Yes.

The home and community-based service waivers, while enacted by statute in 1981, are still very much in their infancy. We have less than 20 which have completed 1 year under the waiver, and as I indicated, many of them are quite small in nature. So the State assessments that we have done are only on those which have completed their anniversary date with us. Our tentative findings are very positive. The States feel that the programs have been successful.

We have not as yet completed a financial assessment in some of these programs, nor have we looked across medicare and medicaid to see what other kinds of Government support went into home care as well.

Senator PACKWOOD. What are these $700 per month per patient savings in Rhode Island? Savings from what? Are those net reductions in cost?

Ms. FEINSTEIN. Why don't you answer that, Larry.

Mr. ODAY. It is essentially little more than waivered services—that is, the home and community-based services that are part of that waiver—versus the presumed institutional cost that would have been incurred in the absence of the waiver.

However, those numbers do not at this point, with respect to Rhode Island, reflect total expenditures for the medicaid program, which would include, most importantly, acute care services, and also services rendered to those people who were not part of the waiver, but were also receiving home health under medicaid.

Senator PACKWOOD. I don't understand your answer.

Mr. ODAY. All right. It is basically at this point a very simple number of the amount per capita that the State has estimated it spent in its first year for the services in the community to the population that is covered by the waiver, versus what it estimated it would have spent had those people been in institutions.

Senator PACKWOOD. And they estimate they save about $700 per patient per month; is that right?

Ms. FEINSTEIN. Yes, that is their estimate.

Senator PACKWOOD. All right. Now, that appears to be a saving. Are you saying, however, there are other costs that they are not including? That this isn't a correct figure?

Mr. ODAY. Well, not necessarily.

The difficulty is, that there are two forms that we require the States to fill out. The first form is the one that just goes to the kinds of numbers that are listed in there—purely, the waivered services versus the institutional services.

There is a second form that is required 6 months after the end of the first year of the demonstration which goes to all costs for all populations under the medicaid program. It is really those numbers that are the more relevant ones.

Senator PACKWOOD. Following you there is going to be a panel. I have only read Mr. Gumb's and Mr. Zeigen's statements so far, but both Kansas and Oregon claim they are saving money on the waivers, or think they are saving money; maybe they are not, but they think they are.

Ms. FEINSTEIN. We are very hopeful that they are. I guess what we are saying is that these programs are too new and haven't been operational long enough so that we can be certain that total Government expenditures are less.

Senator PACKWOOD. When you say "total government," do you mean Federal, State, and local? That somehow, even the Federal Government might be saving costs on medicaid, but the costs may be shifted off to some other unit of government, and the total net is not really a saving?

Ms. FEINSTEIN. I am saying that's the area we need to make sure of. That is the area we need to explore.

Senator PACKWOOD. I understand the argument about overutilization, and I can understand your concern. We got burned on that on medicare. When we had our original cost estimates on medicare in the midsixties, there wasn't any organization that was close, by half, as to what the program would end up costing. I am impressed by the figures that you have that only about 20 percent of the people who might be eligible for institutionalization are institutionalized, and that at the moment the rest stay home with relatively little outside care. If a comprehensive home health care program was available, they might get it; otherwise, they might never have any care.

But I find it hard to believe that a straight 1-to-1 trade somehow can end up costing the Government money, if you can take someone from a nursing home and take care of them in a home.

Ms. FEINSTEIN. No, I don't think on a straight 1-for-1 basis one could in any way, shape, or form make that argument.

What we have seen in some instances is that it is not a straight 1-for-1 trade for medicare. Oftentimes, the person getting services at home would not have been in an institution. It isn't even straight between medicare and medicaid when one considers other Government supports such as food stamps and SSI but that oftentimes go into the home are not required when you are in an institution.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator DURENBERGER. Senator Bradley?

Senator BRADLEY. Thank you very much, Mr. Chairman.

I find this testimony really very interesting, and I would like to compliment you on it.

On page 17 you say that your "research and demonstration activities have yielded some positive findings." And then you go on to say "community based care can be cost-efficient if targeted to appropriate individuals," and "strengthening informal care supports can preclude the necessity of providing formal care." Do you want to expand on that?

Ms. FEINSTEIN. Briefly, I think the theme that runs through much of our R&D results is that the key is this whole notion of targeting and the tremendous difficulty of doing that—which we have seen on the programmatic side through the 2176 waivers—

and the fact that States are only asking us for permission to cover a very small number of people, by and large.

I think in some instances, like in South Carolina, States began with us through an R&D waiver in channeling services to beneficiaries. They felt that they gained sufficient expertise and then came back for a 2176 waiver.

The keys to targeting are subjects that we spend a lot of time talking about at the office, and they are very difficult to assess. I think they are broader than medical targeting.

Folks have suggested, and I think some of the previous witnesses, that the whole subject of housing is one which has to be part of this targeting methodology.

Linda, would you care to speak to the demos?

Ms. HAMM. I think you are going to hear Tom Brown who runs the South Carolina project that Ms. Feinstein mentioned on the next panel, That is a project that was started out of R&D dollars; it is a project that has yielded some preliminary data, and I will let Tom decide how much of that data he wants to share with you, because it isn't public yet and is preliminary. But it looks interesting at this point in time.

You might also ask him how South Carolina goes about targeting since every R&D project that we have ever developed and undertaken has done it in a slightly different manner.

Tom's project is one of our earlier channeling-type projects. It led, in part, along with all the others, led to the national channeling demonstration project. Senator Bradley, you have a project in your State, and Senator Heinz has one in his.

We are experimenting with a new approach to targeting in that demonstration that builds on what we have learned from all the other earlier demonstrations. We are very hopeful that we will learn a better approach that takes into consideration such things as housing which Ms Feinstein mentioned, such things as the nature and extent of the support system that exists for the informal care-givers and for the client. How burdened is the family at this point in time? Are they indeed doing a good job taking care of the elderly member? Are they about to be absolutely burned out from the experience? What is it that we can do to shore up that family and provide some respite for them so that they will continue doing that a little longer? Those are some of the things that we are looking at.

Senator BRADLEY. But are you saying that the more targeted a program is, the more likely that it will succeed?

Ms. FEINSTEIN. I think most definitely we are saying that.

Senator BRADLEY. Are you saying, even in a targeted program, that you determine cost effectiveness not only by the costs it would have cost the family if the person had been in a nursing home versus at home, but also the fact that if the person is at home they can get other kinds of supplements that they wouldn't get in a nursing home setting? Is that what you are also saying?

Ms. FEINSTEIN. Yes. And I think the point that Dr. Scanlon made in the first presentation—that an elderly person living alone needs someone to deliver those home services and some of the things that go with it—is broader than simply a trade-off of one Government program for another. But what other community activity is there? And who is supporting that?

You asked another question about families and what we were doing. We have a project that is looking at a voucher-type approach, where families are being given $600 a year that they can use for paid respite services for a period of time. Maybe they could have 2 weeks of vacation if they could only get their elderly person somehow cared for during those 2 weeks. They might be willing to resume the care responsibility for the other 50 weeks of the year. So we are looking at some of those things as well.

Senator BRADLEY. If you were designing a program today and the President told you that you had to have it ready by tomorrow, what criteria would you use for eligibility for home health care?

Ms. FEINSTEIN. Well, I think it all sits behind the backdrop of the state of the trust funds and the state of the medicaid long-term care budget.

Senator BRADLEY. That would mean you would want to draw it narrowly.

Ms. FEINSTEIN. That would make you want to target it to those truly at risk of institutionalization, to those who would truly be in institutions were it not for this other kind of service.

Senator BRADLEY. So there is a strong argument for that population to receive home health assistance?

Ms. FEINSTEIN. There is a strong need, I think, to target services at the appropriate level to those people. It may not be home care; it may be institutional care.

Senator BRADLEY. But you are designing a home health care program.

Ms. FEINSTEIN. Well, I think I would want to be designing a program for those most at risk of institutionalization and care for them in the most appropriate way, be it at home or in an institution.

Senator BRADLEY. Let me ask you about premise. Do you accept the premise that home health care is an appropriate and humane form of health care that should be encouraged by the Federal Government?

Ms. FEINSTEIN. I think it is an appropriate form of health care that should be reserved, like these other programs are, for those truly at risk of institutionalization. I think we could all use a little home health care, Senator Bradley.

Senator BRADLEY. Thank you.

Senator DURENBERGER. Well, I am not sure where this "targeting response" and the "request from the President" was leading us. I would like to assume from the response I heard from you that if the President came up to you and said, "By tomorrow morning I want a home health program," you would either say, "How many homes"?—you know, if that's a home health program, to get *x* number of homes out there, you can design that overnight very easily, I would guess. But if, more logically, the President comes to you and says, "We have a population of so-many millions of people out there who need services; develop a program," I take it that is going to take a longer time.

My question of you is: What is HCFA's strategy in case the President does make that latter phone call—not the first phone call, you know, "Design me a home health system," but "Give me a system for America's elderly indigent?" What is your strategy? Is there a point in time when you can answer all of these questions with a proposal? You know, "Here is where the country ought to go on this"?

Ms. FEINSTEIN. Yes, I think there is a time when we can answer these questions. I think the difficulty is, it's not today. I think we have in place a very, very rich research and demonstration agenda that will bear fruit if we are patient enough to wait.

Senator DURENBERGER. When? When does the first apple fall off the tree, and when can we start picking? [Laughter.]

Senator BRADLEY. When the President calls. [Laughter.]

Ms. FEINSTEIN. Well, as with so many things, it is not tomorrow. And it is difficult to tease apart the changes that we just put in place on the acute-care side and the effect of these acute care changes by themselves versus their intersection effects with all of these demonstrations that we have going. I think these demonstrations will help us structure reimbursement so that the long-term care provider community has incentives to take sicker patients. I don't think any of us could claim this kind of incentive exists today.

Senator DURENBERGER. I haven't read the testimony of the next four witnesses. Suppose they come in and just say, "Give us more money, and we will answer the President's problem?" Is that part of the solution? Are you systematically reviewing each of these activites, so that if he had to have something right away you could say, "Hey, I will send you the Oregon plan, the Kansas plan, the South Carolina plan?" Is that sort of the state we are in now? Is that the best we have, the State demonstrations?

Ms. FEINSTEIN. Well, I don't want to underplay the important nature of these demonstrations. While we are not in a research vein in a university, looking at some data, we do have people getting services today through social HMO's in small instances, and we are able to watch that. Likewise, we are also able to observe the section 2176 home and community-based service waivers. We now have people getting these alternate kinds of services with a mechanism in place to look at the cost effectiveness of those services. And I think we have to keep that focal point.

Senator DURENBERGER. I won't belabor the point, but we can watch grass grow, too, and at some point we need to feed it to someone or to cut it, or whatever. Are we getting close? What do you mean by tomorrow? A year? Two years? Three years? Do you have any comfort level, or do you want to leave it somewhat vague?

Ms. FEINSTEIN. No, I think we are getting close to having that fruit ready to draw some conclusions from, but I guess you asked a question of another witness that I would like to answer, which was: Is there any other set of questions we ought to be asking ourselves? I think we haven't looked hard enough at the private side: private long-term care insurance and whether or not that is appropriate. You are going to hear somebody testify about that today. Delivery systems through the private side—whether we mean hospitals, or other institutions—as the result of prospective payment, may be moving themselves into the long-term care area. So I hope we look at the private side as well as the public side.

Senator PACKWOOD. When you say private side, do you mean paid for by the private side?

Ms. FEINSTEIN. Much the same way that hospital insurance is so prevalent on the private side.

Senator BRADLEY. Can you tell me when all the data will be in from the channeling grants?

Ms. FEINSTEIN. The final report will be available the first part of 1986, but there will be interim process reports coming along in the next month to several months, and I can certainly submit for the record a schedule of when every one of those will be available.

Senator BRADLEY. If you could, Mr. Chairman, that might give us some numbers that we need.

Senator DURENBERGER. Right. That would be very helpful.

[The information follows:]

Schedule of Evaluation Reports for the National Channeling Demonstration

April 1983	The Planning and Implementation of Channeling: Early Experiences of the National Long Term Care Demonstration
End of May 1984	1) Baseline Comparability Report 2) Report on Caregiver Characteristics
End of August 1984	Preliminary Impact Report
End of January 1985	Targeting, Intake and Case Management
End of March 1985	1) Channeling Project and Service Environment 2) Channeling Project Cost Report 3) Preliminary Analysis of Provider Record Extracts
End of May 1985	Survey Procedures
End of June 1985	1) Caregiver Report 2) Client Well-being
End of July 1985	Sample Design and Size
End of August 1985	1) Claims File Procedure Report 2) Living Arrangements and Mortality Report
End of September 1985	Service Utilization and Costs
End of October 1985	1) Attrition Bias 2) Cost-effectiveness Report
End of November 1985	Analysis of Service Choice Report
End of January 1986	Final Summary Report

Senator DURENBERGER. Are there any other questions?

Senator PACKWOOD. Well, just a word of warning. One of the reasons we got into the medicare jam we are in now—and it's more the Republicans' fault than the Democrats' fault—we kept saying as Republicans, "Well, private care ought to take care of that. Private care ought to provide for the hospitalization of the elderly and somehow pay." Only, it became very difficult to buy any insurance when you were 68 and were facing long-term hospital care. So we backed into medicare, because we could not find any private alternative. I am not going to lay any criticism after that as to why the medicare costs have gotten to where they are, but if this administration's answer is, "Well, we should wait until we find some private way to pay for this home health care," you may end up achieving roughly the same thing you have achieved in medicare.

Ms. FEINSTEIN. That is a good note of warning. I think Mr. Meiners from the National Center has an interesting proposal to share with you on private health insurance for the long-term care area.

Senator DURENBERGER. Very good.

Thank you very much for your testimony.

Our next witnesses will be a panel of four: Mr. Jackson J. Gumb, administrator, adult care home section, Kansas Department of Social and Rehabilitation Services, Topeka, Kans.; Mr. Robert Zeigen, deputy administrator, senior services division, Oregon Department of Human Resources, Salem, Oreg.; Mr. Thomas Brown, project director, South Carolina community long-term care project, Columbia, S.C.; and Ms. Bonnie Stone, first assistant deputy administrator, family and adult services, human resources administration, city of New York.

We can start with Mr. Gumb, and we will proceed in the order in which you were introduced.

STATEMENT OF JACKSON J. GUMB, ADMINISTRATOR, ADULT CARE HOME SECTION, KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES, TOPEKA, KANS.

Mr. GUMB. Mr. Chairman, members of the committee:

I am happy to be here, from Senator Dole's homeland. In Kansas the average intermediate care cost per month is $554. The average home and community-based service cost is $410 a month. We would say today that we are saving money with the home and community-based service program.

Currently we are serving 453 recipients, using 14 different programs. It is estimated that these 453 recipients are saving the State $65,000 a month, or approximately $780,000 a year. It is not much, but I think we need to consider the fact that these individuals who are in the home and community-based service program are nursing home eligible, and it is their choice to use the home and community-based service program. If they were not in the home and community-based service program they would be in a nursing facility of some kind.

In Kansas, our goal is to expand the services throughout the State. We do have a statewide program; we do serve veryone—the elderly, the disabled, and the mentally retarded.

I think our major frustrations with the home and community-based service program are in three areas:

The Health Care Financing Administration's reporting requirements. There appears to be no coordination within HCFA on their new forms that they have developed, the HCFA 371 and the 372. They want statistics before these individuals went into home and community-based services, and they want them afterward. I think on the surface these requests sound reasonable, but they cannot be pulled up manually. We have to add into our MMIS system another add-on to pull these statistics out. Any additional add-on to our medicaid management information system costs money.

We asked the Health Care Financing Administration why they needed these two new reports, and they said, well, they thought it would be good statistics. In Kansas, we do not consider that real cost effective, just to have good statistics.

The second frustration we are experiencing is in the family participation. We have found several cases where the families want to participate in the cost of the care.

In the nursing home program we do pay for 24-hour nursing care, and any additional to that we agree is supplementation. But in the home and community-based service program we are paying for usually 8 to 10 hours of some service. If the family wants to participate in services beyond those times, we do not consider that supplementation. So we would ask consideration on the supplementation issue.

The third frustration that we are experiencing is in the eligibility determination. Whenever there is the client obligation for a medicaid service, the Social Security Act requires that client to pay for that payment to the provider of services before he is medicaid eligible. We would recommend that the Social Security Act be amended to allow the State to collect the obligation for the home and community-based service when the client is determined to be medicaid eligible. We feel this would be a great benefit to the home and community-based service program.

That change would also assure the provider of services payment, and it would also assure that the client would be eligible.

In closing, we believe that the home and community-based service program is a good program, that it enhances the quality of life, and that it saves the State and Federal government money.

Thank you.

[Mr. Gumb's prepared statement follows:]

STATE OF KANSAS
JOHN CARLIN Governor

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

INCOME MAINTENANCE AND
MEDICAL SERVICES

ROBERT C HARDER Secretary

State Office Building
TOPEKA KANSAS 66612

November 1, 1983

Sheila Burke
Senate Finance Committee
Room SD 219
Dickson Senate Office Bldg.
Washington, D.C. 20510

Dear Ms. Burke:

Enclosed is Kansas' Summary and the written testimony for the November 3rd Senate Finance Committee.

I plan on testifying on November 3rd.

Sincerely,

Jackson J Gumb

Jackson J. Gumb
Administrator
Adult Care Home Section
Division of Medical Programs

JJG:klc
1155G
Enclosure

Senator Dole and Committee Members:

The following is a summary of the written testimony regarding Long Term Care and Home and Community Based Services.

The average cost of care in Kansas intermediate care facilities is $554 per month. The average cost of care in the Home and Community Based Services Program is $410 per month.

Before any individual is offered Home and Community Based Services, they need to be screened by a screening team composed of a registered nurse from a county health department, home health agency, or private nurse and an agency social worker.

The screening team is responsible for assessing the medical, social, and psychological needs and functional capacities of the applicant/recipient to determine the most appropriate type of services to meet the needs of the individual in the least restrictive setting. The basis for approval of adult care home placement must be medical need for services of the adult care home.

The screening is conducted by interview and observation of the individual, review of all referral information and contact by the nurse with the applicant's/recipient's physician. The family is contacted when appropriate.

The screening team determines the plan of care for the applicant/recipient. If the individual is deemed appropriate for adult care home (nursing home) placement, the screening team offers Home and Community Based Services to the individual.

Two of the major frustrations with the HCBS Program is the Health Care Financing Administration' program reporting requirements and in eligibility problems.

To make the changes that HCFA is requesting would involve a complete change in our Medicaid Management Information System (MMIS) reporting system.

Whenever there is a client obligation for a Medicaid service, the Social Security Act requires the client to assume obligation for payment to the provider of services before there is eligibility for Medicaid. It would be our recommendation that the Social Security Act be amended to allow the state to collect this obligation (for HCBS services) when the HCBS client is determined eligible for Medicaid if the monthly client obligation is met. This change would (1) assure the provider of services payment for services rendered, and (2) would assure the state that the client would be eligible. This would be a very positive change in the HCBS program.

In summary, we believe that the HCBS Program is a good program, that it enhances the quality of life, and saves the State and Federal Government money in long term care.

Jackson J Gumb
Administrator
Adult Care Home Section
Division of Medical Programs
Kansas Department of
Social and Rehabilitation Services

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11-1-83

Senator Dole and Committee Members

Thank you for this opportunity to testify before the Senate Finance Committee regarding Long Term Care and Community Based Alternatives.

In Kansas we have 395 Adult Care Homes (nursing homes) in the Medicaid Program. Kansas is reimbursing for 11,500 Medicaid recipients in these homes. Out of these 395 homes, 329 are intermediate care facilities (ICF), 43 are skilled nursing facilities (SNF), and 24 are intermediate care facilities for the mentally retarded (ICF-MR). The average cost of care in the ICF's is <u>$554. per month</u>. The average cost of care in the Home and Community Based Services Program is <u>$410. per month</u>. Our fiscal year 1984 nursing home budget is $90.9 million.

In 1980, Kansas started screening Medicaid applicants and recipients who wanted to be admitted to an Adult Care Home or who were already in an Adult Care Home and who were running out of private resources to pay for their care and were applying to the Medicaid Program. There was an initial pilot project of 4 counties in Southeast Kansas. When this project proved to be successful, the Department initiated state-wide screening in December, 1981. At this same time the State set up an Alternate Services Program funded out of all State funds for those recipients who did not have any medical needs.

The State of Kansas submitted its request for the Home and Community Based Service Waiver on January 8, 1982. Offical approval was received March 22, 1982.

At the outset, while the request was being written, an Oversight Committee was appointed with representatives of Social Services, Mental Health and Retardation, Rehabilitation, Public Assistance, Research and Statistics and Medical Services. Additionally, an Advisory Committee of other interested agencies and provider groups was established. That a group such as this can have input and concur with the content of an approvable waiver demonstrates our committment to the program.

Who can get Home and Community Based Services?

To be eligible for Home and Community Based Services under the Title XIX waiver, a recipient must meet all of the following conditions:

1. Referral by a community based screening team or an independent professional review team.
2. Be 18 years of age or older.
3. Have medical assistance eligibility confirmed by Income Maintenance.

Only those recipients who are eligible for a Skilled Nursing Facility, Intermediate Care Facility or Intermediate Care Facility for the Mentally Retarded shall be offered the choice of utilizing the alternate Community Based Services provided under the waiver program.

Each recipient's needs and abilities will be assessed by a screening team. The screening team is made up of a social worker from the Area/Local Social and Rehabilitation Services Office and a registered nurse from the County Health Department, Home Health Agency or self contracted with the Department. The screening team is responsible for assessing the medical, social and psychological needs and functional capacities of the applicant/recipient and determine the most appropriate type of service to meet the needs of the individual in the least restrictive setting. The basis for approval of adult care home placement must be medical need for services of the adult care home. The screening is conducted by interview and observation of the individual review of all referral information and contact by the nurse with the applicant's/recipient's physician. The family is contacted when appropriate.

The screening team determines the plan of care for the applicant/recipient. The plan of care will be implemented by the case manager.

The screening assessing instrument used by Kansas was develped by the Department of Social and Rehabilitation Services and the Long Term Care Gerontology Center, University of Kansas Medical Center, Kansas City. This Gerontology Center is one of seven in the United States.

The services available under the Kansas Home and Community Based Services Program are as follows:

Adult Day Health: Provides an eligible individual, health & social services, and socially oriented activities usually for four to eight hours per day, one or more days per week on a regularly scheduled basis. Day treatment and day care are the types of services offered in the adult day health services program. Under the supervision of a registered nurse or RN consultant, day treatment offers services which are both medically and socially oriented. Day care offers services that are socially oriented only. Individuals eligible for adult day health services are the elderly and physically disabled 18 years of age and older.

Adult Family Home Services: A range of services provided in family residences which have been registered by the Department of Social and Rehabilitation Services and by the SRS area office. A maximum of two individuals can be cared for in one home. Adult Family Home services enable elderly and/or disabled individuals to live within their home communities.

Adult Residential Services: A range of services provided in a non-medical group residence licensed and certified by Social and Rehabilitation Services or in client's living situation. These services teach disabled persons to live independently in the community.

Congregate Living Home Services: A range of services provided in supervised non-medical group living for mentally ill and mentally retarded adults (ten or less) who cannot live independently. Congregate living homes are assessed and certified by Social and Rehabilitation Services.

Home Health Aide Services: Provides medically oriented care to individuals in their own home or an alternate living setting. These services can include basic personal care and grooming, assistance with bowel and bladder elimination, monitoring vital signs, assistance with food, nutrition and diet activities, and assistance with simple range of motion (ROM) exercises. These services must be provided under the supervision of a registered nurse from a home health agency or public health department.

Habilitation Services: These services help developmentally disabled persons 18 years or older to live as independently as possible in the community. Habilitation services provide training in personal, social adjustment and community living skills, as well as supportive counseling and therapy usually for eight hours a day, (excluding meal time), on a regularly scheduled basis for one or more days per week.

Homemaker Services: Homemaker services consist of general household activities provided by trained homemakers when the individual regularly responsible for these activities is absent or unable to manage the home and care for himself/herself or others in the home.

Hospice Services: This program serves terminally ill patients (expected to live six months or less) and provides support to the family in adjusting to life without the patient. Hospice services are provided by either a Medicare certified home health agency, a hospital, or Hospice agency which is a member of the Kansas Hospice Association and has an approved Hospice program.

Medical Alert: The medical alert system, through use of a small instrument carried or worn by the client, provides support to the individual having a medical need which could become a crisis at any time. The person receiving the medical alert must be alone a large part of the day. Without this support system, the client would be unable to summon needed assistance.

Medical Attendant Care: Medical attendant care provided under the supervision of a registered nurse according to a physician's plan of care provides long-term maintenance or supportive care, as opposed to short-term care required for some acute illnesses. This service enabled a client to continue to be treated by his/her own physician as an out-patient.

Non-Medical Attendant Care: Provides personal, non-medical, in-home services to persons with a disability who do not require daily medical and nursing care, so that individuals may remain in their own homes as long as possible.

Night Support: Provides overnight assistance to elderly and/or disabled clients in their own homes for a period not to exceed 12 hours. Clients have available to them an attendant who is ready to call the doctor, hospital, or other assistance should an emergency arise during the night. An attendant is available to assist client to bathroom, re-position client, remind client to take medication, etc.

Respite Care: Provides relief to families caring for elderly and/or disabled persons for emergencies or planned short or extended periods up to a maximum of thirty days per twelve month pericd.

Wellness Monitoring: Provides long-term routine medical surveillance of patients in their own home or in alternative living situations by a registered nurse. Wellness monitoring is a service designed to monitor the patient's state of health and maintain a laision with patient's physician. The registered nurses work cooperatively with a home health agency or public health department for support in decision-making.

It was believed and has been proven to be true that all the services described are necessary to maintain the elderly or disabled in the community. As of this date, 453 recipients have chosen to participate in the Home and Community Based Program.

Kansas does serve everyone (elderly, mentally retarded, developmentally disabled) in the Home and Community Based Services Program as opposed to some states who select certain groups.

Since the Kansas Department of Social and Rehabilitation Services is an umbrella agency, these Home and Community Based Services recipients are also eligible for other services in the Medicaid Program such as hospital, physician and pharmacy. These services are not covered as Home and Community Based Services in Adult Care Home Services.

So far in this program, we have found that there are more services and providers in the Metropolitan areas of the state.

Our major frustrations with the Home and Community Based Services Program is in three areas - Health Care Financing Administration Program reporting requirements, family participation and eligibility problems.

In December, 1982 a Health and Human Services memorandum was received from Health Care Financing Administration requiring that we report all services provided to both Home and Community Based Services recipients and Adult Care Home residents. This will require extensive system changes at a cost of which has a 90% federal match. This will not add to the evaluation of the program, is not cost effective and when we asked why it was needed we were told these would be good statistics to have. We don't believe this is how money is saved.

Family participation in payment for services has caused problems. Families that cannot carry the burden of paying for all the care are willing to pay for a part of the care. This we were told is supplementation and could not be allowed. This frequently means the recipient goes to the nursing home and we pick up all expenses at a much higher rate. In the Adult Care Homes (nursing homes) we pay for 24 hour nursing care and in the Home and Community Based Services Program we are paying for an approved amount of hours.

Eligibility Problems -

Whenever there is a client obligation for a Medicaid Service, the Social Security Act requires the client to assume obligation for payment to the provider of services before there is eligibility for Medicaid. It would be our recommendation that the Social Security Act be amended to allow the State to collect this obligation (for Home and Community Based Services) when the Home and Community Based Services client is determined eligible for Medicaid if the monthly client obligation is met. This change would (1) assure the provider of services payment for services rendered; and (2) would assure the State that the client would be eligible. This would be a very positive change in the Home and Community Based Services Program.

In closing we believe that the Home and Community Based Services Program is a good program, that it enhances the quality of life and saves the State and Federal Government money in long term care.

Jackson J. Gumb
Administrator
Adult Care Home Section
Division of Medical Programs
Kansas Department of Social and
Rehabilitation Services

Senator DURENBERGER. Our next witness is Mr. Zeigen.

Mr. Zeigen, welcome.

STATEMENT OF ROBERT ZEIGEN, DEPUTY ADMINISTRATOR, SENIOR SERVICES DIVISION, OREGON DEPARTMENT OF HUMAN RESOURCES, SALEM, OREG.

Mr. ZEIGEN. I am Bob Zeigen, the deputy administrator of the senior services division, and I am pleased to be here on my own behalf and speaking for Dick Ladd, our administrator.

I think at the outset we would like to say that we strongly favor having more resources for maintaining persons at risk of institutionalization in the community. Based on our experience, when funds are available for alternative care, independence is enhanced at reduced overall costs to long-term care programs.

In my overall handout I described some of the background which led to the formation of the senior services division in 1981. All long-term care and aging programs were consolidated into a single State agency, and these included the medicaid long-term care programs, social service block grant, Oregon Project Independence—which is a State program for those not eligible for these other programs and which does include a fee for service based on ability to pay—and the Older Americans Act. We did receive the medicaid waivers for home and community care in December 1981, which allowed us to increase the amount of community services that we could purchase, or could be purchased.

As a result of that availability, we were able in February 1982 to initiate a very active and careful program to help people who have been in nursing homes to move back into the community. And we were able to help, to date, somewhat over 1,500 persons. This is part of the statement that has already been made that we are saving about a million dollars monthly in the long-term care programs. And we have actually reduced our home, medicaid nursing home caseloads by 5.6 percent.

It is important that you realize this reduction took place at a time when the State was seeing a 3-percent growth in what we consider our "risk population," which is the population 75-plus. This growth was the basis for the Oregon legislature approving the senior services division budget for the 1983-85 biennium.

I would like next to briefly talk about some components of a long-term care system, based on our experience. The scope of such a system should allow the States to be able to meet the service needs of the person funded from all available sources, including medicare and medicaid.

Reference has been made to targeting of services—we agree with that.

You will have to establish priorities of care. As part of this, a preadmission screening team should be diverting people from nursing facilities and helping those in institutions leave them when they are capable of doing so.

There is a need for a common assessment approach, which would permit consistent assessment of need. There should be professional case management staff to coordinate and monitor delivery of services.

There are a number of cost implications. To avoid increasing public costs, those most in need should have first priority, with some cutoff point of impairment and income.

A second point is that States should have the ability to set service rates. Competition alone does not keep the costs down in this kind of program. There has to be some other mechanism.

Third, there should be an independent evaluation of quality and appropriateness of care in the community. We do that in the nursing homes through various means, but it also should be done in the community.

Finally, in this regard, the individual should cost-share when their income allows.

Next, there should be certain considerations under service provisions. Reference has been made to adult foster homes. There are also larger facilities called residential care facilities. We need to have a variety of living situations available in which to deliver services.

Second, the service supervision should not exceed that needed for the service being delivered. Most home care does not require medical skills.

Last, I want to mention that if other States, for example, are not able to integrate their long-term care programs as they have done in Oregon, there should be some coordination of service delivery; there should be coordination at the State level, the local level, and among the providers of services. This we have found to be a very effective way, without necessarily changing the whole organizational structure.

Thank you.

Senator DURENBERGER. Thank you very much.

Mr. Brown?

[Mr. Zeigen's prepared statement and answers to Senator Durenberger's questions follow:]

TESTIMONY
BY ROBERT S. ZEIGEN, DEPUTY ADMINISTRATOR
SENIOR SERVICES DIVISION
OREGON DEPARTMENT OF HUMAN RESOURCES
NOVEMBER 3, 1983
TO THE
UNITED STATES SENATE FINANCE COMMITTEE, HEALTH SUBCOMMITTEE

Mr. Chairman, on behalf of Richard Ladd, Administrator, Senior Services Division, Department of Human Resources, State of Oregon, I am pleased to appear before you today.

The Senior Services Division strongly favors increasing the resources available for non-institutional care in the community for elderly and disabled persons who are at risk of institutionalization. Our experience in Oregon clearly demonstrates that, when funds are available for alternative care in the community, the desires of the elderly and disabled to live as independently as possible can be met at reduced overall costs to long-term care programs.

In my testimony, I would like, first, to describe the comprehensive Oregon long-term care system, which is somewhat unique, nationally, and then outline what we believe are the key components of a comprehensive long-term care system.

Background:

In 1979 Oregon began to address the rapid growth of long-term care/Medicaid costs. The Department of Human Resources initiated a demonstration project jointly funded by the Health Care Financing Agency and Administration on Aging, to evaluate the effectiveness of home and community care waivers as alternatives to costly nursing facility care under Medicaid. The demonstration also looked at the role of coordination of service delivery at the local and state levels.

This three-year program showed that a combination of coordination and waivers allowed more persons to be served in the least restrictive living setting and with overall savings for the Medicaid program.

In part, as a reaction to these findings, but also in response to the strong feelings of Oregon's seniors to improve coordination of various fragmented programs for the elderly at the state and local levels, the Senior Services Division was established in 1981 as the State Unit on Aging to administer all long-term care programs for the elderly. This included combining the programs providing service under Medicaid, the Social Services Block Grant, Older Americans Act and Oregon Project Independence. The last named is a state-funded program, initiated in 1975, to provide in-home services for persons who are not served by other programs and includes a sliding fee schedule based on income. As a result of this consolidation, a single agency is able to plan for, implement, and adjust programs and budgets for all long-term care concerns of Oregon's elderly and disabled. The Senior Services Division and the Area Agencies on Aging are meeting the charge of the Oregon legislature to "insure that the elderly citizens of Oregon will receive the necessary care and services at the least cost and in the least confining situation.

On December 21, 1981, Oregon was the first state to receive approval of Home and Community Care Waivers under Section 2176 of the Social Security Act (Public Law 97-35). We were able to respond quickly to the new legislation as a result of actions which began in 1979 to contain rapid growth in nursing facility Medicaid costs and because of the formation of the single state agency.

Without the flexibility afforded by the Home and Community Care Waivers, Medicaid was available only to those eligible for care in a nursing facility or receiving care from two small Medicaid programs, home health and personal care. Few funds were available to develop alternative community-based resources. The waivers changed this situation dramatically. Medicaid funds were used to care for persons at home or in substitute living situations, such as an adult foster home or residential care facility, providing these persons met the requirements for skilled or intermediate care in a nursing facility.

As part of its commitment to the Medicaid waivers, Oregon agreed to use savings from the nursing facility budget to pay for the home and community-based services and at a combined cost that does not exceed the cost of nursing facility care. Frequently, persons remain in nursing facilities beyond the time needed to meet their initial needs. The Senior Services Division initiated a program in February 1982 to assist persons in nursing facilities to return to the community with appropriate services, both paid and voluntary. To date, 1,550 persons have been helped to make this voluntary transition back to the community where they are living more independently, but with necessary coordination and monitoring of service delivery.

This major effort has been accomplished carefully, using comprehensive planning and evaluation by case managers, Pre-Admission Screening Teams, the Professional Services Review Organization (PSRO), the person's physician, the staff of the facility, the family and, most important, the individual themselves. This effort is in addition to actions taken by the Pre-Admission Screening Teams which have diverted persons from entering nursing facilities. While these actions are directed at the Medicaid population, the development of resources is indirectly affecting the ability of private paying persons to avoid entering a nursing facility. For example, in Eastern Oregon there were few adult foster homes before the Medicaid waivers were available. As a result of these waivers additional adult foster homes were established. Although initially certified for Medicaid-eligible persons, we now find these substitute living situations are being increasingly used by private paying persons who, formerly, would have entered a nursing facility.

We estimate that our Medicaid costs have been reduced by approximately $1,000,000 each month as a result of these actions while we have been able to serve an increased number of persons at risk of institutionalization. This is greatly facilited by the availability of Oregon Project Independence to serve persons not eligible for Medicaid. In the process, the Medicaid nursing facility caseload has been reduced by 5.6 percent.

Without the Medicaid waivers this dramatic accomplishment would not have been possible. Oregon does not have state funds to develop the comprehensive kinds of services in the community. Our state fund home care program, OPI, can only address a limited number of persons. The Medicaid waivers also allow flexibility for the states to become creative in providing care at least cost and in the least confining living situation.

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Components of a Comprehensive Long-Term Care System: Broad elements are outlined below. Any national program should be sufficiently flexible as to accomodate the needs and variations of the individual states.

1. Scope. The care needs of the person must be considered first, with the method of reimbursement being a secondary consideration. Increased flexibility would be achieved by developing a system which would allow the use of Medicare and Medicaid funds in a flexible manner, depending upon the eligibility requirements for these programs. Even with this consolidation, the states may find gaps requiring additional programs which the individual states may wish to fund. Long-term care budgets need to be looked at in the whole, rather than limiting expenditures within categories of services e.g., nursing facilities, home care, substitute living care.

2. Targetting of Services. It will be necessary to establish priorities of care for those in need. A person's abilities to accomplish various activities of daily living might be appropriate to achieve and assure targetting. Our expereience in Oregon indicates the following elements need to be considered:

    A. Pre-Admission Screening. Persons can be diverted from nursing facilities with the help of professional screening teams. Many persons and their families are not aware that care can be provided outside nursing facilities for frail and disabled persons. Screening of persons before they enter nursing facilities could prevent unnecessary and premature institutionalization. Physicians and hospital discharge planning teams must be involved in this process, and be aware of the alternative community resources.

    B. Common Assessment Approach. A common approach to assessing need should be required within each state. This will assure consistency in determining the ability for the person to remain in the community.

    C. Periodic Reassessment. The needs of the person should be reassessed periodically. This will assure services remain appropriate to the individual's needs.

    D. Case Management. As the Pre-Admission Screening Teams can be looked at as initially determining the person's care needs, the ongoing assistance to the person, including service redetermination and coordination, can be accomplished by a person often labelled as the "case manager". A comprehensive long-term care system cannot function without such professionals.

3. Cost Implications. The fear exists that adding community care to the existing health care costs for Medicare and Medicaid will result in additional public expenditures. Our experience suggests that costs are controllable, providing certain criteria are considered:

    A. Priority of Service. A system must be developed that assures those persons most in need have first priority to available services. There must exist a cut-off point of impairment as well as income, above which public funds are not used to purchase services.

B. Cost Containment. The states have various methods of establishing reimbursement rates for Medicaid nursing facility care. Medicare separately establishes rates for skilled nursing facility and home health care. A fiscally sound comprehensive long-term care system should allow the states the ability to set rates for all services, regardless of funding source or type of care. The ability of the states to control Medicaid long-term costs has been demonstrated. The process used to establish rates should involve public input.

C. Quality Assurance. Some method of independently evaluating the quality and appropriateness of care should be required. Presently, the Professional Services Review Organizations do this in nursing facilities. A similar function should be provided for persons served in the community.

D. Cost Sharing. Various alternatives should be considered and, potentially, allowed. This could include a captitation rate. Any approach should establish maximum out-of-pocket costs.

3. Service Provision:

A. Programs. A comprehensive long-term care system must allow the states flexibility in identifying which programs to fund. This is necessary given the differing directions taken by the states in developing existing service delivery programs. In allowing services in the home, this should include substitute non-medical living situations since many persons cannot live alone or no longer have a home in which to live. Some method of certifying or licensing these facilities should be required, to assure adequacy of health and safety standards.

B. Supervision. Many persons can be served in their homes with services which do not require medical skills. To avoid unnecessary administrative costs, service delivery supervision should be appropriate to the care being provided. Nurse supervision is not required for most in-home services. With a program of quality assurance and case management, sufficient evaluation of care is available.

C. Category of Care Need. Under Medicaid, the individual states have some latitude in defining skilled and intermediate levels of care. Consequently, the elements of both skilled and intermediate care should be considered when evaluating risk of institutionalization.

D. Coordination. Not every state can or may wish to consolidate all long-term care and aging program under a single agency. Where several state agencies plan for and deliver long-term care and aging programs, they should be required to coordinate these programs.

Conclusions:

The need for and the possibility of initiating a responsible comprehensive long-term care system is at hand. Our experience, in Oregon, suggests that a state administered program, capable of identifying the needs of a person and most effectively utilizing the available funds, is feasible and desirable.

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VICTOR ATIYEH
GOVERNOR

Department of Human Resources
SENIOR SERVICES DIVISION
313 PUBLIC SERVICE BUILDING, SALEM, OREGON 97310

December 5, 1983

The Honorable Dave Durenberger
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger:

Attached are my answers to the questions you sent November 15, 1983 following my testimony to the Senate Finance Health Subcommittee on November 3, 1983. I appreciated the opportunity to report on Oregon's successful long term care program and the insights it may provide for implementing similar programs elsewhere.

Sincerely,

Robert S. Zeigen
Deputy Administrator

RSZ:ds

Enclosure

1. QUESTION: Can you describe how you have actually combined funds under Medicaid, the Social Services Block, Older Americans Act, and Oregon Project Independence under a consolidated program? Does this mean that the budgets for home care services under these programs have been consolidated?

   RESPONSE: The Senior Services Division budget includes Older Americans Act, Oregon Project Independence, some Social Service Block Grant plus Medicaid funds. In addition we are able to claim Medicaid reimbursement through the Title XIX Waivers for home and community-based care. Except for the Older Americans Act funds, the funds are contained in a single appropriation. This permits the agency to allocate funds where needed without obtaining a change in statute.

   Since a single agency is involved, priorities for providing services and the clients to be served are established more uniformly.

2. QUESTION: Could you describe how the Oregon program maintains control and oversight of the cost and scope of community-based services received by a person accepted into the program? Do case managers, for instance, have budgets or limits for their clients?

   RESPONSE: Oregon maintains control and oversight of the cost and scope of community-based services by the following:

   a. Establishing standards for providers and setting maximum payment rates for each specific service.

   b. Establishing the number of hours of service based upon a care plan which specifically identifies the clients' needs. The care plan includes an assessment of the health, functional, social, and economic needs of the client and identifies resources available to meet any part of these needs. The agency authorizes only services which cannot be met through other resources.

   c. Payments over stipulated amounts must have Central Office approval.

   d. Monitoring of care plans and promptly making adjustments, when needed, in the type and amount of service(s) provided.

   e. Monitoring of data on trends, as well as average cost per person of service provided, numbers of persons served, and other data which allows us to quickly note overall changes and determine the reason(s) for change.

   f. Monitoring of assessments/care needs, provision of services and costs by quality assurance staff.

3. QUESTION: You indicate on page 4 of your testimony that not every state can or may wish to consolidate all long-term care and aging programs under a single agency. In your work on this program and conversations with other states' administrators, are other states interested in following Oregon's lead in consolidating long-term care services for the elderly under one administrative authority?

RESPONSE: Numerous inquires have been received from states as well as from local organizations, such as area agencies on aging. The Senior Services Division has responded with written material, describing our integrated long-term care and aging system, as well as orally in meetings and through telephone requests. Some states are considering the Oregon model. California passed legislation one year ago similar to that which established the Senior Services Division, with the added proviso that a committee prepare an implementation plan. I am aware of at least one other state giving consideration to Oregon's approach. There are barriers, however, which may prevent a replication. For example, Oregon emphasizes local planning and delivery of services, including case management. The area agencies on aging have the option of participating in this way where a governmental entity is the area agency. To date, seven of 18 area agencies have so opted and five of these have requested that the state employes become employes of the area agency. In some states, this kind of transfer back and forth between local and state governments or even supervision of state employes by local government is forbidden by statute.

A key, in my opinion, to achieving the Oregon model is an evolutionary process which introduces key elements over time. It would probably be difficult to accomplish in one or two years what it has taken more than four years to achieve in Oregon.

4. QUESTION: You indicate in your testimony that a system must be developed that assures that those persons most in need have first priority to available services. Could you please describe for us who these persons are in Oregon? What is the nature of their impairments, for example?

   RESPONSE: Oregon has established a policy which identifies persons to be served in order to best utilize limited funds for a client population of elderly and disabled persons. The policy is aimed at serving those individuals who most likely would enter a nursing facility. Staff assesses the health, functional, and social and economic needs of each client to determine whether the person is within the high or immediate risk range. The functional assessment tool is computerized for all clients for whom services are provided. The data for nursing facility and community served clients is similar.

5. QUESTION: Do you find that home and community-based are available and accessible in most communities in Oregon? Are they able to serve those most in need?

   RESPONSE: Home and community-based services are available in most communities in Oregon. These include foster and residential (non-medical) facilities, home-care (homemaker, housekeeper, personal care, home health services, home-delivered meals, and a range of other home or health services). The agency makes a concerted effort to develop community resources. In 1975, Oregon's legislature authorized a state-funded home care program (Oregon Project Independence) which makes home care services available to frail persons 60 years of age and older whose resources are slightly above Medicaid eligibility standards. The combination of this program and the former Title XX home care program resulted in an extensive service network throughout the state before Oregon received the Medicaid

Home and Community-Based Waivers. As a consequence, necessary additional expansion of Community-Based Care was possible in a relatively short time and with a modest increase in resources.

6. QUESTION: What have you found to be the most frequently utilized service under the program?

   RESPONSE: Homecare is the most frequently used service in the community and intermediate care is the most frequently used level of nursing facility care.

7. QUESTION: You indicate that Oregon's Medicaid costs have been reduced by approximately $1 million a month. Do these represent total savings on simply state savings? What have been the savings to the federal government as the result of your efforts?

   RESPONSE: Savings of about $1.7 million per month occur if the 1979-81 legislatively approved caseloads are projected through June 1985 and that projected caseload is compared to our July 1983 actual data. A comparison to the projected caseload for the 1981-83 biennium indicates almost $900,000 per month in savings. In both instances, these savings are in total funds and are reduced by about $400,000 per month because of increased community-based care expenditures.

   The maximum savings in federal funds are about $700,000 per month and the minimum savings are about $300,000 per month. It should be noted that Oregon receives approximately one percent of federal funds based on its population.

STATEMENT OF THOMAS E. BROWN JR., PROJECT DIRECTOR, SOUTH CAROLINA COMMUNITY LONG-TERM CARE PROJECT, COLUMBIA, S.C.

Mr. BROWN. Thank you, Mr. Chairman and members of the committee.

I appreciate the opportunity to talk about the South Carolina community long-term care program, which we have been working on since 1978. I want to address, first, the research project, which is still ongoing, using section 1115 medicaid and section 222 medicare waivers, and then describe our State program.

The concerns that were mentioned earlier about the growing number of older people and growth in medicaid cost, particularly for nursing home care, were the reasons that we got into this research program in 1978.

The program is targeted on medicaid-eligible individuals, most of whom are medicare eligible; so we are getting at the dually eligible population.

I am not going to give the details of the program except to say that the intervention included a case-management system which incorporated the preadmission screening for nursing home admission for medicaid sponsorship, and a number of new community-based services including a waiver of eligibility to cover those people under the current system who are eligible only if they enter the nursing home. These are the folks whose income is above the SSI level and below the nursing home medicaid cap. The community long-term care program is a systems intervention.

Some of the findings from a preliminary evaluation report are very positive, and I want to report on those.

The first finding is that most of the people in the experimental group, given the choice to stay home with community services, did in fact stay home. This study includes about 300 experimental clients and about that same number of control group clients who entered the program at nursing home level of care. So these clients were medicaid-eligible and at skilled or intermediate, and could have entered the nursing home at their time of entering into the program.

Sixty percent of the control group was admitted, while only 43 percent of the experimental group. We have been able to serve a number of folks at home who were attempting to enter the nursing home.

Second, we have decreased significantly—and this difference is statistically significant—the number of nursing home days. The experimental group used 37 percent less days than the control group.

Third, we found that, over time—and this gets at the quality question which was raised earlier—there really were no differences between the two groups as measured by health status, either mortality or functional change or mental status. That can be viewed very positively, however, because we can say that the folks that stayed at home in the experimental group—those who mostly stayed at home, at least—were not any worse off than the folks in the control group who mostly used nursing home care. The project didn't do any harm in that area.

Third, we have shown that the total cost and the cost per recipient and the cost per person per day in the experimental group were less than what these costs were for our control group. We have been able to demonstrate a cost reduction for services or a system of services which focuses on community care as opposed to institutional care.

Based on these findings, we are now moving parts of our program into the rest of the State. In 1982 and 1983 we began a case management system for medicaid-eligible clients who want to enter nursing homes. Again, we are using the preadmission screening approach to target on those folks that not only are skilled or intermediate level of care but also who intend to use nursing homes. This is presently in place.

In 1984-85 we are budgeting, and hopefully it will be approved, to expand services to add into the rest of the State those things which we presently have only in the demonstration areas.

We also plan on providing expanded eligibility for that group of clients that presently are eligible only in the nursing home.

In my prepared statement there are a number of issues that we addressed in our recent demonstration project.

I think the primary one that still is of concern, the one that Bob just raised, is the interface with the existing system for medicaid and medicare, title XX and title III services. This seems to be one of our biggest problems.

In closing I would like to say that if we can target through the mandatory preadmission screening process on those medicaid and medicare folks—potentially medicare, at least—that do want to enter nursing homes, who not only qualify but do want to enter, we can in fact serve them at home and this system of care can be cost-effective.

I think also there are some things that need to be done in the future, like the notion of risk sharing and whether the social HMO really will work. I would encourage us to look not so much now at the targeting and cost issues as to organized care that can be available to this larger population.

Thank you.

Senator DURENBERGER. Thank you very much.

Ms. Stone?

[Mr. Brown's prepared statement follows:]

Statement

Thomas E. Brown, Jr.

for the

Subcommittee on Health
Committee on Finance

United States Senate
November 3, 1983

Mr. Chairman and Members of the Subcommittee, I am both pleased and honored to have the opportunity to discuss with you South Carolina's research, planning and implementation activities in the area of provision of community-based long term care services for the elderly and disabled.

My name is Thomas Brown, and I am Director of the Community Long Term Care Program, which is designed to provide assessment, service management and home and community-based services for the Medicaid-eligible aged and disabled populations in need of long term care.

In my presentation, I will describe South Carolina's activities in the provision of long term care services for the elderly and disabled since 1978. At that time there was agreement by the Governor, the General Assembly and the State Agencies involved with services to the aged that the existing system of care, which provided solely institutional care, was inadequate. First, it was not meeting the needs of many older persons who wanted care in their own homes. Second, it was recognized that the State could simply not afford such a system if the system expanded in the same proportion as the number of elderly in need of long term care. From this beginning, the Community Long Term Care Program has moved through a research and demonstration period with Section 1115 Medicaid and Section 222 Medicare waivers into statewide implementation of community-based care under the Section 2176 Medicaid waiver authority.

South Carolina Needs More Long-Term Care Services

South Carolina has recognized the need to plan for the present and future demand for long term care. Between 1970 and 1980, South Carolina's elderly grew by 51%, one of the fastest growth rates in the nation. Over the next 10 years (1980-1990), the 65+ population will grow by an additional 45%, with the fastest growth occurring among those over 75 years. We know that we must expand available resources. South Carolina is largely rural, and we have a disproportionately large number of very poor people; in 1980, for example, 23% of elderly South Carolinians were below the poverty level compared with 17% of the elderly nationally. Many counties in the State have a shortage of physicians and other medical personnel. In terms of medical facilities, the State has 4 hospital beds per thousand persons, which is very close to the national average, and 38 nursing home beds per thousand persons over 65, which is slightly less than the national average.

In FY1983-84, 57% of South Carolina's Medicaid expenditures will be spent for services to the aged, blind and disabled. A substantial portion will be spent on long term care. Policy and program development to meet the growing need for long term care has become a central issue for health planners and public policy makers in South Carolina.

The Community Long Term Care Demonstration Project

Community Long Term Care is an experimental demonstration program which has been testing the effectiveness of community-based services for meeting long term care needs.

The purpose of the project is to help provide answers to two main questions:

> Can Community Long Term Care use a program of community-based services and professional case management to provide effective, affordable in-home help to more of the elderly and disabled in South Carolina than are presently served with the current Medicaid long term care system, which relies heavily on institutional long term care?
>
> Can community-based services reduce the use of nursing homes by elderly and disabled South Carolinians?

The CLTC project was established because of concern that disabled South Carolinians had few resources for long term care other than nursing homes. In 1978, the South Carolina General Assembly established the Community Long Term Care Project under the direction of the multi-agency Long Term Care Policy Council, which includes the Commissioners of the Departments of Social Services, Mental Health, Health and Environmental Control, and Mental Retardation; the Director of the Commission on Aging; and the Governor (or his designee).

Since Medicaid is a major funder for long term care services and since South Carolina is very concerned about the phenomenal growth in the Medicaid budget, the project participants were disabled adults who were very likely to use Medicaid nursing home benefits if other sources of long term care were not available. CLTC participants included disabled and elderly adults who were: 1) sufficiently disabled to qualify for Medicaid-sponsored long term care in a nursing home and 2) able to meet Medicaid financial eligibility requirements for nursing home care.

A key element of the project is the experimental design. Each project participant is assigned to either the experimental or control group. The control group receives only the services for which they are eligible under the current Medicaid system. The experimental group receives, in addition to regular Medicaid services, case management, access to a group of experimental services established by CLTC, and expanded eligibility for Medicaid-sponsored community services. The experimental service package is discussed in detail below.

Policy Initiatives Tested by the CLTC Project

CLTC was designed to test three major policy initiatives.

-The Service Management Model. All experimental clients receive ongoing assessment, case planning and service coordination from Project service management teams composed of a social worker and a registered nurse. In order to ensure that all Medicaid-eligible disabled persons in the project area will have access to CLTC, pre-admission screening for persons seeking Medicaid nursing home benefits is mandatory. The use of the service management concept was intended to guarantee that Project clients would have access to all available services and to ensure that available services would be efficiently and parsimoniously targeted to those clients who would receive the most benefit.

-Community-based Services Using Both Medicare and Medicaid Waivers. Many poor, disabled people (particularly among the elderly) are "dually eligible" for both Medicare and Medicaid benefits. For the dually eligible people, the effectiveness of the health care system depends on how well Medicare and Medicaid services are coordinated to provide continuity of care. The project was designed to use both Medicare and Medicaid resources so that fully integrated, coordinated long term care could be provided to project clients.

-Expanded Services and Expanded Eligibility. South Carolina had two major impediments to testing a community-based long-term care system. First, a number of community services which had been shown in previous demonstrations to be very effective were not available. Second, South Carolina used a "two-tiered" system of Medicaid eligibility. SSI recipients were eligible for Medicaid services in the community, while disabled individuals with incomes between 100% and 300% of the SSI maximum were eligible for Medicaid benefits only in nursing homes. To remedy these gaps, the Long Term Care Policy Council authorized: 1) the establishment of new community services in the project area to strengthen the community-based long term care system (expanded services) and 2) eligibility for community-based services for experimental clients who would otherwise have been eligible for Medicaid services only in nursing homes (expanded eligibility).

New community services available to CLTC experimental clients are:

a) personal care
b) medical day care
c) home delivered meals
d) medical social services
e) physical therapy, speech therapy and occupational therapy
f) respite care

All new services are not available throughout the project area. In order to avoid duplication of services and to insure the quality of expanded services, an expanded service was established in a county only if: 1) the service was not available or 2) there was consensus among providers that current services would not be able to meet the needs of all experimental clients. Expanded services were established through contracts with provider agencies. In all cases, expanded services are provided by agencies who had been serving the elderly and disabled prior to the inception of the project. This active recruitment of existing providers was seen as a way to maximize the use of existing service resources. In most cases, CLTC project staff provided technical assistance to the provider. For example, the Project Director and Area Director worked closely with a nursing home administrator to design and establish the medical day care program. All expanded services were designed by CLTC project staff, and adherence to the service specifications was part of the contractual agreement.

To guarantee that expanded services were being used effectively and were not duplicating existing services, three additional procedures were established. First, all non-project community services had to be exhausted before expanded services could be put in place. Second, a Utilization and Review team of independent health professionals reviewed case records for experimental clients in the community. Third, service managers made cost estimates of each service plan written and were required to keep expanded services costs for each client at or below 75% of the amount the client would have required for nursing home care.

Two methods were used to establish reimbursement rates for expanded services. Prospective rates were used to contract with providers who had had experience with the service being provided. Prospective rate contracts defined the service to be provided and established a unit rate. Interim rate contracts were established with providers who did not have the experience to estimate the actual cost per unit. Under interim rate contracts, the service to be provided was defined and a provisional rate for the service was specified. Contractors were audited by State Auditor's Office at the end of the contract year, and an adjusted unit rate based on their actual cost was determined.

Project Research Findings

Research findings indicate that the Community Long Term Care model is an effective, affordable method for providing long term care. A recently completed study of participants who entered the project during the first experimental year indicated that:

-Experimental clients had lower average Medicaid cost.

After 18 months, the average cost for clients served with the CLTC experimental program was $1.25 (9%) less per day than the average cost for participants served with the current Medicaid program. If control participants had been served with the experimental program, the saving would have been $160,000 for the 18 months. It should be noted that the cost for experimental clients included the cost of expanded services, the cost of expanded eligibility, and the cost of case management. The cost of case management was $1.00 per day per client.

-Experimental clients used nursing homes less.

Experimental clients spent an average of 124 days in nursing homes, while control participants used an average 187 nursing home days. Put another way, the experimental group spent 30% of their total participation days in nursing homes while control participants were in nursing homes for 49% of their participation days.

Most of the reduction in nursing home use occurred because many more experimental clients did not use nursing homes. Over an 18 month period, only 119 (43%) of experimental clients entered nursing homes, compared with 202 (60%) of control participants. The remainder of the reduction was the result of some experimental clients who eventually entered nursing homes being able to remain at home longer than they would have if they had been part of the control group.

-Most clients preferred to stay at home if they could.

All participants in this study could have voluntarily entered a nursing home. Yet, only 60% of the control group and less than one-half of the experimental group actually entered nursing homes. These findings and previous research indicate that community-based care will continue to be preferred by most disabled and elderly South Carolinians.

Some people will choose nursing homes, even when other options are available. For others, nursing homes will be the least-cost alternative. Nursing home care is, and will continue to be, an important part of a comprehensive long term care system. However, these findings show that community-based services should also be an integral part of a comprehensive long term care system, since they are usually preferred by eligible clients and since they can be equally or more effective for meeting long term care needs.

-All project participants (both experimental and control) were handicapped and clearly in need of long term care services.

All participants in this study were sufficiently disabled to qualify for care in a nursing home when they entered the project. After 18 months, four out of five surviving participants were still qualified for nursing home care; 20% in each group had improved to the point that they no longer qualified for nursing home care.

Levels of impairment, death rates and amount of improvement in functional health were virtually identical for both groups. These findings generally supported the conclusions that: 1) all CLTC participants were "at risk" because of impaired health and functioning, and 2) participants in both groups were in need of ongoing assistance to preserve health and safety.

Statewide Implementation

In March, 1981, the S. C. Long Term Care Policy Council began a review of the CLTC project to determine if any portion of it deserved consideration for expansion into other parts of the State. There was immediate consensus that the project had very little experience with the waivered services and that any decisions regarding their statewide implementation should be postponed for several years. The Council did, however, feel that the project's experience with service management for Medicaid long term care patients was positive and should be replicated statewide. The Council requested funding for the CLTC Service Management System for implementation in FY 82-83. Putting this system in place was the first phase of a two-phase process for establishing a comprehensive long term care service system for Medicaid eligible persons in need of long term care. The second phase would involve implementation at a later time of those community-based services which were shown to be beneficial and cost effective.

In March, 1983, the Council began implementation of a statewide program for pre-admission assessment for Medicaid sponsored nursing home applicants and service management for community-based long term care patients. The CLTC program serves only those Medicaid clients who are in need of skilled or intermediate nursing care. It consists of the following functions: assessment, level of care determination, service planning, case management, counseling, reassessment and revision of care plans. As of August 1, 1983, this program was available throughout South Carolina. CLTC nurse/social worker service management teams, working in conjunction with the current system of community services, assist many Medicaid long-term care patients to delay or prevent institutionalization. Linking the CLTC service management system with the State's mandatory preadmission screening function enables the CLTC program to target its efforts on those Medicaid clients who not only qualify for institutional care but who have expressed an intent to utilize institutional care. It is our strong feeling that this approach is the only method that will identify those truly "at risk" of institutionalization.

In FY 84-85, the State is planning to implement the full set of home and community-based services which were proven successful in the demonstration project. This phase will complete the overall system change which was begun in FY 82-83. New services to be added to the Medicaid program for long-term care patients who choose to receive care in community settings will include: personal care, medical day care, home delivered meals, respite care, expanded home delivered therapies and medical social services. Also, the State is planning to provide eligibility for community-based services for those individuals who are currently eligible for Medicaid only if they are institutionalized (up to 300% of SSI). Medicaid coverage for this group of long-term care patients is an extremely important policy decision for South Carolina. State demographic data indicate that approximately 50% of the elderly population has income between SSI and 300% of SSI. Therefore, this group under the current system potentially would be eligible for Medicaid sponsored nursing home care. Provision of Medicaid eligibility offers these patients other options for long term care services and, as indicated in the earlier report of CLTC project findings, can be done at less cost per patient for the Medicaid program.

Key Issues for Planning Home and Community Service Programs

The CLTC program is being implemented under Section 2176 waiver authority. This option has given states much more flexibility to develop home and community-based long-term care services. With this new option, there have also been new challenges from federal, state and local groups. I would like to review what I feel are salient issues which states must address as part of their planning for home and community service programs.

First, from the federal perspective, states must assure the Health Care Financing Administration that they will spend no more with the home and community-based waiver program than they would have spent without the waiver program. The two main ways of achieving this objective are to reduce the number of Medicaid-sponsored nursing home patients and/or to place a moritorium on the construction of new nursing home beds in favor of the development of community-based care. I do not believe that in the near term the number of nursing home patients can be decreased. In fact, based on the significant rate of growth in South Carolina's elderly population, I foresee a steady demand for institutional care even with the presence of community service options. The second approach has been selected for South Carolina. Implementation of the CLTC program is viewed as an alternative to constructing new nursing home beds. Based on the anticipated impact of the CLTC service management system, the State Health Plan's formula for determining the need for nursing home beds has been modified downward to 36.18 beds per 1000 elderly from 39.33 beds per 1000. The effect of this change will be to hold the number of nursing home beds relatively constant over the next two years.

From the State's perspective, there are a number of concerns. First and possibly foremost is the question of whether the minimum, essential community-based services for the long term care target group are affordable in the near term and over the next ten to twenty years. Population projections place many State legislatures and Governors in a very difficult position. Years ago they implemented institutional care under Medicaid and now realize that this type system of care will not be affordable in the future. The question is, "Are we simply jumping from the frying pan into the fire with home and community-based services?". Based on the research findings I discussed earlier, I believe that this major issue can be satisfactority addressed. Obviously, it will take increased funding to serve the increasing number of Medicaid long-term care patients; however, the addition of home and community-based services does allow states to serve more people for the same money. Under the current system, these funds would have been expended on a smaller number of institutionalized patients.

When states decide to initiate a system of community-based care, they must address a number of other issues. For South Carolina, these were:

-definition of the target group,
-definition of the new home and community-based services,
-identification of reimbursement methods and policies,
-development of systems to monitor and assure quality of services provided,
-provision of technical assistance to new providers, and
-development of appropriate systems relationships between the current system of service to the elderly under Titles XVIII, XIX, and III and the Social Services Block Grant and the new Medicaid home and community-based service system.

I am not going to discuss each of these questions in detail except to indicate that we have addressed them and resolved most as we have proceeded with implementation. These same issues are reflected, albeit more narrowly, in the concerns of local agencies. We constantly hear from these agencies that a "controlled" system, such as the one provided with the CLTC centralized intake and case management system, is not needed. Who receives services and in what amount should be a local issue, based solely on the agency's unique knowledge of the community. "Just give us the money" is often stated by local agency personnel, especially when their agency is not in a leadership position in the CLTC program. We also hear proclamations that the CLTC program is not needed since "we (the local agency) are already doing it." Unfortunately, two independent studies conducted by the CLTC program and the S. C. Commission on Aging do not support these claims. In fact, both studies indicated that the current system of home services funded under Title III and the Social Services Block Grant are used primarily by individuals who would not qualify for nursing home admission. This less impaired population is in need of services, but claims of preventing institutionalization through the provision of services to this group are not founded. The CLTC study also indicated that economic benefits, i.e., SSI, Food Stamps, Energy Assistance and Housing Assistance, were much larger in dollar amount than Title III and SSBG services. The results of these studies and the findings from the CLTC project strongly support the advisability of the CLTC model of targeting on the most needy through the mandatory preadmission screening mechanism and providing centralized service management with professional social workers and nurses.

Beyond FY84-85, South Carolina will continue the moritorium on approval of nursing home bed construction until the system of community-based care is fully implemented. If the statewide system replicates the project experience, we should achieve a major increase in the number of home care patients. During this period, I hope that the planning technology for the long term care service system can be improved in order to define the total need for long term care in terms that will include both nursing home care and community-based care.

Future areas of State interest for research and demonstration in long term care will focus on the organization and financing of long term care through controlled service delivery models with capitated reimbursement. We are also concerned about the process through which individuals move as they make the transition from private (Medicare) status to Medicaid eligibility. This issue raises questions about the relationship between Medicare and Medicaid, as well as the feasibility of risk sharing and the role of individually purchased long term care insurance.

Summary and Conclusions

Since 1978, South Carolina has been engaged in a major effort to plan for the rapidly growing need for long term care services. The Community Long Term Care demonstration has tested the feasibility of three major policy initiatives:

- mandatory pre-admission screening and centralized case management
- integrated services and continuity of care with Medicare and Medicaid waivers
- expanded services and expanded eligibility to provide the widest possible eligibility for comprehensive community services.

The demonstration results have been very positive.

Beginning in FY1984-85, South Carolina will implement the CLTC model as the State's long term care system. Accomplishing this major innovation required changes in the Federal, State and local levels. The result should be substantially improved long term care services for poor, disabled people in South Carolina.

There is some danger that our success will lead to complacency, however. The CLTC system should only be the beginning, not the end, of system modifications to provide affordable, efficient, comprehensive long term care services to all low and moderate income people. The next steps must include:

- improved planning methods and evaluation techniques
- the continued development of efficient long term care service models so that available resources can be used to serve greater numbers of people
- the development of long term care insurance plans and capitated reimbursement plans, such as Social and Health Maintenance Organizations which will increase the pool of long term care resources
- reduced reliance on institutions for long term care.

Effective, affordable community-based long term care is a reality. It is now time to begin the development of improved planning and evaluation techniques, the development of even more efficient long term care services, and the development of concepts such as long term care insurance and Social/Health Maintenance Organizations which will make community-based long term care available to all elderly who need the service.

STATEMENT OF BONNIE STONE, FIRST ASSISTANT DEPUTY ADMINISTRATOR, FAMILY AND ADULT SERVICES, HUMAN RESOURCES ADMINISTRATION, CITY OF NEW YORK

Ms. STONE. Thank you for inviting us to testify before this committee.

I will be presenting only a part of the testimony that I presented in full for the record, and I will focus on the home care services that are provided in New York City today.

During the past several years, New York along with a number of other States has made a great deal of progress toward addressing the institutional biases in the long-term care system and toward making much more extensive use of inhome services.

New York State has relied primarily on the personal care provisions of the medicaid statute and regulations. Our experience with providing an extensive program has been that it is possible to avoid institutional care for many individuals, whose impairments range up to the extremely severe levels, without having to resort to institutional care that would otherwise be necessary.

The average cost of providing a home care worker in client's home in New York City today is about $10,800, which is substantially less than the cost of New York City nursing home care, which ranges from $15,000 to $20,000 for ICF's and $25 to $35,000 for skilled nursing facilities.

New York operates the largest medicaid-funded personal care (program in the Nation. More than 37,000 clients are currently served. Depending on a client's need, a home care) worker may be scheduled for as few as four hours a week, to 24 hours a day, 7 days a week around the clock. The client will be visited from time to time by nurses who will monitor changing needs and provide direction to the worker.

Our home care clients are generally older, sicker, and poorer than the average elderly New Yorker. Twenty-four percent are 85 years of age or older; the median age is 77. Most of them are women; 70 percent live alone; and many of the rest live with elderly or impaired persons who cannot help them or are also recipients of care.

There is a significant group of younger severely disabled clients, including paraplegics and quadraplegics, and other individuals, who combine a high level of physical dependence with what is often an intense desire to live independently.

In terms of illness, serious heart disease in one form or another is characteristic of the majority of clients. Most home attendant clients require assistance with such basic activities as grooming, bathing, and walking, and approximately a quarter have such a high level of dependency that they need assistance in eating or toileting.

Approximately 15 percent require an attendant to live in around the clock.

There is no question that home-attendant clients manifest levels of impairment which are comparable to those of clients in nursing homes. One study that we did, we scored home-attendant clients, using the same instrument that is used in New York State to determine the eligibility for nursing homes. Slightly over a half of our clients were at the skilled level, and 95 percent qualified for the intermediate care or the skilled level.

The existence of this major program has helped New York City and New York State to maintain a level of nursing home bed supply which is significantly lower than the national average. New York was fortieth out of 50 States in per-capita bed supply in a recent study written by Bruce Vladick.

In response to the financial pressures stemming from the increased demand for home care services, HRA has initiated a number of steps to maintain accountability and service effectiveness. An extensive monitoring system has been created which includes case workers and nurses visiting at home. Quality-control monitors who are senior homemakers make periodic unannounced visits to the homes to insure that quality of service is maintained.

We have also recently engaged the professional standards and review organization to provide us with document review and in some cases to make inhome visits by doctors and nurses, to help us assess the needs of the clients.

HRA also has begun a demonstration project in the Community Alternative Systems Agency, and we expect to serve about 2,500 people in the Bronx this year. This will help people come to one program which will help them decide what care to take.

We have also established a special home care program for AIDS victims, which has been a tragic situation in New York City.

I would like to summarize and suggest that in New York City—which is perhaps a different situation from the rest of the country—there is an extensive home care program. Much money is already being spent, and we would hope that in the formulation of national policy the use of block grants would be dismissed, since it would penalize New York City and New York State for already entering into this field in a very extensive way.

Thank you very much.

Senator DURENBERGER. Thank you. Let me indicate that the full statements of all of the witnesses will be made a part of the record.

[Ms. Stone's prepared statement follows:]

TESTIMONY

BEFORE THE
SENATE FINANCE COMMITTEE

NOVEMBER 3, 1983

THE CITY OF NEW YORK
HUMAN RESOURCES ADMINISTRATION

Testimony on Home Care Services for Senate Finance Committee - 11/3/83

Thank you for the opportunity to appear before you today to testify on the important issue of long-term care services for our elderly and disabled population. I would like to focus today on the home care services we provide in New York City.

In approaching the problem of long term care in the U. S., we have often had in the past a disproportionate emphasis on institutional care as the primary vehicle. As recently as the late 1960s and early 1970s, very little publicly financed in-home care was provided nationally. In its 1977 study of long term care, the Congressional Budget Office found that only about 10% of public long term care funds were being spent on in-home care while the rest went primarily to nursing homes. CBO also reiterated the findings of many other studies that because of the scarcity of non-institutional alternatives, nursing homes were often being used inappropriately for patients who did not truly require institutional care. CBO summarized the results of 14 studies of the appropriateness of placement in nursing homes. Estimates of inappropriate placement ranged from 10% to 70%, and CBO concluded that 10% to 20% of skilled nursing facility patients and 20% to 40% of intermediate care facility patients were inappropriately placed.

Clearly, institutional care plays an essential role in long-term care, both in the form of nursing homes and in the form of more specialized units like the four chronic care facilities operated by New York City's Health and Hospitals Corporation. (These are widely known for their contributions in areas such as the care of spinal cord injury patients.) However, in a well balanced long term care system, in-home care should play a major role. During the past several years, New York along with a number of other states has made a great deal of progress towards addressing the institutional biases in the long term care system and towards making more extensive use of in-home care where appropriate. New York State has relied primarily on the "personal care" provisions of the Title XIX statute and regulations. Our experience with providing an extensive personal care program has been that it is possible to avoid institutional care for many individuals whose impairments range up to extremely severe levels, without having to resort to the institutional care that would otherwise be necessary. The average cost of providing a home care worker in a client's home in New York City, at about $10,800 per year, is substantially less than the cost of New York City nursing home care, which is in the neighborhood of $15,000 to $20,000 for intermediate care facility care and $25,000 to $35,000 for skilled nursing facility care.

In addition, the consensus is overwhelming that care at home for the clients we are serving is far more satisfying and humane from the client's point of view, and allows clients to maintain a much higher level of independent functioning. Our studies have shown overwhelmingly that our clients have a powerful dislike and fear of the nursing home alternative. Even the best institution is still an institution, with a less independent way of life for its residents. The ability to be surrounded by their own possessions of a lifetime, to determine their own time schedule, their own menu, and own household activities is extremely precious to our clients. Our own experience of client satisfaction with the home care alternative has more recently been added to by some statistical evidence suggesting that in fact, care at home, by preventing the trauma of major life disruption and the syndrome of dependency and "institutionalization", can actually extend the lives of clients.

New York City operates the largest personal care program (under Title XIX) in the nation. More than 37,000 clients are currently served, 27,000 of whom are in the largest of our three home care programs, the Home Attendant program. In fiscal yeqr 1983 the program cost for adult care in these 3 programs was $323 million. Most services are provided through non-profit vendor agencies funded by HRA to provide specified services to eligible clients in accordance with an HRA medical and social assessment.

Typically, a client applying for home care services is a person of advanced age suffering from chronic illness, who can no longer independently manage the basic activities of daily living such as dressing, bathing, preparing meals, maintaining the home in a clean and orderly condition, shopping, and getting around the home. After the medical and social assessment, a trained worker will be assigned to provide specified kinds of help to the client in the client's own home. Depending on the client's needs, the home care worker may be scheduled for as few as four to eight hours of care per week, up to and including care on a live-in basis. The client will be visited from time to time by nurses, who will monitor her or his changing needs, and provide instruction and direction to the home care worker.

Home care clients are generally older, sicker and poorer than the average elderly New Yorker. Fully 24% are age 85 or older and the median age of the home attendant client is 77. Because of the greater life span of women combined with the greater likelihood of their being alone in old age, 84% of clients are women. Seventy percent of clients live alone, and many of the rest live with an elderly or impaired person who cannot provide them with help (and who in some cases is also a recipient of the home care service). There is also a significant group of younger, severely disabled clients, including paraplegics, quadraplegics, and other individuals who combine a high level of physical dependence with what is often an intense desire for independence.

In terms of illnesses, serious heart disease in one form or another is characteristic of the majority of clients. In addition, 23% of home attendant clients suffer from diabetes, 36% from arthritis, 16% from mental disorders, and 6% from malignancies. Seventy-eight percent have impaired vision; 83% have impaired ability to walk; 58% cannot walk outside even with aids, and 55% need assistance in walking around indoors.

Most home attendant clients require assistance with such basic activities of daily living as grooming, bathing, and walking. Approximately a quarter have such a high level of dependency that they need assistance in eating and/or toileting. Approximately 15% require an attendant to be present on a live-in basis; even in these cases we have found that home care is cost effective compared to skilled nursing facility care.

There is no question that home attendant clients manifest levels of impairment which are comparable to those of nursing home patients. In one study, HRA home attendant clients were scored on overall disability level, using the instrument established for nursing home eligibility in New York State. Slightly over half the clients studied were scored at the skilled nursing facility level, while the great majority of the rest fell within the intermediate care facility range. Altogether, 95% of the cases studied qualified for one or the other of these two institutional levels of care.

The existence of this major personal care program has helped New York City and New York State to maintain a level of nursing home bed supply, which is significantly below the national average. In his recent important book on nursing homes, Bruce Vladeck reported that in terms of beds per 1000 elderly, New York State was 34% below the national average. New York was 40th of the 50 States in per capita bed supply.

The personal care program cannot meet the needs of every long-term care patient — in fact, New York City, like other cities, continues to have serious difficulties with placing certain hospitalized patients with multiple or difficult care needs after their need for acute care has passed. But it is clear that the personal care program has taken on a crucial role in meeting overall long-term care demand, even by the very severely impaired, in New York City.

In response to the financial pressures stemming from the increasing demand for home care services, and to ensure that service is delivered efficiently and at a high level of quality, HRA has initiated a number of steps to maintain accountability and service effectiveness. An extensive monitoring system for the provision of home care services has been created. Cases are monitored through case management visits to client's home by caseworkers as well as home visits by nurses. Quality Control monitors, who are senior homemakers on HRA staff, make periodic quality control visits to the beneficiary's home to evaluate the quality of services being delivered. This procedure helps HRA monitor the overall quality of services being delivered by vendor agencies and provides a check on time and leave and other management controls.

Along with these monitoring procedures, HRA has focused on home attendant training as a means for ensuring service quality. To this end, we have established a rapid assessment unit to evaluate the level of skill and knowledge of home attendants and to prescribe specific training needs for those attendants who need further training. Since mid-1979, more than 23,000 home attendants have been tested through this process.

In order to assure the most effective use of program funds, HRA has recently developed a revised set of assessment procedures and standards. HRA has also entered into a contract with a Professional Standards Review Organization to assist us in making the most accurate possible assessments. Doctors and nurses from the PSRO perform document reviews and, in appropriate cases, make in-person assessments in the homes of applicants for service.

In order to address the problems of fragmentation in the long term care system which have been identified in many studies, HRA has recently implemented a new program which is designed to provide a single point of assessment and referral for all long term care, ranging from nursing homes through in-home care and including a variety of other alternatives, such as domiciliary care (homes for adults), adult foster care, and home health agency care. This program, called Community Alternative Systems Agency (CASA), was implemented in demonstration districts in the Bronx in May 1983, and is expected to serve more than 2500 beneficiaries in its first year.

In response to the needs of one specialized sub-population which has been, tragically, growing at a rapid rate, HRA is establishing a specialized vendor agency to meet the special needs of clients with acquired immune deficiency syndrome (AIDS).

Another significant initiative designed both to minimize program costs and at the same time, to provide maximum protection to clients, has been the use of emergency call devices. With the use of these devices clients are able to call for help, even if they cannot get to the telephone, if an emergency should strike at a time when the attendant is not present. This project enables the agency to avoid authorizing unnecessary hours of care while providing the client with the assurance that help is available at all times if it is needed. Recently, one of the clients in this pilot project suffered a heart attack at a time when the attendant was not present. The use of the call device enabled help to be summoned immediately, and was credited by staff at the hospital to which the client was taken with saving the client's life.

Another important HRA program is the Long Term Home Health Care (Lombardi) program, which provides a comprehensive service program including case management, nursing and personal care services, transportation, and other services to clients otherwise eligible for institutional care. Begun in 1979, this program has served over 2000 New York City residents.

The New York City Department for the Aging, for the past two years, has operated a demonstration home care program targeted to those individuals whose income and resources are in excess of the Title XIX level but who cannot afford to pay for services themselves. This program was implemented through an HHS Administration on Aging grant and a Medicare waiver.

While New York City has been able to accomplish a great deal under existing laws and regulations, much more needs to be done at the federal level to ensure adequate access to home care service and equitable funding of these services on a national basis. The cost of providing long-term care services through the Medicaid program has become an extremely severe burden on states and, in states where they share in the non-federal costs, on localities as well. Long-term care costs now account for more than 40 percent of Medicaid costs nationally. We would like to work with you to develop more equitable and adequate funding arrangements which would redress some of this burden.

We would be extremely concerned about any proposals which would substitute block grant funding for existing matching provisions. Block grant approaches could easily result in penalizing States which have a history of accepting more responsibility for the long-term care needs of their citizens, or which are subject to changes in demand or fixed costs beyond their control. The history of appropriation accounts suggests that States and localities could be at significant risk through a block grant approach. Since nursing home costs in the short run are extremely difficult to control, a block grant approach rather than producing more appropriate, cost-conscious use of various levels of care could end up having just the opposite effect, by producing arbitrary limitations on the provision of home care in States facing an impending overrun on available block grant funding.

One approach which we think makes a great deal of sense is the general approach taken under S.1614, which addresses the important question of coordination between Title XVIII and Title XIX benefits. S.1614 would establish a 20-state, three year demonstration project that would provide home care to persons who are eligible for both Medicare and Medicaid. Extending Medicare home care benefits for individuals who are eligible for both these programs would improve access to services in many areas while providing fiscal relief for hard-pressed states and localities.

The provision of home care alternatives under Medicaid should be encouraged and existing pro-institutionalization biases redressed by increasing the Federal reimbursement percentage for home care services. This concept is included in Senator Hatch's bill, S.1540. Under such an approach, it would be essential that personal care providers as well as Title XVIII certified providers be included, since the former usually can provide services at lower cost.

I would like to thank you again for the opportunity to appear before you on this most important subject. We are happy to be working together with you to help improve access to and quality of these essential services provided to our most vulnerable citizens.

Senator DURENBERGER. I very much appreciate the brevity of the summaries of all of the witnesses.

Senator Packwood?

Senator PACKWOOD. In the experience with all of you, do any of you have any question that with proper targeting and screening you could provide more people with adequate care for the same amount of money that you are now paying for institutionalizing people with medicaid or other public funds?

Mr. ZEIGEN. Mr. Chairman, Senator Packwood, no. There would be no question that we could not be able to serve more people.

Senator PACKWOOD. I saw your three statements ahead of time, but I did not have a chance to see yours because I didn't have it. But all three of you seem to come to that conclusion.

I understand the problem of overutilization and a whole group of people coming in that are not covered; I am simply talking about with careful screening and trying to make sure that people who are otherwise institutionalized, or going to be institutionalized, are not—that you could literally do more for more people with the same amount of money.

Mr. BROWN. Yes, sir. That, in a nutshell, was the finding in our project in the cost evaluation. Unfortunately, those differences were not statistically significant. So you know what we can and can't say about that. But we can say, just as you have stated, that for the same amount of money we could serve more people.

Mr. GUMB. Senator Packwood, in Kansas we are also implementing a statewide program for screening the private-pay sector, naturally on a voluntary basis; but at least it is a beginning.

Senator PACKWOOD. Good.

Ms. STONE. I think, in terms of the need for care of clients, we spend more money in the aggregate with the home care program, because I think what happens is that many people who would refuse or would find other ways not to enter into an institution would avail themselves of home care. They would genuinely need and deserve to pass through any eligibility requirements and would indeed receive home care, when they are not currently receiving it.

So I think it is an extraordinarily helpful program. It is extensive in New York, and we would like to see it continue. But I would be loathe to say that it is less expensive in general.

Senator PACKWOOD. Well, I don't mean in general. You are talking about people receiving home health care who would not otherwise receive any care—institutionalize or otherwise—aren't you?

Ms. STONE. Yes, they would be. But, as I said, in terms of their needs and their disabilities, they are often very similar to people who do receive that care.

Senator PACKWOOD. I am aware of that. But I am also aware of the justifiable fear—we have a limited number of dollars. For example, say only 20 percent of the people are now receiving care under a Federal program and say that of the remaining 80 percent, 20 percent who are not now receiving care, would receive care under an expanded home care benefit. Despite the fact you could save money on the original 20 pecent who are now receiving care, those savings may not offset the costs of the additional 20 pecent who would receive care under an expanded program. Your total costs are going to be higher. I don't think anybody is even quarreling with that. You can only take care of so many people.

But we are trying to find within the budgets that we have, if there is a better way and a more humane way to take care of the people who are or should be receiving care now.

Ms. STONE. Well, clearly, home care is amongst the most humane care that we have seen in New York City.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator DURENBERGER. Senator Bradley?

Senator BRADLEY. Thank you, Mr. Chairman. I think all of the statements are extremely helpful, and I appreciate them very much.

Let me ask Ms. Stone: You claim that people who receive home health care are not those people who would, in many cases, be in a nursing home. Is that because home health care delivers a new type of service to meet different needs? Or is that because there is simply such a shortage of nursing home beds? Other panel members can give their opinion, too.

Ms. STONE. I suspect that the reason is that home health care was provided by families, friends, and others in the community, or not provided at all to those people in the community, and not that it is a different kind of care. And when government enters and offers a program of home health care, many people are eligible. In New York we have seen a tripling of the population in the last 5 years, and it continues to grow.

Senator BRADLEY. And they are receiving what kinds of services?

Ms. STONE. We send aides into their homes from anywhere from 4 hours a week to 24 hours a day, 7 days a week. And just to give you a sense of the cost of that, it would range from approximately $1,000 to up to $20,000 a year depending on how much service is delivered.

Senator BRADLEY. That sounds to me like a health care need that would not otherwise be met.

Ms. STONE. It would not otherwise be met by government.

Senator BRADLEY. Anyone else on the panel?

Mr. BROWN. I would like to address that, Senator. I usually carry a chart with me everywhere that looks like a pyramid. The very top of it is the most frail, the most disabled group, and the bottom of course would be older people who are walking around and are healthy. The question is, how far down do you want to go with the targeting. And in fact, as you go down to less and less impaired groups, the number of people that potentially could use the service get much larger.

I think there certainly is a need for service by a lot of people that are midway in that pyramid; but if cost is one of the major concerns, then I really believe we have to start at the top and start working down.

Senator BRADLEY. Limit it to the disabled, essentially?

Mr. BROWN. Yes, sir.

Senator BRADLEY. Thank you, Mr. Chairman.

Mr. GUMB. Senator Bradley, we might indicate that in Kansas we also have a State-funded alternate care program for those individuals not determined adult-care home-eligible, and through that program we have prevented about 500 admissions in adult care facilities. So that has helped keep the occupancy down.

Senator DURENBERGER. Both of my colleagues here are on a little committee of the subcommittee of the full committee, and they are searching for dramatic tax increases and spending reductions. And one of them I just looked at is a 3-percent reduction in Federal participation in medicaid. Is there anybody here who would favor that as a way to come to grips with our problem?

Ms. STONE. We are looking for an increase in federal participation, not a reduction.

Senator DURENBERGER. In terms of a general Federal participation, would you encourage us? And this set of three hearings on long-term care is sort of the first edition of about a year of looking at indigent health care in America generally, and sort of taking the medicaid program and shoving it aside, saying, Hey, might there not be a better way for all of us—the Federal, State, local and private sector—to deal with this problem?

But for starters, might we not take the medicaid program and realize that within medicaid there are the poor and then there are the elderly poor, and that perhaps as we look at our role in financing State efforts this is an appropriate distinction to make in terms of the amount of moneys that go from the Federal to the State level?

Mr. ZEIGEN. Mr. Chairman, I think, obviously, you have to take care of those who are least able to take care of themselves, to start with. I think that goes without saying. And then extend as far as you can go beyond that. And that's what I was trying to say, as to taking care of those who are most in need first.

Senator DURENBERGER. But when a State is getting pulled, like we have been the last 3 years, you are getting pulled by unemployment and increases in AFDC and the number eligible, and so forth, on the one side, and then on the other side you have your elderly population problems. And they are all pulling at the same kind of a program. Does that not create problems in terms of your ability to do imaginative and innovative things at the State level?

Mr. ZEIGEN. Mr. Chairman, if you constrain say the waivers, for example, if they were constrained, I would predict a fairly quick increase in nursing facility caseloads. There is just no doubt in our minds that, based on past history, the first funds that would disappear would be the care in the community. We just don't have those kinds of funds. States are poor right now, and without the kind of help that the medicaid waivers have provided, the kind of unique and innovative advances, really, in delivery of care in the community cannot take place.

Senator DURENBERGER. There is a little pressure on a bill called health care for the unemployed to create a new block grant to facilitate the growth of the home health industry in America.

Assuming we were to do something even if we had the money while we are trying not to have the money, if we were going to move in that kind of direction through a block grant that is somewhat targeted, would we not be better advised to move toward community-based services in a more general sense and let you people help the elderly make decisions as between home health and a lot of these other programs you are experimenting with now?

Ms. STONE. I want to suggest a little caution. You suggested caution before, and now it is going back the other way.

In New York we use the medicaid program to fund home health care, which means that it is an open ended eligibility program. And the result of that is that we have a home care program which rivals and in some instances exceeds the size of our nursing home population. And it is a wonderful program. It is growing. This year it will grow by approximately 10 percent; in past years it has been 20 and 30 percent. Our nursing home beds have been basically steady. So overall, our costs have been growing enormously.

We would like to see the Federal Government step in and help us out in terms of increasing their share. But the growth of the program is one that I think you have to consider very carefully if you talk about an open ended program.

On the other hand—and I again caution—where programs have been done extensively, like in New York, if you do a block grant program you hurt the very States that have already done it.

So it is a dilemma. We would be delighted to participate further in finding solutions to it. And I wish you luck.

Senator DURENBERGER. I have a big long list of questions that we prepared in advance for each of you, none of which have been asked so far. And because they get into some of the details of the sort of we don't have any information testimony that we were hearing earlier, I would like to be able to submit all of those questions to you in writing, which I will do, and ask that you respond for the record.

[The questions and answers follow:]

STATE OF KANSAS
JOHN CARLIN, Governor

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

INCOME MAINTENANCE AND
MEDICAL SERVICES

ROBERT C. HARDER, Secretary

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

December 15, 1983

Dave Durenberger, Chairman
Subcommittee on Health
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Senator Durenberger:

This letter is responding to your letter dated November 11, 1983, regarding 7 questions that time did not permit to ask on November 3rd.

1. The Home and Community Based Services used the most in Kansas are non-medical attendant care, homemaker services and wellness monitoring. The first two services are used the most of any of the other services.

2. The program maintains control over the amount and cost of community based services by using a case manager. The case manager is required to keep a running record of expenses of services. This has to be 10% less than the Adult Care Home cost, or we determine the client not eligible for Home and Community-Based Services. The kinds of follow-up services we provide are a monthly visit by the case manager, a monitoring visit by a nurse from a health department or home health agency as deemed necessary and an annual review by a nurse and social worker to determine adequacy of the care plan.

3. Family participation in payment for services has caused problems. Families that cannot carry the burden of paying for all the care are willing to pay for a part of the care. This we were told is supplementation and could not be allowed. This frequently means the recipient goes to the nursing home and we pick up all expenses at a much higher rate. In the Adult Care Homes (nursing homes) we pay for 24 hour nursing care and in the Home and Community Based Services Program we are paying for an approved amount of hours. Thus, we would recommend that when the family wants to buy more Home and Community Based Services than the State is paying for, they should be allowed to do so.

Senator Durenberger
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4. We feel the Home and Community Based Services Program has been very successful in diverting clients who would have otherwise gone to an adult care home. We currently have diverted 453 clients from an adult care home.

5. In some areas of the State of Kansas there is a shortage of beds but over all there is not a shortage. We do not feel we are serving any person who would not have received Medicaid payment for adult care home care because of a shortage of beds.

6. $3,307,388.

7. The 1983 Kansas Legislature passed a law which does include the screening of private pay residents who are likely to become a Medicaid resident in a short time. This law is voluntary at the present time.

If further information is needed, please let me know.

Thank you for allowing us to comment.

Sincerely,

Jackson J Gumb

Jackson J. Gumb
Administrator
Adult Care Home Section
Division of Medical Programs

JJG:klc
cc: L. Kathryn Klassen
John Schneider

SOUTH CAROLINA COMMUNITY LONG TERM CARE
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Post Office Box 1520
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December 20, 1983

Senator David Durenberger, Chairman
Subcommittee on Health
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger:

Thank you for the opportunity to testify before the Health Subcommittee and to respond to the questions you prepared.

Please contact me at any time for clarification or further information.

Sincerely,

TEBrown

Thomas E. Brown, Jr.
Director

TEBjr/tlj

RESPONSES TO QUESTIONS FROM SENATOR DURENBERGER

1. HOW DOES THE PROGRAM ESTABLISH CONTROL OVER THE AMOUNT OF SERVICE UTILIZED BY A CLIENT ACCEPTED INTO THE PROGRAM? IF THE COST OF CARE FOR A CLIENT IN THE COMMUNITY EXCEEDS 75% OF THE AMOUNT OTHERWISE EXPENDED FOR NURSING HOME CARE, HOW ARE REARRANGEMENTS IN THE COMMUNITY-BASED CARE PLAN MADE?

Medicaid cost for experimental project clients consists of 3 components: 1) the cost of regular Medicaid services, 2) the cost of case management, and 3) the cost of experimental expanded services. Expanded services, you will remember, are the services such as respite care, personal care, home delivered meals, etc. which are established in the project area to supplement the regular service system. These are available only to experimental clients.

CLTC establishes explicit cost controls only on the cost of experimental expanded services. When service managers write care plans, they must: 1) authorize expanded services only when no other usual provider in the client's community will be able to provide the services, and 2) be sure that the cost of the expanded services they authorize will not exceed 75% the cost of a nursing home for the client, over a 13 week period. The Project Director can, in exceptional cases, authorize expanded services of a greater amount for a short period of time. Special authorizations are made when large initial service outlays are expected to be offset later by low service utilization. For example, if a client were going to her working daughter's home to recuperate from a hip fracture and if we expected that the client would be virtually independent ~~once~~ she was back on her feet, we might authorize a large number of personal care and in-home physical therapy units to assist in rehabilitation. Our rationale would be that, once rehabilitation was accomplished, this client would use very little service, and the average use of service would be lower than the cost of a nursing home.

If we found that the cost of expanded services were going to be greater than 75% of nursing home cost over an extended period of time, the service manager would work with the client, family and physician to determine whether:

- a family member could provide additional caretaking, to reduce the need for formal services;
- some other untapped source of support, such as a church group, might be available;
- some of the paid services could be safely reduced; or
- some other kind of equally effective but less expensive service could be substituted.

If a service plan could not be written which kept expanded services under the 75% cap, we could not provide community services, and we would recommend nursing home placement. You should know, however, that this is a very rare occurence. I discussed this question with our case managers, and none of them could remember ever recommending nursing home placement only because the service plan was too expensive. The principal reasons for recommending nursing home placement were either that the client chose to go to a nursing home or that the services that would have been necessary to keep the client at home were not available at all.

2. DO CLIENTS WHO PARTICIPATE IN THE EXPERIMENTAL PROGRAM CONTRIBUTE ANY OF THEIR OWN FUNDS TOWARD THE COST OF CARE?

Experimental clients who receive expanded Medicaid eligibility (i.e., those clients whose incomes are between 100% and 300% of the SSI maximum and would be eligible for Medicaid benefits only in a nursing home under the current regular Medicaid system in South Carolina) pay each month for their Medicaid cards. The amount paid depends on the client's income and currently ranges from $12.20 for clients with incomes only slightly over SSI ($304) to $36.70 for clients whose monthly incomes are 300% of the SSI maximum ($912). Clients pay these fees regardless of the level of use of services.

3. ARE THE SAVINGS WHICH YOU DISCUSS IN YOUR TESTIMONY STATE AND FEDERAL SAVINGS? WHAT WERE THE FEDERAL SAVINGS? CAN YOU ESTIMATE WHAT THE TOTAL SAVINGS TO THE FEDERAL AND STATE GOVERNMENT WOULD BE BY IMPLEMENTING THE COMMUNITY LONG TERM CARE PROGRAM?

The cost figures I included in my testimony were combined State and Federal Medicaid expenditures. In my testimony, I mentioned that the experimental group used an average of $1.25 less per day per participant than the control group. This difference was for Medicaid expenditures only. If the control group had received the experimental program, I estimated that at least $160,000 could have been saved for the Medicaid program. Based on South Carolina's current Medicaid reimbursement formulas, approximately 70% of any savings would be Federal savings and 30% would be State savings.

Since I presented my testimony, we have received Medicare Part A claims for these participants. A frequently asked question is whether savings to the Medicaid program will be offset by increased use of Medicare. As you can see from the table below, Medicaid savings were not offset to any substantial degree by increased Medicare utilization. The average Medicare and Medicaid cost per participant per day for the experimental group was $1.21 (5.6%) less than the cost per day for the control group.

Average Cost Per Participant Per Day

	Medicaid	Medicare	Total
Experimental	$13.29	$7.03	$20.32
Control	14.54	6.99	21.53
Difference between Groups	($1.25)	$ .04	($1.21)

Savings Per Participant Per Day
to Federal and State Governments

From	Savings to State	Savings to Federal	Total Savings
Medicaid	$0.375	$0.875	$1.25
Medicare	0	(0.04)	(0.04)
Total	$0.375	$0.835	$1.21

Average daily Medicare utilization was almost identical between groups. Put another way, Federal savings in the Medicaid program were only minimally offset by increases in Medicare utilization. From this, we conclude that use of CLTC experimental model resulted in a net saving to the combined Medicare-Medicaid health care system. There are two caveats, however. First, the Medicare data reported here are Part A claims and include claims for hospitalization, skilled nursing facilities, and home health agencies only. We hope to include Part B claims in our final report. Second, these Medicare claims do not include any waivered services authorized by our 222 (Medicare) waiver. You may remember that in April, 1983, CLTC began using combined Medicare and Medicaid waivers. With our Medicare waiver, we are authorized to offer the following expanded services: medical day care, personal care, home-delivered meals, to experimental clients who would otherwise be eligible for Medicare benefits in a skilled nursing facility. These are the same expanded services that we have offered under our Medicaid waiver since the beginning of the project. In the study which I cited in my testimony, Medicare expanded services had not yet become available. You should keep in mind that the figures I have reported represent the impact of a change in the Medicaid system only.

It is unlikely that even a program as effective as CLTC can reduce the total cost of long-term care. The proportion of the population that is very old and in need of long-term care services is growing rapidly, as you know. Even when programs such as Community Long Term Care can reduce the average expenditure per client, the total cost of publicly-funded long term care is likely to continue to grow. Cost avoidance, i.e., slowing the growth in long term care expenditures, is a more realistic expectation. Here is an example from South Carolina's planning for FY 84-85 long term care expenditures.

In FY 1983-84, South Carolina spent approximately $104 million for Medicaid long term care services. In FY 84-85 additional Medicaid eligible clients will enter the system. If South Carolina were to meet this new demand primarily with new nursing home beds, the total cost to Medicaid for long term care services would be in the neighborhood of $135 million. An alternative strategy would be to meet this increased need with additional community services. We estimate that implementing this stategy as part of the current system would cost about $130 million. Neither alternative reduces total expenditures from the previous year. However, the incremental cost increase will be smaller with the community services option. The difference is projected to be $5 million in FY 84-85. Of this amount, $3.5 million would be the Federal share and $1.5 million would be State funds.

Senator **DURENBERGER**. Was there any additional response to that last question?

Mr. **GUMB**. Senator, I think one thing we would like to bring up as a concern is that the individuals we are seeing in the facilities now are for the most part very heavy care types, very appropriate in these settings. And I am afraid that in the future they may cost more to care for, since they are a heavier-care resident than what the homes have had in the past. Even the private side are waiting longer before they go into these facilities.

Mr. **BROWN**. Senator, I would like to address the question of reductions in the match. Our State is one of the poorer States; in fact, we have a very meager medicaid program. The legislature and the Governor are considering an expansion of community-based care for this group of older people in the medicaid program next year of $10 million. We spend about $100 million for nursing home care.

If the Federal match was changed, we wouldn't make it to Christmas, because the priority would be on maintaining the current system, there is no question about that. And politically we couldn't compete with those other interests.

Senator **DURENBERGER**. Thank you all for your testimony; I appreciate it a lot.

Our next and last panel is composed of Dr. Mark Meiners, senior research manager, intramural program, National Center for Health Services Research, U.S. Department of Health and Human Services, Washington, D.C.; Dr. William Weissert, senior research associate, The Urban Institute, Washington, D.C.; and Dr. Bruce Jacobs, associate professor, public policy analysis program, the University of Rochester, Rochester, N.Y.

I thank each of you for being here. I thank you for your patience. I trust we have all learned something here this afternoon, and Bob and I are certainly anxious to learn from you.

Your statements will be made part of the record, and you may now proceed to summarize them.

Senator **PACKWOOD**. I might say, Dave, I have read Dr. Meiners' statement, and I am reading now Dr. Jacobs' statement. I find them most interesting. I don't have a statement from our third witness yet.

Dr. **WEISSERT**. The one from Dr. Jacobs is a joint one with me.

Senator **PACKWOOD**. Well, they are both very interesting.

Dr. **WEISSERT**. Thank you.

Senator **DURENBERGER**. You may proceed.

Dr. **WEISSERT**. Yes.

STATEMENT OF WILLIAM WEISSERT, PH.D., SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, D.C.

Dr. **WEISSERT**. I want to talk about the relationship between home equity held by the aged and the possibility of using that equity to perhaps pay some of the costs of the needs of the group that is most at risk of needing nursing home care or home health care.

You have already heard a lot about the costs of long-term care, and let me just add one number to that, and that is that one study showed that half of all catastrophic costs in health care were incurred in the nursing home.

We also find, on the other hand, that the probability of needing a nursing home as a long-stay patient is very low, as is the probability of becoming someone who needs personal care assistance, which is the kind of care most often rendered in home health aid programs. You get little help from medicare for this, and for medicaid you have got to spend down to poverty.

So our question in this research was: What is the possibility that the people who have home equity are also the people at great risk of needing financing to pay for long-term care? And we defined being at risk as having a high probability of being dependent in personal care—bathing, dressing, transferring, toileting, incontinence, eating.

Now let me turn to my colleague Dr. Jacobs to give you the results of our research—the preliminary results.

STATEMENT OF BRUCE JACOBS, PH.D., ASSOCIATE PROFESSOR, PUBLIC POLICY ANALYSIS PROGRAM, THE UNIVERSITY OF ROCHESTER, ROCHESTER, N.Y.

Dr. JACOBS. Our major preliminary conclusion can be stated fairly briefly:

We estimate that approximately one-third to one-half of all elderly homeowners at high risk of need for home health care could finance it out of their home equity, and a much larger percent of those at high risk of entering a nursing home could finance a catastrophic nursing home cost insurance policy out of their home equity.

As you know, nearly three-quarters of the elderly in this country are homeowners, and, in fact most poor elderly people are homeowners. My estimate is that the net home equity that elderly homeowners have tied up in their home as illiquid assets averages approximately $53,000.

Many low-income elderly homeowners have substantial amounts of home equity. A fifth of the poor and a third of the near-poor have more than $50,000 tied up in their homes.

Recently, some creative financial instruments generically known as reverse-annuity mortgages have begun to offer elderly homeowners the opportunity to get a lifetime stream of income without selling their homes and moving. Our major research question was: To what extent could the income so derived support or help support the cost of long-term care or long-term care insurance for the elderly?

We find that the characteristics most associated with the risk of need for long-term care—namely, being very old and living alone—are also associated with the greatest potential for home equity conversion into income. One-half of those in the highest risk group we identified could get a lifetime income stream starting out at $2,000 a year and increasing at 8½ percent a year for life.

About a third of all high-risk elderly homeowners—that is, homeowners who have at least 10 percent chance of needing home health care—could support that home health care out of reverse-annuity mortgage payments or payments derived from a similar financial instrument.

For the highest risk group, those who are old and alone, the analogous figure is one-half—48 percent, to be exact. That is to say, percent of those at highest risk of a need for home health care who are living alone could buy it out of their homes without having to sell them and move.

These estimates, moreover, are conservative, for reasons that we detail technically in our statement; but we feel confident that these are base figures, and the better the financial instrument, the more money elderly homeowners would be able to get out of their homes.

We have also done some calculations for the financing of an insurance instrument that would guard against catastrophic nursing home cost for elderly homeowners, and we find that a substantially larger percentage of all high risk elderly homeowners—in this case, those at high risk of institutionalization, this is, of having to enter a nursing home—could finance such an insurance instrument.

We do have to do a bit more financial modeling and refining of the instrument, and we are reluctant to declare a particular number to carry away from our testimony as the percentage who could finance such a catastrophic health cost insurance plan, but we are confident that it is over 50 percent, and I suspect it may be closer to 75 percent.

I want to emphasize that these results are preliminary. Our major hypothesis was that the profile of risk—of need for home health care or for catastrophic insurance financing—was a good match with the profile of opportunity for home equity conversion into income for the elderly.

Our findings confirm this hypothesis. However, we will be doing further detailed analysis to estimate more precisely the potential for home equity financing of health care. Then we will consider the implications for public policy that derive from these results.

Thank you.

Senator DURENBERGER. Thank you very much.

Our final witness?

[Drs. Weissert and Jacobs' prepared statement follows:]

Home Equity Financing of Long-Term Care for the Elderly

Statement by

Bruce Jacobs
The University of Rochester
and
William Weissert
The Urban Institute

before the

Hearings on Long-Term Care
Senate Finance Subcommittee on Health
November 3, 1983
Washington, D.C.

Views expressed are those of the authors and do not necessarily represent the views of the University of Rochester, The Urban Institute, or the Robert Wood Johnson Foundation. This project is supported by a grant from the Robert Wood Johnson Foundation. Results presented are preliminary.

SUMMARY

The catastrophic costs of long-term care for the aged are borne heavily by the patient and his or her family. Medicare--the health insurance program for the aged--does almost nothing to help: Only 2 percent of nursing home costs are paid for by Medicare; and only about 2 percent of Medicare dollars are spent on home health care. Medicaid--the health insurance program for the poor--pays about half of nursing home costs. But patients must "spend down" to poverty to qualify for this coverage.

Our research explored the possibility that the substantial equity held in their homes by elderly persons could be unlocked to finance home health care and nursing home insurance in a way which would allow the elderly person to remain in their homes while using their asset value to remove this major source of anxiety--the threat of catastrophic long-term health care costs.

Our work required matching up two sets of numbers: an estimate of the amount of dollars available each year from the equity held by old homeowners, and the probability of those same homeowners needing long-term care either in the community or in a nursing home. Our statement provides details of our methods and results. In summary, we can say that the results are very favorable. Of the substantial number of aged persons who have home equity, almost a third could afford to buy a large measure of home health care each year for the rest of their lives. Even more encouraging, among those at highest risk of needing such care, almost half could afford such care from their equity each year. Furthermore, an estimated 80 percent of all homeowners could afford the annual premiums on an insurance policy which would pay for catastrophic nursing home care should it be needed.

While our work is preliminary and our estimates will be further refined, they show considerable promise of being useful in the context of trying to find ways of helping old people reduce the burdens and anxieties of long-term care.

Mr. Chairman and members of the Committee:

The problem of catastrophic costs of long-term care and its burdens on the patient and the family are well documented:

- half of all catastrophic health care costs are incurred in the nursing home;
- half of all nursing home costs are paid by the patient or family members;
- 85% or more of long-term home care is delivered by family members;
- public health insurance programs pay little or nothing towards these costs and do nothing to relieve the burden on families:
  - Medicare contributes less than 2% of nursing home revenues;
  - only 2% of Medicare expenditures go for home health care, and coverage is very restrictive and typically very short;
  - Medicaid--the health care program for the poor--covers nursing home care but only after the patient has been reduced to abject poverty;
  - and Medicaid--even with its celebrated new experimental home and community care program--covers only a tiny fraction of the demand for home care among the aged;
  - nor has the private sector helped much. It is not possible to buy long-term care insurance despite the fact that the long-term care problem shares much in common with the classic low probability-catastrophic loss situation which underlies most types of insurance.

What is needed is a more generous, more widely available, more reasonable source of financing for long-term care. Our research project was designed to explore the possibility that financing for long-term care at home, or insurance premiums to pay for nursing home care, could be drawn from the equity held by elderly homeowners. In our statement today we will present preliminary results, and so we want to note that because our work is still in progress our estimates will be revised and refined.

Homeownership is the dominant housing tenure status of the elderly population. Three-quarters of all elderly headed households are owner-occupied. Sixteen million elderly people (those aged 65 and over) live in about 12 million homes they own, and over 80 percent of these owners have paid off their mortgages. For most aged Americans, net home equity (home value minus any outstanding debt) represents their largest asset.

While the higher-income aged have more home equity on average, about 65 percent of all elderly poor are homeowners, and many of the poor and near poor elderly have substantial assets in their homes. Table 1 shows that 22 percent of the poor and 32 percent of the near poor have more than $50,000 in net home equity.

Jacobs has shown in previous research that a large number of elderly homeowners could convert their net home equity into a lifetime stream of supplementary income. To anticipate some of the results to be presented in later tables, we report in Table 2 the potential reverse annuity mortgage (RAM) payments for various elderly income groups. More than a quarter of the poor and more than a third of the near poor could receive RAM payments of at least $2,000 per year. These payments would increase at a yearly rate of 8.5 percent and continue for a lifetime.

Data reported in Table 3 reveal that those elderly homeowners who live alone potentially have the greatest equity-based annuity. Weissert has previously shown that living alone puts elderly people at greater risk of institutional residency. Thus, there may be a close match between need for health care financing and potential home equity-based RAM payments.

Given these impressive statistics on home equity, our specific purpose in this study was to determine the extent to which those who need or are likely to need long-term care have home equity. And if the two groups overlap, to

Table 1

Relationship Between Poverty Status and Net Home Equity

Net Home Equity*	Income as a Percentage of the Poverty Line: Less than 100%	100% to 124%	125% or More
to $25,000	42	27	14
$25,001 to $50,000	36	41	36
$50,001 to $75,000	14	19	28
$75,001 to $100,000	5	7	12
More than $100,000	3	6	10
TOTAL	100	100	100

*Expressed in 1983 dollars.

Table 2

Size of Potential Yearly RAM Annuity
By Poverty Status

Potential Annual RAM Payment	Income as a Percentage of the Poverty Line: Less than 100%	100% to 124%	125% or More
$1,000 or less	40	31	29
$1,001 to $2,000	32	31	36
$2,000 to $3,000	13	16	15
$3,001 to $5,000	9	13	12
More than $5,000	6	9	8
TOTAL	100	100	100

Table 3

Size of Potential RAM Annuity, by Family Structure and Low Income Status

Potential Annual RAM Payment	Singles		Couples	
	All	With Low Income*	All	With Low Income*
up to $1,000	25	32	40	51
$1,001 to $2,000	31	31	39	34
$2,001 to $3,000	17	15	11	8
$3,001 to $5,000	15	12	6	5
more than $5,000	11	9	3	2
TOTAL	99**	99**	99**	100

*Income less than 125 percent of the poverty line.

**Not equal to 100 because of rounding.

what extent can the costs of the care they need--or the insurance they need--be paid for by the equity they hold in their homes.

Methods

Need for long-term care has been defined by Weissert as manifestation of need for human assistance in the Katz Activities of Daily Living Scale--bathing/dressing, toileting/feeding, also referred to as need for assistance in personal care.

Weissert and Scanlon have also identified the determinants of nursing home residency using a data set which combined the 1977 National Nursing Home Survey and the 1977 National Health Interview Survey. They found that personal care dependency was among the most important determinants of residency in a nursing home among the aged.

To estimate the risk of dependency in personal care faced by elderly homeowners (and their elderly spouses) we analyzed data from the 1977 National Health Interview Survey and the 1977 National Nursing Home Survey. The combined data set was representative of all living people aged 65 and over. First we split the sample randomly into two halves, each having over 6,000 observations. Then using one part of the split sample, we estimated an equation predicting the probability that an elderly person would be dependent in personal care. Logistic regression was used for the estimation because of the low probability of dependency in the entire sample (8.7%). The equation included measures of a person's age, sex, marital status, race and various interaction terms and transformations of these measures.

The equation was then used to estimate the risk of dependency for each person in the second part of the split sample. We then compared the risk estimate with the actual prevalence of dependency in personal care. Table 4, showing the results of this procedure, reveals that the risk estimates were

Table 4

A Comparison Between Estimated Risk and Actual Dependency in Personal Care

Estimated Risk of Dependency (%)	Actual Percent Dependent	Percent of Elderly Population
less than 3%	2.9	30
3 to less than 5	4.5	26
5 to less than 10	8.4	19
10 to less than 15	10.9	9
15 to less than 20	19.3	5
20 to less than 25	21.0	3
25 to less than 35	25.7	4
35 or more	41.6	3
TOTAL	8.7	99

Source: Special tabulations from the 1977 National Health Interview Survey and the 1977 National Nursing Home Survey very good measures of the actual likelihood of being dependent in personal care. Of those whose estimated risk was between 3 and 5 percent, for example, the actual prevalence rate was 4.5 percent, etc.

The exact same procedure and model were used to estimate the risk of institutionalization. Over all, 4.6 percent of the subsample were residents of nursing homes. In Table 5 we report the close match between estimated risk and actual institutionalization rates.

These results suggest that the equations we derived should provide reasonably reliable estimates of risk of dependency and risk of institutionalization.

To address the central research question of this study, we then turned to the 1980 Annual Housing Survey. We limited our analysis to those homeowners who live alone or live only with their spouses, who are 65 years old or older, and whose spouses, if present, are similarly aged. In 1980, there were 8 million such households, 55 percent of which were elderly individuals living alone. For each elderly homeowner, we used the derived equations separately to estimate risk of dependency and risk of institutionalization. For married couples the probability that at least one of the pair would be dependent was then calculated as was the probability that at least one would be institutionalized.

Each household was characterized with respect to these risk estimates, its poverty status, its family structure (including age and sex), its regional location and its net home equity.

The next step was to estimate the potential annual RAM payments individuals and couples could receive. Under a separate grant from the Robert Wood Johnson Foundation, which is also funding the research that we report, Professors Jack Guttentag of the Wharton School, and Robert Garnett of the

Table 5

A Comparison Between Estimated Risk and Actual Rates of Institutionalization

Estimated Risk of Institutionalization (%)	Actual Percent Institutionalized	Percent of Elderly Population
less than 3%	1.1	61
3 to less than 5	2.8	11
5 to less than 10	8.3	15
10 to less than 15	12.4	6
15 to less than 20	18.8	2
20 to less than 25	19.0	2
25 or more	37.2	2
TOTAL	4.6	99

Source: Special tabulations from the 1977 National Health Interview Survey and the 1977 National Nursing Home Survey.

School of Business at Southwest Texas State, have been modeling financial instruments which might be used to convert home equity into lifetime annuities or periodic loans to finance health care or other expenses. We have used one such instrument to estimate the size of the RAM payment that could be garnered for each $1,000 of available home equity. The size of the elderly homeowner's RAM payment is based on the initial home equity and the age and sex of the owner (and spouse). The instrument is designed to generate an internal rate of return of 12.4 percent. It would produce a lifetime annuity that would grow by 8.5 percent each year (the inflation rate of analogous health care costs over the last dozen years). It also assumes that home values will inflate at 2.5 percent less per year, a conservative assumption.

Findings

Table 6 uses the estimation model to predict risk of dependency in personal care by family structure: living alone or being a member of a two-person aged couple.

The table shows that household risk of dependency does not differ substantially by family structure though couples are on average younger and have individually lower probabilities of dependency. Table 7, however, shows a substantial difference in household risk of institutional residency. Singles are much more likely to be at high risk of living in a nursing home. Our analysis shows that some small portion of the difference is due to the generally older age of singles, but most of the difference is explained by the availability of social support, in this case the spouse.

These differences by family structure become very important in the following tables for three reasons: Singles have the greatest risk of institutional residency; they are presumably much less likely to have informal care available to them when they become personal care dependent; and because

Table 6

Risk of Dependency in Personal Care
by Family Structure

Risk of Dependency	Singles	Couples*	All Households
less than 5%	25	27	26
5 to less than 10	47	50	49
more than 10	28	23	26
TOTAL	100	100	101**

*Probability that at least one spouse will be dependent in personal care.

**Not equal to 100 because of rounding.

Table 7

Risk of Institutionalization
by Family Structure

Risk of Institutionalization	Singles	Couples*	All Households
less than 5%	56	84	69
5 to less than 10	24	12	19
10 or more	20	4	13
TOTAL	100	100	101**

*Probability that at least one spouse will be instituionalized.

**Not equal to 100 because of rounding.

they are older, they are likely to die sooner than couple members. Consequently, they have a shorter life expectancy, which means that they have more money available from their equity for each year of their lives if it is paid out on a life-long basis. This is true despite the fact that couples tend to have somewhat higher equity than singles.

In short, singles--those with the highest probability of need--are also the group with the most annual equity conversion potential available.

This is shown dramatically in Tables 8 and 9. Table 8 shows that 56 percent of high risk elderly single homeowners have the potential to produce at least $3,000 worth of annual annuity. Though couples have lower potential annuity payments, it is also true that couples with the highest risk also have the highest payment potential.

The same is true in Table 9: Those with the highest risk of institutional residency also have the largest potential annuity: 65 percent of elderly singles who have at least a 10 percent chance of institutional residency could use their equity to produce an annuity of at least $3,000. Half of them could receive an annuity of more than $5,000.

Now, let me point out that the model we have used for the annuity estimates is based only upon age and sex for its estimates of life expectancy. Consequently, it is quite conservative because it does not reflect the almost certainly higher-than-average probability of early death among those who are personal care dependent and need long-term care. If such an adjustment could be made, the size of the yearly annuity would be much larger, based on the short life expectancy of those with the greatest need.

Table 10 gives the bottom line for the potential of using home equity to finance home care: It shows that nearly half of all single aged homeowners

Table 8

Potential Annual RAM Annuity, by Family Structure and Risk of Dependency in Personal Care

	Estimated Risk of Dependency		
Potential Annual RAM Payment	less than 5%	5% to less than 10%	10% or more
		Singles	
up to $2,000	86	56	29
$2,001 to $3,000	9	23	15
$3,001 to $5,000	4	14	28
more than $5,000	1	7	28
TOTAL	100	100	100
		Couples	
Potential Annual RAM Payment	less than 5%**	5% to less than 10%	10% or more
up to $2,000	93	81	57
$2,001 to $3,000	4	13	17
$3,001 to $5,000	3	4	18
more than $5,000	0	2	9
TOTAL	100	100	101*

*Not equal to 100 because of rounding.

**Probability that either spouse is dependent in personal care.

Table 9

Potential Annual RAM Annuity, by Family Structure and Risk of Institutionalization

Potential Annual RAM Payment	Estimated Risk of Institutionalization less than 5%	5% to less than 10%	10% or more
		Singles	
up to $2,000	75*	41	20
$2,001 to $3,000	15	25	15
$3,001 to $5,000	8	20	32
more than $5,000	3	14	33
TOTAL	101*	100	100
		Couples	
Potential Annual RAM Payment	less than 5%**	5% to less than 10%	10% or more
up to $2,000	84	59	33
$2,001 to $3,000	10	18	12
$3,001 to $5,000	4	16	36
more than $5,000	2	7	19
TOTAL	100	100	100

*Not equal to 100 because of rounding.

**Probability that either spouse is dependent in personal care.

Table 10

Percentage of Elderly Homeowners Who Could Purchase $3580 Worth of Homecare Each Year, by Family Structure and Risk of Dependence

	Risk of Dependence		
	less than 5%	5% to less than 10%	10% or more
All Homeowners	2	8	30
Singles	3	15	48
Couples	0	1	3

who fall into the category of being at high risk of needing personal care assistance also have the equity available to pay for it each year.

Again, we used conservative estimates. Our estimate of $3,580 as the cost of home care among those dependent in personal care comes from two sources: Weissert's results from a Medicare-financed homemaker services demonstration in which services were offered free of charge and averaged 387 hours per patient per year, and a current charge quotation for homemaker services obtained from the San Francisco Home Health Agency--one of the largest nation's largest home health providers but one which operates in a very high cost area. That agency's average charge, and the one used in our annual cost estimates, is $9.25 per hour for homemaker services.

So in other words, for several reasons, it is very likely that more people with equity could afford even more care than we have estimated.

Now, we started out talking about two types of long-term care--home care and institutional care. We have produced but not distributed a table which makes similar estimates for the proportion of elderly homeowners who could afford an insurance premium which would pay for long-term care. We built several assumptions into the estimate. We took account of the very high turnover rates in nursing homes, which show that most patients who enter a nursing home are gone within three months either to death, back to the community, or back (an unknown proportion) to the hospital or another nursing home and possibly then to a possibly quick death. We used the finding by Weissert and his colleagues that patients who stay four months or more are likely to stay an additional two years. And we took into account that the average length of stay in nursing homes is two years to produce a policy which would have a large deductible--four months, and an average stay of two years. Based upon these factors and the average probability of risk of institutional residency among the aged, and the current costs of nursing home care taken from the National Nursing Home Survey, it appears that over 80 percent of elderly homeowners could afford a premium which would give the kind of nursing home coverage we have described.

However, the model must be refined further before it can be reported. One consideration is that the model has yet to be adjusted for the increasing risk of using a nursing home which comes with each additional year of advanced age, assuming that people enter the program at differential ages.

Finally, another major question which we have not yet addressed is the proportion of elderly homeowners who could afford both kinds of care--that is, those who want nursing home insurance to protect against catastrophic loss but also need to use some of their equity each year to pay for home care. And we have not addressed the difficult issues of moral hazzard and adverse selection which are implied by combining insurance for one type of care which might be used as a substitute for another being paid for by the insured.

Implications

These findings do not translate directly to policy recommendations. We have not yet addressed the difficult issues involved in designing a program which would give elderly homeowners a greater range of options without making them subject to inequitable burdens made possible only by their prudence. But the numbers do suggest that serious thought should be given to the possibility that home equity might be used to relieve some of the substantial economic and emotional strains faced by the aged, while at the same time being responsive to their strong preference to remain in their own homes.

Conversely, the data also show that renters and younger owner couples would not be good candidates for this program. Consequently, to whatever extent the program is a benefit to some elderly persons, it offers little or no promise of help to others.

Finally, we want to emphasize the need for serious thought rather than premature action. These numbers are very preliminary. Considerably more work is needed before they can make a useful contribution to policy development.

STATEMENT OF MARK MEINERS, PH.D., SENIOR RESEARCH MANAGER, INTRAMURAL PROGRAM, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Dr. MEINERS. Mr. Chairman and members of the subcommittee, it is an honor for me to be here today. I am speaking to you today as a researcher. I work for the National Center for Health Services Research, which is part of the Department of Health and Human Services, and I will be presenting information from a paper that I recently had published in the Journal of Health Affairs, which provides an overview of my research on long-term care insurance. A copy of that paper has been attached to my statement.

It is interesting to me that you hear first about a way to finance long-term care. It is a bit like putting the cart before the horse; so I am going to give you the horse now.

You need to have an insurance product out there before it can be financed.

As you have heard today, long-term care expenses are frequently catastrophic for the elderly. The problem is that medicare is really designed to be an acute care program, and medicare supplemental insurance is largely there to fill the gaps. As a result, you have a situation where there are tremendous out-of-pocket expenditures for the elderly.

Our recent national medical care expenditures survey suggests that out-of-pocket expenditures for all health care services—hospital, physician services, drugs, everything—is about equal to the out-of-pocket expenses per capita for nursing home care alone. So it is a tremendous strain private sources.

And this in turn implies that many people who fund their own extended nursing home stays tend to become candidates for the medicaid roles.

Wider availability of private insurance for long-term care has some real potential for relieving some of these problems; consumers who buy such coverage would have protection from having to go on medicaid. There are a number of interesting potential benefits from this: They could conceivably have their homes to return to—something that is acknowledged to be an important ingredient and incentive for them to get better—their spouse would not have to dramatically change their lifestyle to pay for care; assets could be passed along to family rather than liquidated and spent down; access to care may be improved because providers view private-pay patients as preferable. And once the insurance is paid, the elderly would have a more relaxed and comfortable spending of their final resource, because they would have this important risk covered.

Now, from the Government's point of view, of course, if we can slow the spend-on process and perhaps avoid it altogether for some people, there are going to be some savings to the medicaid program.

However, the market for long-term care insurance is underdeveloped. Only a few insurance companies have attempted to provide meaningful benefits.

A major barrier to development has been the lack of information on which to base estimates of utilization and costs. But my research suggests that many of the barriers that are thought to preclude the development of this market are subject to resolution by some careful policy specifications. And in the paper I cover such topics as services covered, waiting periods, length of coverage, benefit payments, and financing mechanisms.

Just to summarize, the prototype features is designed to recognize considerations important to buyers and sellers. It covers skilled and intermediate-level services in State-licensed nursing homes at a fixed payment for up to 3 years. Home health care can be substituted at the rate of 3 visits per week for a nursing home visit of up to three years. A 90-day elimination period is required before benefits begin, and the annual premium rate is fixed at the time of purchase, with the implicit assumption that there are reserves accumulating to cover some of the increased risk as the individual ages.

Nursing home care is emphasized over home care, because payments for nursing home care are the largest single out-of-pocket expense for the elderly, and there is a need to improve this coverage.

The home health benefit is included for several reasons: It should help to relieve the bias toward long-term institutionalization by providing beneficiaries the option of being discharged to home. Elderly consumers are more likely to be interested in purchasing such a product if home health care is included in it.

To the extent that they are able to use the home health care benefit, the insured's liability may actually be reduced by encouraging direct substitution of nursing home days for home health care.

The 90-day elimination period was chosen to provide protection against catastrophic expenses. The 90-day period is also likely to act as a significant barrier to unwarranted use.

Several important barriers that cannot be construed as simply technical in nature include regulatory restrictions and rigidness, the availability of medicaid as a potential hindrance to the private market, and the limited capacity of the elderly to finance long-term care insurance.

As I have put in my testimony, it is not absolutely necessary that this be marketed only to the elderly, though that is where I have started, because I view that as the toughest thing to do initially.

The substance of these issues, however, has been examined in the paper, and for the most part, with the exception of regulatory concerns, these barriers do not appear to be as formidable as commonly thought. There is clearly substantial progress to be made, but I think in particular it is important to improve the consumers' knowledge of their insurance coverage, and this will assist insurers in being able to market a reasonable product. My research suggests that a reasonable case can be made for long-term care insurance existing.

I have found that around the country there are at least 13 examples of insurance companies, who are out there marketing varioius versions of long-term care insurance, many with provisions something on the order of what I have proposed.

Thank you.

[Dr. Meiners' prepared statement follows:]

STATEMENT

BY

MARK R. MEINERS

BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

THURSDAY, NOVEMBER 3, 1983

The Case for Long-Term Care Insurance

by

Mark R. Meiners, Ph.D.

National Center for Health Services Research

Abstract

Long-term care expenses are frequently catastrophic for elderly persons needing such care. Private insurance is not generally available for these services. As a result, most elderly needing long-term care end up on Medicaid. The potential for relieving this problem through private long-term care insurance is examined in this paper. The reasons for market failure are outlined and discussed in the context of the current insurance market for nursing home and home health services. A prototype policy is formulated as a basis for recommendations concerning services covered, waiting periods, length of coverage, benefit payments, and financing mechanisms. Insurance regulation, Medicaid, and private financing capacity are examined as potential conributors to the market failure. Evidence is provided which suggests that a private market for long-term care insurance can exist and that it may serve to relive some of the current pressures on the Medicaid system brought about by the long-term care needs of the elderly.

Mr. Chairman and Members of the Subcommittee

It is an honor to appear before you today.

I am here as a researcher. I work for the National Center for Health Services Research and thus for the Department of Health and Human Services. I will be presenting information based on a paper that was recently published in the journal Health Affairs that provides an overview of my research on long-term care insurance. A copy of this paper is attached to my statement.

Long-term care expenses are frequently catastrophic for elderly persons needing such care. Medicare is not designed to cover long-term care and private insurance is not generally available to fill this gap. Without the benefit of private insurance for long-term care, payments for those services have come to represent the largest out-of-pocket health care liability for the aged. Recent estimates indicate that the per capita out-of-pocket nursing home expenses for the elderly are nearly twice the amount spent out-of-pocket by the elderly on hospital and physician expenses combined. This, in turn, results in many people who fund their own extended nursing home stays becoming candidates for Medicaid.

Wider availability of private insurance for long-term care has the potential of relieving these problems. Consumers who buy such coverage would have protection from having to go on Medicaid. Potential benefits are that they will have their homes to return to, an important ingredient and incentive for getting better; their spouse will not have to dramatically change their lifestyle to pay for care; assets can be passed along to family rather than being liquidated and spent-down; access to care may be improved because providers view private-pay patients as preferable; and once the insurance premiums are paid, the remaining personal resources can be more comfortably spent knowing this important risk is covered. Government payors will benefit if private insurance replaces Medicaid and other long-term care for the middle class, or at least slows down or negates the incentive to divest assets.

The market for long-term care, however, is underdeveloped. Only a few insurance companies have attempted to provide meaningful benefits. A major barrier to development has been the lack of information on which to base estimates, utilization and cost. My research suggests, however, that many of the barriers that are thought to preclude long-term care insurance are subject to resolution by careful policy specification. In the paper I have outlined a prototype policy that serves as a basis for recommendations concerning services covered, waiting periods, length of coverage, benefit payments, and financing mechanisms.

The prototype has features designed to recognize considerations important to buyers and sellers. It covers skilled and intermediate level services in state licensed nursing homes at a fixed daily rate for up to three years. Home health care can be substituted at the rate of three visits per week of nursing home care up to three years. A 90-day elimination period is required before benefits begin. The annual premium rate is fixed at the time of purchase with the implicit assumption that reserves will accumulate in the early years to pay for the increased risk as the individual ages. The reasoning behind these specifications is discussed in detail in the paper.

Several important barriers that cannot be construed as simply technical in nature include regulatory restrictions and rigidness, the availability of Medicaid as a potential hinderance to the private market, and the limited capacity of the elderly to finance long-term care insurance (though it is not essential that this be marketed exclusively to the elderly). The substance of these issues is examined in the paper and with the possible exception of regulatory concerns, these barriers do not appear to be as formidable as is commonly thought.

There is clearly substantial progress to be made in improving our understanding of long-term care and how to insure it. The lack of consumer knowledge about health insurance in general and long-term care in particular is a real barrier. Insurers have been hesitant about the market because there is little or no private experience on which to base their estimates and the public experience with financing long-term care is only beginning to be understood. My research suggests that a private market for long-term care insurance can exist and that continued efforts to support that development are warranted.

THE CASE FOR LONG-TERM CARE INSURANCE

by Mark R. Meiners

Prologue: *Total national expenditures for nursing home care grew tenfold between 1965 and 1980. Now the Department of Health and Human Services estimates that such expenditures will more than quadruple by 1990, reaching some $82 billion. The median age of a nursing home patient is eight-one years; thus, not only are most nursing home residents on fixed incomes, but their resources have largely dwindled by paying for institutional care. This set of circumstances poses a dilemma for the nation's health care system, a dilemma which Mark Meiners discusses in this paper. Meiners, who holds a Ph.D. in economics from Georgetown University, heads efforts at the National Center for Health Services Research to examine long-term care issues. The center's work has gone on under Democratic and Republican administrations. As a repository of knowledgeable economists and analysts, the center serves as an important policy resource for the office of the secretary of the Department of Health and Human Services. Interest in the subject of long-term care insurance also is increasing in the private sector. One reflection of this increasing activity is a long-term care task force created by the Health Insurance Association of America. Meiners articulates a "reasonable case" for the market potential for long-term care insurance. His proposal comes at an interesting time, with the population aging and thus the need for long-term care increasing. Also, a Republican administration that favors private-sector solutions is in power and, with a staggering federal deficit already looming, little in the way of new public monies is likely to be made available anytime soon. But there would be potential benefits for consumers, too. Now, there are really only two options open to elderly consumers who need long-term care. One is to expend resources down to the level necessary to qualify for Medicaid, and the other is to transfer assets to qualify for Medicaid. Though the second option has been the preferred route, changing government policies may soon close it off. In the face of this prospect, new private sector options must be more closely examined.*

Financing long-term care for the elderly is one of the most challenging health care problems facing us today. The dramatic increase in health expenditures for long-term care is straining public budgets and the spectre of a rapidly aging population suggests that the problem will become worse. Frequently overlooked, however, is the fact that financing long-term care is also a significant drain on private resources and that the options for privately insuring against such expenditures are extremely limited.[1] Elderly persons with resources who need long-term care must pay for such services out-of-pocket. Since such care can be quite expensive, particularly if it is at a level that requires a nursing home stay, people who need it become candidates for the Medicaid rolls.

This paper examines the potential for relieving this dilemma through privately financed long-term care insurance. The reasons for the underdeveloped market are outlined. Medicare and private coverages are reviewed. A prototype policy is formulated and cost estimates are presented as a basis for suggesting the factors which could serve to overcome the resistance to such a market. Barriers associated with insurance regulation and Medicaid are assessed and the private capacity to finance long-term care insurance is examined. The paper concludes that the availability of private long-term care insurance may serve to relieve some of the current pressures on the Medicaid system by providing the elderly with an acceptable alternative to poverty and Medicaid nursing home entry. Suggestions for stimulating the growth of such a market are also provided.

Reasons for Underdeveloped Market

The reasons for the lack of development of a private insurance market for long-term care for the elderly are not entirely a mystery. Bishop, for example, bases her argument for a compulsory national long-term care insurance program on the desirability but unavailability of individual private coverage.[2] She suggests that private coverage is unavailable for a variety of reasons, most notably, the discrepancy between income and the cost of such coverage and the availability of public long-term care programs as a "safety net" for those who are poor or may become poor. Other problems that tend to reinforce private insurers' lack of interest in covering long-term care are the traditional insurance concerns of adverse

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selection, insurance-induced demand, administrative economies, and premium pricing difficulties due to inflation.

Individuals in the insurance business added a number of additional and perhaps overlapping concerns. Meaningful limits for long-term care were felt to be too difficult to establish. Some insurers fear that people who need such care will need it for the remainder of their lives, resulting in an open-ended liability. Traditional thinking within the health insurance field is that nonmedical services are not insurable. Since long-term care is often defined to include personal and social services such as homemaker care, nutritional services, and respite care, along with medical and rehabilitative care, this is thought to have stymied innovation. As a result, targeting coverage on the basis of level of care is felt to be arbitrary and open to challenge. Futhermore, there has been an absence of reliable data on which to base estimates of utilization and costs, particularly data that reflects actual experience with such insurance. Finally, regulation was cited as a barrier.

Evidence also exists that elderly consumers simply do not understand their insurance coverage, or the health care risks they face, enough to effectively demand coverage for long-term care.[3] Some elderly believe that they are already adequately covered for such services under Medicare. Others think they have coverage for long-term care with their purchase of a Medigap policy that includes nursing home benefits.[4]

There also is a preference on the part of most consumers for "first dollar" coverage and the elderly are no different in this regard. Currently, gap-filling insurance products dominate the private health insurance market for the elderly, possibly because of an expressed preference on the part of the elderly or because of an effective marketing campaign on the part of the industry. This may limit the amount of money available for other insurance products such as coverage for long-term care.

What is clear from this discussion is that there are a number of significant concerns that, if accepted, would deter private health insurers' involvement in covering long-term care services for the elderly. Perhaps the most compelling deterrent at this stage is that there has been, until just recently, little interest in investing in the research necessary to challenge the legitimacy of these concerns and whether they can be feasibly overcome.[5] Nonetheless, it appears there may be some clear benefits from doing so. In particular, the availability for long-term care could provide the elderly a better choice in guarding against catastrophic long-term care expenses and this could reduce the growing pressures placed on the Medicaid system by the elderly needing this care.

Medicare and Private Coverage

As a starting point for reviewing the major barriers to determine whether they can be overcome, it is helpful to examine the market as it exists today. To do this, we must retreat from the concept of long-term care and focus on Medicare coverage for nursing home and home health care.

As many of our elderly have become painfully aware, Medicare was not designed to address the need for long-term care. Though it covers up to 100 days of skilled nursing home care, with the first twenty days completely covered and a copayment for the remainder, users of the benefit have averaged only about twenty-seven days of covered care per year.[6] Medicare's claims criteria are often complex, restrictive, and subject to the individual judgements of claims reviewers which can vary substantially.[7] Also, only a portion of all nursing home beds are certified for Medicare, limiting a beneficiary's access to covered care.[8]

Medicare covers home health if an individual needs part-time skilled nursing, physical therapy, or speech therapy and the benefits were recently expanded from 100 visits to unlimited visits. In practice, home health users, like nursing home users, receive nowhere near the limit of care that is covered. Home health users average only about twenty-three covered visits under the old rules.[9] Under the new rules some increased utilization of home health care is expected. However, it is unlikely to be substantial because of the continued requirement that the patient be homebound and receive primary skilled care.[10]

The predominant involvement of private insurance in nursing home care is simply that of filling the gaps in Medicare's nursing home benefit. Some policies provide for Medicare-defined skilled care to be covered for a fixed amount per day for those days over 100, usually for 365 days but sometimes longer. These coverages are of minimal benefit since few people qualify for much Medicare SNF care beyond the twenty free days.

Removing the requirement that the beneficiary receive care in a Medicare-certified SNF bed is an improvement. As noted earlier, requiring that care be given in a Medicare certified facility limits a beneficiary's access to covered care. Some insurers have recognized this and require only that the nursing home be licensed as a SNF by the state.

The coverages outlined thus far represent the state-of-practice in private coverage of nursing home care. Since they rely on Medicare's narrow definition of skilled care, it is not surprising that only 1.5 percent of the elderly's nursing home expenditures were paid by private insurance in 1980,[11] in spite of the fact that a recent national survey found that about 59 percent of the elderly own an insurance policy that covers nursing home care.[12]

Some examples of improved private coverages can be found and they are suggestive of the way to proceed.[13] One improvement is to simplify the benefit language to cover any confinement in a state licensed skilled nursing home for the purpose of receiving skilled nursing care, thus avoiding Medicare's narrow skilled care definition. However, coverage below the skilled level is important for the elderly.

Coverages below the skilled level are typically referred to as intermediate care and custodial care. The definitions for these types of care are difficult to pin down. The concept of intermediate care comes from the Medicaid program.[14] It is intended to cover what amounts to personal care, with skilled nursing services necessary, but on a less frequent basis than would be the case with skilled care In practice, the intermediate care definition varies greatly by state with many viewing it simply as a cheaper version of skilled care. The definition of custodial care also varies, ranging from personal care with some nursing to only personal care to simply sheltered living with no specific provision for personal assistance.

Clarifying the distinction between skilled, intermediate, and custodial care has been a major barrier to the development of nursing home insurance. A number of approaches have been used to address this problem by those few insurers who have offered coverage for care below the skilled nursing level.

One approach has been to limit the coverage to skilled and intermediate coverage only. This has the effect of assuring that the care received must be at least personal care with nursing in order to qualify for payments. This type of limitation is essentially the same as exists when custodial care is covered but only when the individual is confined to a SNF or Intermediate Care Facility (ICF).

Another approach is to make the availability of intermediate or custodial care contingent on a SNF stay. For a few liberal policies the SNF stay need only be one day. To guard against unwarranted use of the benefit, insurers have added a requirement that a physician periodically review the patient's status and certify that no greater or lesser care is needed than is covered.

Although the market is still very limited, it is encouraging to find that some private insurers do cover long nursing home stays for care below the skilled level. Long-term home health care insurance is rare. The fear is that home care will be so much more desirable than nursing home care if it is made available that there will be excessive utilization, particularly since any further liberalization of Medicare means removing the homebound requirement or reducing the care required below the skilled level.

Prototype Policy

As a basis for discussing the important considerations of workable long-term care insurance, I have outlined a simple prototype policy. The major features are that it focuses on nursing home care, it is sold to the elderly at age sixty-five during a limited open period, it covers a stay of up to three years after a ninety-day deductible is met, and it is an indemnity policy paying a fixed amount per day with a maximum payable limit.

The data, assumptions and calculations are summarized in Exhibit 1.

Assuming the hypothetical group of purchasers follow current utilization patterns, the annual costs of the benefits paid are estimated to be about $326. Using a loss ratio of .75 for group coverage and .60 for indi-

Exhibit 1
Long-Term Care Insurance Prototype Premium Estimates: Data, Assumptions, and Calculations

- Policy covers up to three years of care after a ninety-day waiting period.
- Policy pays $35 per day. The 1977 private pay monthly charge for those with stay of six to twelve months is $710.[a] The December, 1981 National Nursing Home Input Price Index is 143.5 (1977=100.0).[b] $710 x 143.5=$1019 per month, $1019 ÷ 30=$33.96 per day.
- Life expectancy at age sixty-five is 16.3 years.[c]
- Forty-six percent of all nursing home residents were discharged or died after a stay of at least ninety days.[a] Thirty percent of those persons discharged alive within ninety days went to another health facility, and may possibly have to return to continue a nursing home stay. Assuming all of those discharged to another health facility who didn't die there came back to continue their stay, a maximum of 62 percent of all discharges had a stay of ninety days or more.
- Assume that all those who have a stay of ninety days or more will remain in the nursing home at least three years.
- Assume that the lifetime nursing home admission incidence rate for the elderly is 20-25 percent.
- If 20 percent of the elderly are admitted to a nursing home and 62 percent of them qualify for full coverage under the policy, the incidence rate for full coverage is 12.4 percent. If 25 percent is the nursing home admission incidence rate, the lifetime incidence rate for full coverage is 15.6 percent. Assume a 14 percent lifetime incidence rate for full coverage.
- If 14 percent of a hypothetical population of purchasers actually use the full 2.75 years of benefits the average lifetime liability per purchaser is $35 x 365 days x 2.75 years x .14 = $4918.
- Assuming that 86 percent pay the premium for their expected lifetime (16.3 years), and that the 14 percent who are expected to be users, pay the premium an average of eight years (after which they are no longer required to pay), the weighted average payment period is 15.1 years.
- Given a lifetime liability per person of $4918 and an average payout period of 15.1 years the annual benefit cost is $4918 ÷ 15.1 = $326.
- Assuming a loss ratio of .75 for group policies and .60 for individual policies, the annual premiums would be $435 and $543, respectively.

[a] National Center for Health Statistics: The National Nursing Home Survey: 1977 Summary for the United States, by J. Van Nostrand, et. al. *Vital and Health Statistics.* Series 13-No. 43. DHEW Pub. No. (PHS) 79-1794. Public Health Service (Washington, D.C., U.S. Government Printing Office, July 1979).

[b] Daniel R. Waldo, *Health Care Financing Trends,* 3:1 (Washington, D.C.: Health Care Financing Administration, 1982).

[c] U.S. Department of Health and Human Services: *Health U.S. 1981,* DHHS Pub. No. (PHS) 82-1232, December 1981.

vidual coverage (the minimum proportion of the premium paid out in benefits as recommended by the Voluntary Certification Program, a federal effort to meet certain standards for regulating Medicare supplement health insurance policies), the annual premium would be $435 and $543, respectively. In other words, the monthly premium would be in the range of $36-$45.

These estimated premiums are not considered insignificant since they would have to be paid over the lifetime of the aged purchaser (users of the benefit are assumed to pay until the benefits begin). Nonetheless, they are an encouraging first approximation. The estimated premiums are substantially less than had been suggested during my initial conversations with individuals from the insurance industry and they are based on several assumptions that are clearly conservative. To simplify the calculations, I have assumed that all those who are in a nursing home for more than ninety days will stay the entire three years and, thus, qualify for 2.75 years of coverage. This contributes to an overestimate because people are actually discharged over the entire period. Also, the discharge data imply that some allowance for additional payments should be made to account for the fact that about 35 percent of those discharged within ninety days went to another health facility and may actually have a longer stay than can be determined from the available data. Erring on the high side again, I have assumed that all these discharges would qualify for the full benefit period. This raises the estimate of the proportion of long-stayers from 45 percent to 62 percent and raises the estimate of the incidence rate for a stay of three years from 10 percent to 14 percent.

Unfortunately, no information was found to reasonably adjust the estimates for insurance induced demand or selection factors. However, the average utilization frequencies derived from the general population, by including the large portion of patients relying on Medicaid or other public programs, do reflect some of the effect of third-party payments. Also, careful selection by insurers, such as rejecting applicants in poor health or with other characteristics that make a nursing home stay more likely, could reduce utilization below the patterns found in the general population. Average frequencies derived from data covering the entire population were used because the intent is to examine the feasibility of covering a substantial proportion of the population.

It is beyond the scope of this paper to attempt a more refined set of estimates though this work is currently underway in an effort to provide a better understanding of the trade-offs involved in alternative policy specifications. The calculations, however, do demonstrate that there are some reasonable limits that could be placed on such insurance which may be acceptable to both the buyers and sellers.

The fear that everyone who enters a nursing home will be there for a long stay is not substantiated by the best available data. A significant proportion (38-55 percent) of people who use nursing homes are short-stayers. They enter from a hospital after an acute episode and either get better or die within ninety days. Furthermore, only about 10 percent of the people who are admitted to a nursing home are there for more than three years and only about 4 percent are there for more than five years.[15] Thus, there are distinct, limited periods during which coverage might reasonably be sought by the elderly. For those who exceed these limits, Medicaid may be expected to be more acceptable. In the following sections further elaboration on some of the important features to be considered in structuring insurance coverage for long-term care is provided.

Service Benefits

Though the prototype policy focuses on a nursing home stay, it is not my intent to limit the benefit to only nursing home care. Rather, the allowable cost of the nursing home stay serves as the basis for the upper limit of the insurance company's liability. The services to be covered should include home health care along with the other services which can be provided in the home to substitute for care in the nursing home. Broadening the coverage to these other services would avoid a bias toward institutionalization and provide the beneficiary the opportunity to shop around to obtain the maximum benefit for his premium dollar. In some circumstances noninstitutional care will cost more than the nursing home care, in which case only an amount equal to the nursing home stay would be paid and the beneficiary would have to pay extra for choosing a preferred, but more expensive, set of services.

It would be best if eligibility for home care benefits could be determined prior to institutionalization. We would like to be able to screen individuals on the basis of a set of criteria (for example, need for assistance in activities of daily living, such as feeding and going to the bathroom) which would be limited in scope so as to keep administrative costs down, reliable enough to determine whether a person would otherwise need institutional care, and that would stand a legal test. This is a difficult challenge and potentially controversial in light of the state of the art in preadmission screening but we are moving in the direction of developing such screening devices.[16] With this kind of assessment, the insurer could feel more comfortable in approving home care as a substitute for nursing home care prior to any institutionalization. The most likely first step for insurers, however, is to allow the home health services after a covered nursing home stay begins. This is the safest approach because it provides some assurance that the beneficiary is in need of nursing home care.

Home care benefits are also likely to be important for purposes of marketing this type of insurance. There is a general distaste for nursing homes on the part of the elderly. Allowing for consumer preferences may serve to assist in selling the idea to the elderly. Insurers will also benefit if beneficiaries seek out care packages which cost less than a nursing home stay. The one area where cost savings appear to be captured when alternative long-term care services are offered is in the context of insurance plans where substitution of one level of care for another can be directly encouraged by the provisions of the policy.[17]

The amount of coverage offered for home health care is not directly addressed in the prototype policy. Relatively little is known about utilization patterns for home health care and, as noted earlier, there is an understandable wariness on the part of insurers to cover such services at all, much less for an extended period. There are several possible approaches to this problem. One is to limit the period of coverage, another is to limit the amount of visits, and a third is to limit the amount paid per visit. Any of these would reduce the insurer's potential liability. For the consumer, the most acceptable approach would be to limit the number of visits per week. Since it is reasonable to assume that someone who chooses to be cared for at home can get along on intermittent care, a maximum of three to four home visits could be specified. Leaving the maximum allowable period of coverage in the prototype as three years of either home care or nursing home care or some combination, we could actually reduce the estimated cost because some of the people we assumed might stay the full three years will be able to go home. Even if the beneficiary required care for all of the remaining benefit period and we agreed to pay up to $35 per visit, the visit limit would substantially cut benefit costs.

Waiting Period

The choice of ninety-day waiting period for benefits to begin has considerations worthy of note to both buyers and sellers. About three months in a nursing home tends to be the critical break between whether a patient is going to be a long-stayer or a short-stayer.[18] It is the long-stayer who needs protection from catastrophic long-term care expenses. Without such protection, the likelihood of having to go on Medicaid because of heavy medical expenses is greatly increased. Though a stay of three months in a nursing home will cost at least $3,000, some of this expense may be covered by Medicare if the care needed is continuous and skilled. However, since Medicare tends to cover only between twenty to thirty days of care per beneficiary, the policy owner might expect to have to pay several thousand dollars for their own care before their private insurance benefits begin. There is no question that this is a significant amount. In fact, it is the situation now faced by an elderly person needing extended nursing home care. The benefit to the consumer and his family, however, is that there is a foreseeable limit to how much they may be liable. For the insurance company, the ninety-day waiting period represents a significant deductible which should serve to deter unwarranted utilization of benefit and one which the elderly beneficiary is unlikely to want to fulfill unless it is really necessary.

Associated with the specification of the waiting period is the issue of whether there should be a link with prior utilization, such as the Medicare requirement that a skilled nursing facility stay be preceded by a three-day hospital stay for the same injury or illness. There has been considerable debate on the value of such a clause. The intent is to limit utilization to services that are clearly medically necessary. Critics argue that it simply increases the cost of care by imposing an expensive hospital stay when the patient could have been directly placed in the skilled nursing facility. A recent evaluation supported the latter claim, but the research has been criticized by the Department of Health and Human Services (DHHS) as overestimating the amount of excess hospitalization that occurs.[19] With a ninety-day elimination period it is questionable whether such a clause is necessary. However, I expect the level of care covered would have to involve, at least, the need for intermittent nursing care and not be solely custodial care. If purely custodial care were offered, it would be reasonable to make it contingent on receipt of a higher level of care for at least some portion of the elimination period. Similar issues would have to be considered for a home health benefit waiting period. As mentioned earlier, the most acceptable first step would be to link the benefit to a covered nursing home stay.

Length of Coverage

The three years of coverage specified in the prototype policy is an arbitrary choice intended to encompass a reasonably large portion (90 percent) of all nursing home stays. The National Center for Health Statistics (NCHS) data indicate that if the coverage had been for two years, 85 percent of the stays would have been covered, and that if coverage would have been for four or five years the proportion of stays covered would be 94 percent or 96 percent, respectively. Even allowing for some underestimation of actual length of stay for those who were discharged to another health facility and ultimately continued their nursing home stay, coverage for up to three years would substantially reduce the likelihood of an individual ever having to use Medicaid. The other options for length of coverage could also be offered with appropriate adjustments to the premium. For those beneficiaries whose stay exceeds their benefit period, Medicaid would act as the payer of last resort.

Indemnity Benefit

Most health insurance sold in this country is designed to pay the "reasonable and customary" charge for specific services when they are actually provided and billed to the policyholder. The prototype policy does not follow this approach. It is an "indemnity policy" designed to pay a fixed amount for each day of covered service. There are a number of good reasons for using the indemnity benefit approach for long-term care insurance.

The most obvious reason is that it is a simple way to limit the insurers' liability and reduce the risk of providing insurance. Service benefit policies are much more open ended. With insurers already hesitant about their ability to put limits on long-term care coverage, this additional risk should probably be avoided.

The indemnity benefit approach may also serve to hold down costs. Open-ended service benefits in health insurance policies have been criticized as a primary contributor to the rapid inflation in health care costs. By removing much of the financial risk from the beneficiary and paying whatever providers usually charge for services, there is little or no incentive on the part of any of the important decisionmakers to hold down costs. The indemnity benefit approach, by setting definite limits on the amount that will be paid, will encourage the beneficiary to be cost conscious and signal providers that their patients do not have unlimited resources available for their care. With this spelled out in advance, providers should be able to work with the patient and their family to plan an affordable long-term stay in a nursing home, should it be necessary.

The choice of $35 as the daily benefit in the prototype policy represents an estimate of the amount necessary to cover 100 percent of the current average daily charge. In some areas of the country this will be too high and in other areas too low. The amount necessary will also vary depending on the level of care actually received, which itself may vary over the period of coverage. It is relatively easy for an insurer to offer a choice of alternative daily benefits at the time of purchase. It is not so straightforward to provide for protection against inflation.

Adjusting the indemnity benefit for inflation clearly seems necessary. Nursing home costs have been the fastest growing component of our national health accounts and the largest portion of that rise has been attributed to inflation.[20] While the recent estimates show signs of diminishing growth in nursing home expenditures and the general inflation rate has dropped, optional inflation protection is likely to be an appealing and worthwhile feature of long-term care insurance.

One approach would be to offer an annual inflation adjustment. The additional coverage would be optional, limited in amount, and require only that the beneficiary pay the increased premium. This type of option has become fairly common with life and disability insurance plans. Large increases in coverage could be offered but probably would have to require that the beneficiary fulfill the same requirements as in the original application for coverage and also fulfill an additional pre-existing condition waiting period before the increased benefits could be paid.

Another consideration is that the indemnity benefit approach is likely to be more acceptable to long-term care providers than for most other health care providers. Because of the heavy involvement of Medicaid in financing nursing home services and the fact that most states use reimbursement systems with limits that effectively amount to flat rate payments adjusted for inflation, the nursing home industry is already heavily reimbursed using what amounts to an indemnity benefit approach similar to that being suggested.

This is not to say that the nursing home industry is particularly satisfied with Medicaid reimbursements. Private pay patients tend to be preferred because they can be charged what the market will bear, and nursing homes are selective about the Medicaid patients they admit. They prefer to take the lighter care patients first so as to maximize coverage of their costs. Nonetheless, nursing homes do depend on Medicaid payments for about half their patient revenues. In the current environment of limits and the spectre of cut-backs in government funding, providers are concerned about encouraging additional private funding. Providers may well view a private indemnity payment at the level of what Medicaid covers in their state as a preferred alternative, particularly if it leads to a reduction in the uncertainty and paperwork associated with the public programs.

Financing Mechanisms

Up to this point the discussion has focused on the insurance coverage of the prototype policy. The financing mechanism for such coverage can be viewed as a separate issue with several alternatives. The suggested approach is modeled after whole life insurance where the purchaser agrees to pay a fixed annual premium over the life of the policy in return for a lifetime guarantee of benefits at the agreed upon level. It is assumed that people buy the policy at age sixty-five and pay for it throughout their remaining life except when they are actually receiving benefits. This involves a shifting of the costs from those in their eighties to the relatively young elderly.

It might be asked why someone in their eighties would continue to pay the premiums? The answer is that it is for those people that the premium is the best buy relative to their expected risk. The current rate of institutionalization in a nursing home rises from 4.8 percent for those sixty-five and over to 10.3 percent for those seventy-five and over to 21.6 percent for those eight-five and over.[21] The expectation is that, barring unforeseen circumstances, the elderly who purchase the policy would plan to maintain their protection. An optional version could be to structure the payments so that the benefit would be fully paid by a certain age. Also, there is no technical reason why the policy could not be sold to older age groups with appropriate premium adjustments, although there are probably age limits beyond which there may be too many practical difficulties.

Implicit in the level premium approach is the potential for the insurer to earn interest on the excess reserves accumulated in the early years of a policy. The value of these earnings are not factored into the premium estimates provided earlier but they could be used to further reduce the cost or increase the benefits of the plan.

The excess reserves do amount to forced savings, the return on which will be determined by the insurer. In the case of whole life insurance, the rate paid on these savings has been a source of controversy because it is often difficult to know the actual rate of return and some feel that individuals could do better by simply buying term insurance and investing the remainder on their own.[22] An alternative approach then would be to structure payments along the line of term life insurance where the premium payments increase with age to reflect the increasing risk.

There may be several reasons for preferring an increasing payment schedule to fixed payments. One has to do with marketing. It may be difficult to get the "young-old" to purchase the coverage if they feel that the risk of needing it is low. Premiums structured to reflect actual risk at a certain age rather than the expected lifetime risk might be more acceptable and serve to encourage greater participation in the insurance plan in the younger age groups. The problem with this approach is that as people age, their income tends to be inversely related to their expected risk of needing long-term care. What is likely to happen is that the healthiest people will decide to drop their insurance when they reach the higher cost age groups leaving only those who probably will use the benefit as policy holders. This in turn would push costs up, effectively making people uninsurable at the time when their need for such coverage is the greatest. The fixed premium approach avoids this problem and can be structured to have similar incentives for early participation if policies are offered at various ages with the premium cost set at the time of purchase to reflect the age at purchase.

A more compelling argument for the term approach, with its increasing payment schedule, could be uncertainty of government involvement in financing broader benefits through either Medicare or Medicaid or some other national program. If consumers felt there was some chance of expanded public coverage of their long-term care needs, they may well prefer to buy insurance that did not require forced savings. This, as well as concerns about the rate paid on those savings, could be addressed in the level premium approach by allowing for greater sharing of both the risk and return between the insurer and insured such as exists in universal life insurance. Universal life insurance is being marketed currently as a better alternative to the whole life approach because it provides a clearer separation between the savings and insurance component of the agreement.[23] Though there are some features that may be worthy of consideration in structuring the long-term care insurance payment mechanism, those issues are beyond the scope of this paper.

Other possible funding mechanisms include a single premium approach modeled after an annuity and a prefunded approach modeled after Individual Retirement Accounts (IRAs). These approaches overlap in that a lump-sum payment could be made from funds accumulated in an IRA or from any other pension funds or personal savings. The major difference would be that the insurance would be purchased with a lump-sum payment rather than over the life of the policy, (this may entail some adjustment of the premium to reflect the elimination of the risk of withdrawals from the plan). Such preretirement funding has the advantage of reducing the annual payment by spreading the cost over a long period and minimizing adverse selection because people commit themselves to owning such insurance before they could reasonably predict their need for the benefits. Another possibility is to have long-term care insurance included in employee fringe-benefit packages that can be continued into retirement years.

Each of these suggestions for prefunding benefits, however, should be recognized as worthy of attention now as potential mechanisms for financing long-term care for the elderly in the future. They do not address the problem as it exists today. Furthermore, barriers to such prefunding do exist. Unless the tax benefits exceed those currently available with an IRA, any such retirement account for long-term care is likely to receive lower priority in consumer savings decisions because it is less general in terms of the uses to which those funds may be put. Since IRA funds can be used to buy long-term care insurance or anything else, the market for a long-term care insurance account is likely to be limited to those few individuals who can afford to save more than the $2,000 allowed under the IRA program.

Including long-term care insurance as an optional employee benefit may also not accomplish the goal of broader population coverage of long-term care needs. Younger, healthier individuals are likely to choose health insurance policies without such benefits since their risk is so small and they have other options such as disability insurance and greater family resources to draw on. This would result in the situation as it exists today with little or no insurance for anyone for long-term care.

By assuming a targeting of the policy to newly retired elderly, we focus on those most likely to recognize the need for long-term care services at a time when they are considering their options for supplementing Medicare.

It can be argued that this will result in too short a time frame for expenses to be reasonably spread. Perhaps this is true (though the estimates don't confirm it), but the specifics of this argument cannot be clarified until we know more about the actuarial cost, the specific commitment of consumers to continue to participate, and the characteristics of the pool of individuals over which the expense might be spread. Spreading the risk over a broader population is an obvious alternative. Preretirement marketing, however, will probably be most effective if it is targeted for people who are at least fifty. It is around this age that family resources for child rearing expenses begin to be freed-up and the time when adults may begin to consider their own potential need for long-term care as they recognize the effect of the aging process on their parent's health care needs.

Regulation as a Barrier

Health insurance policies sold to the elderly are subject to a complex array of regulatory requirements covering topics ranging from the solvency of the company to the size of print used in advertising materials. Because insurance regulation is traditionally a state function, the requirements often vary from state to state. In such an environment it is not surprising to find regulatory barriers to a new product such as long-term care insurance.

The most interesting case is in Wisconsin where the State Insurance Commissioners's office established a set of specific standards for nursing home insurance that effectively eliminated the sale of all such policies in the state except for one policy with very high premiums which probably should be viewed as experimental.[24] Four key provisions caused concern. First, coverage could not be limited to only certain levels of care. Second, coverage must be for any care received while a resident of any licensed nursing home. Third, coverage cannot be limited to care received after a hospital confinement. Fourth, that policies could be subject to a deductible of no more than sixty days per lifetime. Since the Wisconsin definition of a nursing home is quite broad, including very small boarding homes where only personal care was provided, insurers felt that they were being asked to bear unreasonable risk. The Wisconsin regulations were implemented as a direct response to what was viewed as an inability on the part of elderly consumers to adequately understand the coverage they were purchasing and the potential for abuses arising from the lack of knowledge. Unfortunately, the effect may be to stifle innovation.

More typically, insurers find that they must conform to existing insurance regulations, many of which are not applicable to a long-term care policy. Since such insurance is sold to persons over age sixty-five, it is common to find it subject to the regulations of a Medicare supplement policy even though this may not be appropriate. The New York insurance law, for example, has been interpreted to require that insurance companies must make coverage available to holders of Medicare supplemental insurance for copayment amounts for nursing home confinements covered by Medicare.[25] Regulations of this sort act as barriers to long-term nursing home benefits because they force consumers to spend their limited insurance dollars on gap rather than catastrophic coverage. The New York law actually puts direct limits on the amount of nursing home care that can be offered by requiring a direct trade-off of two nursing home days for one hospital day, not to exceed the number of covered days of hospital care provided under the contract in a benefit period.

Even the recently instituted Voluntary Certification Program has provisions that may hinder the development of long-term care coverage. In addition to encouraging all such policies to fill the deductible and copayment gaps for hospital services in Medicare Part A, the program calls for pre-existing condition clauses of not more than six months and minimum loss ratios of 60 percent for individual policies and 75 percent for group policies.[26]

Clauses for pre-existing conditions are included in policies to protect the insurer from having to pay benefits for people who purchased the policy because they were virtually certain of needing the covered services. While the purpose for such clauses is legitimate, there have been abuses which have prompted regulatory attention. For long-term care insurance, it is not so clear that a maximum six-month, pre-existing clause is appropriate. Given the potentially large liability of such coverage and the difficulties to use it, longer pre-existing waiting periods may be warranted. The resulting reduction of risk for the insurer should lower the cost to consumers and encourage wider availability of such coverage.

Loss ratios, the percentage of premiums returned to the policyholder, are one way to measure the relative value of an insurance policy. Regulatory attention has focused on this measure because some Medicare supplemental policies have been found to return very little to the beneficiary. In the case of long-term care insurance as structured in this paper, we would expect low loss ratios in the early years of the life of a policy to compensate for the higher loss ratios in latter years when payouts increase. As such, it would not be feasible to meet a fixed annual loss ratio requirement until the policy had been sold for a reasonable length of time. Regulation must be flexible enough to allow for differences between long-term care products and Medicare supplemental products.

Long-term care insurance could also benefit from regulatory flexibility in the handling of the reserves for tax purpose. Currently, regulations for health and disability insurance make no special provisions for the earnings on reserves. As a result, about half of the earnings are paid in taxes. In contrast, the earnings on reserves in whole life insurance policies are tax exempt to the extent that they are used to cover premium payments.

Part of the problem is that the regulatory statutes for health and disability insurance are separate from those for other types of insurance, and there is a tendency to be rigid in applying the standards. If state regulations were adjusted to allow long-term care insurance to establish a schedule of reserves that included an earnings factor, the Internal Revenue Service might be encouraged to permit the same tax benefits currently available on whole life insurance.

Medicaid As A Barrier

An important factor encouraging growth in Medicaid long-term care expenditures is eligibility criteria that permit a large portion of those persons needing nursing home care to be reimbursed through the Medicaid program. The core group of aged Medicaid eligibles in every state are recipients of Supplemental Security Income (SSI), a cash welfare program for the aged, blind, and disabled. State programs may also choose the option of covering the "medically needy," those persons whose income exceeds the SSI income standard, but whose medical expenses exceed the difference between actual income and the state medically needy income standard. Thirty-one programs have elected this option, which enables a large portion of a state's nursing home population to be eligible for Medicaid.[27] Most states without medially needy programs have spend-down provisions for institutional long-term care. These allow persons to deplete their assets and income to become eligible for Medicaid.

The elderly who become eligible for Medicaid through the spend-down process must first exhaust most of their assets. The resource limits are often quite restrictive. Frequently, they follow the SSI criteria which puts limits on the value of personal resources of $1,500 ($2,250 for a couple) and on the total equity value of personal effects and household goods of $2,000. Other restrictions can also apply.[28] The assets criteria for Medicaid eligibility are complicated and they vary by state and sometimes by county. Only after a person fulfills the assets criteria do income spend-down provisions take effect.

The elderly who become eligible for Medicaid through the spend-down process must pay the majority of their income toward the cost of care but they are protected from nursing home expenses that exceed their income. Thus, Medicaid functions as a safety net in this country for many persons needing nursing home care. Since the elderly are potentially eligible for basic protection under the Medicaid program, some private insurers and long-term care analysts have hypothesized that long-term care insurance cannot compete with the influence of the existing safety net.

The complexities of the process by which Medicaid eligibility is established, however, can be enormous. After their in-depth review of the process, Davidson and Marmor point out that "any attempt to answer a question as broad as 'who is eligible?' is complicated by the numerous and frequently subtle variations found in both the medical and cash-assistance programs." They go on to conclude that "the effects of spend-down are subtly punitive: an older person does not become eligible for medical assistance until he has been struck by serious illness and has depleted income and assets to a point of total dependency."[29]

To investigate whether a significant number of the elderly are not protected by the Medicaid program, we can begin by using the income standards in the most generous state programs as of 1980. Of the states with "medically needy" programs, Rhode Island provided the highest level of income protection for families of one person and Wisconsin provided the highest level of income protection for families of two persons, $4,400 and $5,544 respectively.[30] Medical expenses which push the family income below these levels may qualify for coverage by Medicaid. Assuming the annual cost of nursing home care was about $12,000, all aged individuals with income over $16,400 and all aged couples with income over $17,544 would be ineligible for any Medicaid nursing home subsidies.

In addition to those who would be ineligible for Medicaid because their income is too high, there are those who would not view Medicaid as a reasonable substitute for insurance because it would pay only a portion of their bills. The income level at which Medicaid is perceived as an adequate substitute for private insurance is an arbitrary choice subject to individual judgment. Two possible criteria would be the proportion of income protected and the proportion of the bill paid. For example, if we assume that people would want Medicaid to protect at least 35 percent of their income (the approximate cost of maintaining a home), our example would yield an income maximum of $12,571 for an individual and $15,840 for a couple, beyond which people would be interested in long-term care insurance. If we assume that people would want Medicaid to pay at least 50 percent of the nursing home bill, our example would yield an income of $10,400 for an individual and $11,544 for a couple.

Based on these three criteria, the number of elderly who would not view Medicaid as an adequate replacement for private coverage would range from 500,000 to 1.3 million one-person families and from 2.2 to 4.0 million couples (7 to 17 percent and 30 to 54 percent of elderly individuals and couples, respectively) according to 1980 income estimates from the U.S. Census Bureau.[31] Though these calculations are rough, it is safe to view them as conservative. They are based on income standards that are substantially more generous than exist in other states and the additional eligibility requirements relating to limitations on assets are not considered.

On the basis of income alone, it seems clear that a significant number of the elderly would not view Medicaid as a reasonable insurance alternative. Other factors such as Medicaid's institutional bias and uncertainties about who can expect to receive benefits reinforce this view and serve to expand the pool of persons potentially interested in long-term care insurance.

Private Capacity to Finance

Not all elderly consumers will find private long-term care insurance attractive. Some already will be eligible for Medicaid and others will be either too poor to pay the premiums or have income and assets so limited in amount that they would not rationally view such insurance as a good buy. To establish the potential size of the market, we must determine the private capacity to finance long-term care insurance.

Income, savings, and the value of liquidated assets are the potential sources of the necessary funds. However, it is discretionary income defined in the broadest sense on which we need to focus. Long-term care insurance, or any other new product or service for that matter, is not likely to be purchased until the standard necessities such as food, housing, clothing, transportation, personal care, and medical care are adequately covered. Annual budget estimates for a retired couple that include these items at three levels of living are made by the Bureau of Labor Statistics.[32] Recent estimates, adjusted to include personal income taxes, indicate that in 1980 retired couples living in lower, intermediate, and higher financial circumstances would have annual budgets of $6,850, $10,150, and $14,450, respectively. On the basis of these estimates, we can assume that a retired couple would need an annual income above these levels before they would consider purchasing long-term care insurance. Comparable estimates are not available for retired individuals, but a reasonable approximation would be to set the levels for individuals at 75 percent of the above levels or $5,138, $7,613, and $10,838 for the lower, medium, and higher budgets, respectively.

The value of personal assets such as savings, stocks, bonds, and most importantly for the elderly, a home, are also potential sources of funds for long-term care insurance. Income from dividends and interest is indicative of asset holdings and increases with higher income groups. In an ongoing analysis, Moon has found that dividend and interest comprise a substantial share of income of those in the upper brackets indicating that higher income individuals and couples are relying on assets for much of their income.[33] In particular, individuals with income above $10,000 and couples with income above $15,000 have substantial assets on which to draw.

Using dividend and interest income as a basis for estimating net worth, Moon's calculations imply that income for elderly individuals and couples could be increased by about 24 percent by converting those assets into an annuity. The annuitized value of a house has an even more significant effect on personal resources, particularly since the 1980 census figures indicate that 70 percent of the elderly own their own homes. Moon's estimates imply a 31 percent increase in income for elderly individuals and 36 percent increase in income for elderly couples from this source. This suggests that estimates of the potential market for long-term care insurance based on income alone may be substantially on the conservative side. In any case, since the levels of income and assets tend to be positively related, it is reasonable to assume that elderly individuals with income above $10,000 and elderly couples with income above $15,000 would be able to pay for long-term care insurance and perhaps be more willing to buy it for the protection of wealth it provides. In 1980, 1.3 million elderly individuals (18 percent of the one-person families) and 2.8 million couples (37 percent of the two person families) had incomes above these levels.

Given the limited development of long-term care insurance options, evidence on consumer demand is lacking. However, several studies are underway and the preliminary results suggest that the elderly are interested.[34]

Who Would Benefit

Consumers and government payers as well as providers and insurers may benefit from the development of private long-term care insurance. Consumers who buy such a policy would have protection from having to go on Medicaid. Potential benefits are that they will have their homes to return to, an important ingredient and incentive for getting better; their spouse will not have to dramatically change their lifestyle to pay for care; assets can be passed along to family rather than being liquidated and spent-down; access to care may be improved because providers view private patients as preferable; and once the insurance premiums are paid, the remaining personal resources can be more comfortably spent knowing this important risk is covered. Providers would benefit by having their pool of private payers expanded and reducing their dependence on public financing. Insurers, looking for new products which capitalize on the aging population demographics and which offer a policy for elders that may receive endorsement from consumer groups for providing important new insurance protection, may view this as a product that can benefit their current operation and have substantial growth potential.

The most intriguing benefit from the development of a private market for long-term care insurance is the potential for relieving some of the pressure of Medicaid. Government payers will benefit if private insurance replaces Medicaid and other long-term care programs for the middle class, or at least slows down the spend-down process or negates the need to divest assets. The problem is that even those persons with personal resources that are quite adequate for a normal retirement will not be able to pay for long-term care should it become necessary. There are essentially two options open to the elderly. One is to spend income and assets down to the level necessary to qualify for Medicaid. The other is to transfer assets to qualify for Medicaid. It is not surprising that people have chosen the latter option. It is usually more appealing to pass along one's estate to close relatives than to pay it out gradually to a nursing home when the end result in either case is that the patient will have to go on Medicaid.

In response to such practices, federal regulations regarding transfer of assets has recently been strengthened to make it more difficult to qualify for SSI and Medicaid. Resources disposed of within twenty-four months of the date of application at below market value for the purpose of establishing eligibility for SSI benefits including Medicaid will be counted in determining eligibility, and the period can be extended if the uncompensated value of the resources exceeds $12,000.[35] The right to extend these restrictions to cover anyone eligible for Medicaid has recently been given to states along with the right to place liens on the homes of nursing home residents. While the extent to which transfers of assets occur is not known, it is clear that these proposed solutions will be difficult, costly, and unpopular to administer. The availability of private long-term care insurance would provide a reasonable alternative for people with assets worth transferring and government payers would be relieved of paying those long-term care related expenses.

Significant government savings may also result from avoiding or slowing the spend-down process. An estimated 54 percent of the elderly who enter a nursing home are not initially supported by Medicaid and most of those people pay more than 90 percent of their bill out of their own resources.[36] The longer that individuals stay in a nursing home, however, the greater the likelihood that they will become Medicaid-sponsored residents.

Conversions from private pay status to Medicaid represent a major portion of nursing home residents supported by Medicaid. Though the available evidence is quite limited, a Government Accounting Office review of several studies indicates that conversions represent 30-38 percent of the residents supported by Medicaid.[37] While one study showed that many conversions occur shortly after admission, the majority (59 percent) converted sometime after a six-month stay. What these figures suggest is that a significant number of those who entered the nursing home as a private payer, but converted to Medicaid, had personal resources sufficient to have paid their nursing home bills for at least six months. Individuals with personal resources of this order of magnitude could probably have purchased long-term care insurance had it been available. Had they done so, some 18 to 22 percent of those now on Medicaid may have avoided needing such government support.

Even if these estimates are off by a factor of two, the dollar savings to the government would be substantial. In 1980, Medicaid spent $10.4 billion on nursing home care. Excluding payments to intermediate care facilities for the mentally retarded, Medicaid's nursing home expenditures were $8.7 billion. A 10 percent reduction would have resulted in savings of $870 million. Using the same relationships, recent projections of nursing home expenditures suggest that these savings would increase to $1.9 billion by 1985, and to $3.4 billion by 1990 if current trends persist.[38]

Summary Discussion

The discussion in this paper constitutes a preliminary analysis of the market potential for long-term care insurance. It suggests that a reasonable case can be made for the development of such a market. Many of the barriers that are thought to preclude long-term care insurance are subject to resolution by careful policy specification. A prototype policy is outlined and serves as a basis for recommendations concerning services covered, waiting periods, length of coverage, benefit payments, and financing mechanisms.

Several important barriers that cannot be construed as simply technical in nature include regulatory restrictions and rigidness, the availability of Medicaid as a potential hinderance to the private market, and the limited capacity of the elderly to finance long-term care insurance. The substance of these issues is examined and with the possible exception of regulatory concerns, these barriers do not appear to be as formidable as is commonly thought.

It is the conclusion of this analysis that significant benefits await the development of a market of private long-term care insurance. The most intriguing benefit is the potentially substantial savings in Medicaid payments that would be gained if elderly individuals were able to protect themselves from the catastrophic expenses associated with the need for long-term care by purchasing private insurance.

The notion that there could be substantial savings to public budgets as well as benefits to consumers, providers, and insurers from the development of a viable private market for long-term care insurance suggests that there is a public role in encouraging that market. This assistance could take several forms including tax incentives, information dissemination, and regulatory relief.

Tax breaks for health insurance have recently fallen out of favor and will no longer be allowed as a separate deduction after this year. With long-term care insurance, however, it would appear that such incentives should be encouraged. The elderly people who are most able to buy this coverage have a sufficient tax liability that the incentive should help stimulate interest in this type of insurance. Also, families who purchase the policy for an elderly relative could be made eligible for the same tax breaks.

An even more appealing opportunity for stimulating the market for long-term care insurance through tax incentives can be found in the current tax benefits for older persons. Up to $125,000 in capital gains on the sale of a home are tax free for a person who has reached the age of fifty-five. Currently, no restrictions are placed on the use of this money. The tax law could be adjusted to require that the savings from this tax windfall be used for something that would be beneficial to the government as well as to the individual. From the analysis presented in this paper, long-term care insurance would appear to be a likely candidate for such support. Using this tax incentive is particularly appealing because it would not result in any reduction in the government's tax base.

An alternative option involving the home is to facilitate reverse annuity mortgages, perhaps giving special consideration to those who use their home equity income to finance long-term care insurance.[39] This approach would allow the elderly homeowner to retain occupancy rights, while at the same time providing protection against long-term care expenses; an informal version of continuing care retirement community arrangements.

There is clearly substantial progress to be made in improving our understanding of long-term care and how to insure it. The lack of consumer knowledge about health insurance in general and long-term care in particular is a real barrier. Regulations regarding health insurance for the elderly have been designed to compensate for this lack of knowledge. They don't help in many cases in spite of the good intentions. Insurers have been hesitant about the market because there is little or no private experience on which to base their estimates and the public experience with financing long-term care is only beginning to be understood. The analysis in this paper suggests that a private market for long-term care insurance can exist and that continued efforts to support that development are warranted.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Center for Health
Services Research
[redacted]
Stop 3-50, Park Building
5600 Fishers Lane
Rockville, MD 20857

November 25, 1983

Senator David Durenberger
Chairman
Subcommittee on Finance
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger:

I'm glad you found our research on financing long-term care helpful. My answers to your follow-up questions are enclosed.

If I can be of further assistance, please let me know.

Sincerely,

Mark R. Meiners, Ph.D.
Senior Research Manager

Enclosure

Written Responses to Questions of Senator David Durenberger

QUESTION 1: You mentioned some regulatory problems at the state level which impede the development of private sector insurance policies for long-term care. Have you been able to identify any particular public policies at the federal level which might also be barriers to the development of this type of coverage.

ANSWER: In my view, there are several barriers at the Federal level that come to mind. One of the most important is that the benefits provided by Medicare are confusing to the elderly. In my view, we have to do a better job of explaining what is not covered. This is particularly true with regard to nursing home and home health care. These benefits are strongly associated with long-term care from the consumers' point of view. However, Medicare does not include long-term care coverage. Many elderly consumers have a false sense of security because these services are included under Medicare without adequate clarification as to who is not eligible. Another problem is that well meaning efforts to help protect the consumer, such as the recent Voluntary Certification Program, tend to encourage Medicare gap-filling coverage rather than catastrophic coverage. If consumers are encouraged to spend their dollars for private insurance products that provide first dollar benefits, they have fewer resources to buy catastrophic benefits such as long-term care insurance. I expect a broadly based long-term care insurance market will depend on getting people to trade off some first dollar coverage for catastrophic coverage.

QUESTION 2: Is it your opinion that the state demonstrations and waiver programs are developing the types of utilization and quality assurance standards which the private sector feels are needed before it is willing to offer long-term care coverage.

ANSWER: Yes. In general I feel the state demonstrations and waiver programs have and will provide the private market a wealth of information on which to base new and profitable interventions like the one I'm suggesting. In fact, I believe that without these ongoing research and demonstration efforts little progress would have been made.

QUESTION 3: In your view, what services should be in a long-term care insurance package?

ANSWER: As I've specified it, the insurance should cover nursing home care at the skilled and intermediate levels (personal care with nursing) and home health care (also broadly defined to include all services that serve to keep the person at home). As I've specified, the coverage of home health care would be available in direct trade for nursing home care and be paid for on an indemnity basis which allows flexibility in choice of services.

QUESTION 4: What will it take to get private insureres interested in providing coverage for long-term care services?

ANSWER: The National Center for Health Services Research (NCHSR) interest in this topic is based on the knowledge that too little was known about the potential for insuring long-term care and that we might serve as a catalyst to further development by providing the necessary background. The paper submitted as part of my testimony provides an overview of many of the key issues. An earlier paper published in the American Health Care Association Journal in March 1982, entitled "Shifting the Burden: Potential Role of the Private Sector in Long-Term Care Insurance for the Elderly," provides further background about our study. Together these have helped to stimulate an interest in the insurability of long-term care.

Several other papers have also been completed. I expect they will encourage further market interest. One provides estimates, based on actuarial techniques and assumptions, of the premiums for alternative prototype long-term care insurance policies. Another reviews the examples of long-term care insurance that I found during my research. Together these papers document useful data and experience that should help insurers assess the market. It is particularily encouraging to know that some insurers have already entered the market. I expect this interest to continue and grow.

Another part of our study is a survey of elderly consumers undertaken in cooperation with Health Care Financing Administration (HCFA) to determine consumer interest and willingness to pay for long-term care insurance. This research is in process and should help to clarify aspects of the demand side of the market..

It is only very recently that people have begun to accept the idea that long-term care is insurable. Major efforts are needed to inform consumers to accept deductibles and copayments in exchange for catastrophic coverage. State regulatory agencies can also assist by giving recognition to this new type of coverage and not automatically view it as just another Medicare supplement. The potential benefits to relieving some of the pressures on the State Medicaid budgets should be an incentive for a careful regulatory review. The potential saving to public budgets should also prompt consideration of tax incentives. Some possibilities are suggested in the overview paper. It would also help to encourage working age persons to save for their long-term care needs. I'm currently exploring financing mechanisms to encourage prefunding for a broad segment of the population. Targeting a specific savings mechanism for the elderly's long-term care needs would serve as a major stimulus to market development. However, as I pointed out in my earlier testimony, it must be competitive with IRAs to be successful.

Senator DURENBERGER. Great.

I want to thank all of you. I don't know whether the three of you were here in the beginning when I made my opening speech. In this committee we spend a lot of time talking about taxes, social security and the so-called welfare programs, and never spend a lot of time putting income security in its larger perspective. There is a tendency sometimes to measure our society in terms of how much money we spend on social security and how much we spend on medicaid and how much we spend on AFDC, and all these sorts of things. We rarely step back and define it the way I tried to do in the beginning, which is to put a value on earnings and savings and make that your No. 1 form of income security, and then move to social insurance, and then only for your failures—in effect, the societal failures, if you will—do you need to deal with the kinds of things that have consumed us for the first 2 hours of this hearing.

So clearly I welcome the work that all three of you have done that might encourage us to take a long-range outlook. Some of these ideas will help people immediately, others may help me when I'm a little older. I take it when we talk about insurance I might be an easier sell than my dad who is 76—unless he happens to have a home or some other assets that he might in effect convert into an insurance policy.

So when we talk about insuring, I take it the market works a little bit better at the younger age; is that not true?

Dr. MEINERS. Yes; I certainly think to get this off the ground in a more solid way we have to focus on both problems. There is a short- and a long-term problem. The short-term problem is people like your father who may well need this coverage also, and the long-term problem is people like ourselves who down the road are going to be faced with the same situation, perhaps with tighter budgets.

It is interesting to note, however, that much of the initial sales of the insurance products that exist are sold to people in their seventies—partly, I suspect, because at that age people are more willing to recognize the potential need for this. And of course, along with that, I fully expect that there is substantial underwriting and risk screening that is going on, which is not really surprising with a new product like this.

Dr. WEISSERT. I would like to add if I could buy it for my mother-in-law, I would buy it on her behalf, since her expenses will eventually become mine.

Senator DURENBERGER. And you need, perhaps, a tax break of some kind to encourage you to do that?

Dr. MEINERS. Well, first of all, I need it to be available. Beyond that—yes, I think there are some tax barriers. There is just no question about that. Bruce could talk about that.

Senator DURENBERGER. The availability problem I would assume—the problems with the availability might have been illustrated in the first 2 hours of this hearing. I mean, we can't make up our minds—we in government, and the folks that preceded you working at the State and local level. We haven't been able to make up our minds in this perplexing problem of what our roles ought to be. Our traditional role appears to have been to create a program for this, a ,m, ,program for that, a program for something else.

Every time somebody comes up with a new idea, there is a new program to finance it. So the incentives to start planning ahead through, in effect, the private sector, through our savings programs and our insurance programs, I am assuming for purposes of the question aren't there yet. Is that part of the problem of why we don't see more activity out there in this market?

Dr. JACOBS. One of the major problems is that home equity is the principal form of savings for most of our elderly population, and until now they have correctly assumed that the only way they could get at that home equity was to sell their home and move, something they dearly do not want to do. And what we see very recently is the development of some financial instruments that will let them get at this asset they have saved with the encouragement of our Federal Government, and use it for whatever purposes they might. But if one of the purposes is to relieve them of the emotional stress and strains that evolve from a need for long-term care, then this is the proper demand-side change.

Dr. WEISSERT. There is another perception problem that I think has been a barrier, and it is one that I feel is very important; that is, that many people believe that long-term care is a totally intractable problem—it is something that happens to you when you turn 65, and so if we are going to deal with it as a society, we have got to deal with it in terms that are staggering: 23 million people today.

Well, the fact of the matter is, if you look at the things that are associated with needing care in a nursing home in a nursing home or in home health, the prevalence of those problems is really quite low. We estimate that as of today only about 2 million people are dependent in personal care.

So if you think about this as a risk that is faced only by about 5 percent of the aged at a point in time—it is a risk faced by everybody, but something that will happen to only about 5 percent of them—it is a problem that we could handle, either through private financing or public financing or some combination.

I think the important thing, though, is that it is not ubiquitous.

Dr. MEINERS. A more direct answer, perhaps to the question of whether you need incentives to get people our age to buy it—I think the answer has to be yes. I mean, we have IRA's out there now that we can put our money into, and when we collect on that, when we can tap that money, we can use it for a lot of different things. So it is not specifically tied to long-term care. We can use it for long-term care, but it is not tied to that.

So if you were to put something like a special health account available to people, I think it would be in direct competition and perhaps a loser, unless there were special incentives to encourage people to put the money into that health account versus an IRA which is more generally usable.

So I think that is some of the thinking that has to be done. That is the competition out there, in terms of going after those savings here and now to have them there later in life.

Senator DURENBERGER. I was reading in some weekly news magazine recently about this debate over whose responsibility are the elderly. I think it was Dick Lamm, the Governor of Colorado, on one side saying there is some familial responsibility here; and on the other side was someone who is an active representative of the elderly saying, no, it is a public responsibility.

And not just because it appeared in a magazine, but I am assuming that there is some period of time in this country in which we are going to have to actively engage in some kind of debate and resolve the issue of where and how this responsibility best gets shared especially if we are to open up this market. The health care market has gone through a lot of transition. In 1965 my predecessors acknowledged a national responsibility to finance access for the elderly and the poor to at least a hospital-based system and then provided them with an opportunity to purchase more extensive coverage and that's when things started to change. And we obviously moved in one direction and immediately private insurance followed suit.

So by the same token, if you could encourage us to come to grips with some of the responsibility issues and if we design the appropriate policies then what I hear from your testimony and I assume is in your studies is that there are opportunities for us to put answers to some of these questions about how to assure quality and access to care and put the decisions in the hands of the consumers of health care by providing them some appropriate financial backup.

Dr. WEISSERT. Senator, there is one area of public policy that we haven't talked about that does represent a potential problem for home equity conversion, particularly, and that is the extent to which various public subsidy programs like SSI or medicaid regard a home equity conversion annuity as income which disqualifies them from the SSI payment that they may be using to pay for living costs.

If this instrument is going to be useful as a way of helping the elderly make some choices, there are going to have to be some changes, I suspect, in the way we regard conversion of equity—whether we look at it strictly as income or we want to perhaps deal with it some other way.

Senator DURENBERGER. Well, I trust that, as I indicated earlier, the long-term care side of this process is just the first. We will be exploring the broader issues concerning the appropriate Federal role in the care of indigent people, and I would hope that we can call again on the expertise of all three of you to help guide us through this process and to suggest to us some alternatives to the current system of meeting the needs that we have in an income-security sense.

If we have other questions after I get to tackle your reports and studies in depth, I will submit them to you in writing and ask you to respond, and we will put your answers in the record.

Thank you very much for your testimony.

Dr. MEINERS. Thank you.

Senator DURENBERGER. The hearing is adjourned.

[Whereupon, at 4:03 p.m., the hearing was concluded.]

LONG-TERM HEALTH CARE

MONDAY, NOVEMBER 14, 1983

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

The committee met, pursuant to notice, at 11:30 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Packwood, Heinz, and Bradley.

[The opening statements of Senators Dole and Durenberger follow:]

OPENING STATEMENT OF SENATOR BOB DOLE

I am pleased to join with my colleagues in welcoming the witnesses scheduled to testify before us today.

The proposals pending before us, each of which would address our long-term care system, provide us with an excellent opportunity to discuss the options for solving one of the most difficult issues facing us.

At the first hearing of this series, which was held on November 3, we heard from a great many witnesses who outlined some very startling facts about the aging of our population and the need for a coordinated, comprehensive system of long-term care services. All of the witnesses seemed to agree that a system must have many different components so as to meet greatly differing needs. One aspect should certainly be home-based care, another, nursing home care. There is also a clear need for coordination and for case management. There is also a documented need for outreach so that individuals in the community are made aware of the services available.

Like many others, I am concerned that we continue to move forward in addressing these needs. However, also like many others, I am convinced that we must proceed with caution. The changes we make could have enormous implications for the medicare trust fund, which is already in serious trouble, and for medicaid expenditures. This caution should not, however, discourage us from seeking the answers to the questions before us. Of particular note are questions relating to methods for coordination of sevices, and patient assessment, and alternative financing options.

Our first witnesses will provide us with a very useful guide to use in examining the bills before us. They suggest we look at factors such as the integration of financing and the integration of services.

I am anxious to hear from all of those here, who, I am sure, will provide us with other helpful suggestions and comments.

STATEMENT OF SENATOR DAVE DURENBERGER

Today is the second in a series of hearings on long-term care. The first hearing provided an overview of the current problems and issues in long-term care. Today's hearing will focus on four major legislative proposals in the long-term care area. These include the Senior Citizens Independent Community Care Act, sponsored by Senator Packwood, the Community Home Care Service Act of 1983, sponsored by Senator Hatch, the Health Care Coordination Act of 1983, sponsored by Senator

Heinz, and the Community Nursing Centers Act of 1983, sponsored by Senator Inouye. The interest and involvement of these and other Senators in the long-term care issue is appreciated by all of us.

As we examine these proposals, I think it is important to keep in mind the issues raised in last week's overview hearing. We heard that home- and community-based care is not necessarily a cost-effective alternative to institutional care. We must be careful not to simply broaden coverage under existing programs without some assurance that total costs will be contained.

We heard about the limitations of current data, and of the need to base any reform of the system on sound information. We heard about the potential of current demonstrations, but of the need to review these efforts carefully before expanding them.

Finally, we heard, again and again, about the importance of family and friends—the informal support system. Any new methods of financing and coordinating long-term care should maintain and support this informal support.

I look forward to hearing from our witnesses today and exploring with them the proposals before us.

Senator DURENBERGER. The hearing will come to order. I apologize for having an odd hour for a hearing, but the chair of the subcommittee was involved in a national municipal league at 9 this morning in Baltimore and making it a little hard to be back here by 10.

Today is the second in a series of hearings on long-term care. The first hearing provided us with an overview of the current problems and the issues of long-term care. And today's hearing will focus on four major legislative proposals in the long-term care area.

These include the Senior Citizen Independent Community Care Act, sponsored by Senator Packwood; the Community Home Care Service Act of 1983, sponsored by Senator Hatch; the Health Care Coordination Act of 1983, sponsored by Senator Heinz; and the Community Nursing Centers Act of 1983, sponsored by Senator Inouye.

The interest and involvement of these and other Senators in long-term care issues is obviously appreciated by all of us. As we examine these proposals I think it is important to keep in mind some of the issues raised in last week's overview hearing.

We heard, for example, that home and community based care is not necessarily a cost effective alternative to institutional care, although we know it ought to be. We must be careful not to simply broaden coverage under existing programs without some assurance that total costs will be contained. We heard about the limitations of current data, and of the need to base any reform of the system on sound information. We heard about the potential of current demonstration, but the need to review these efforts carefully before expanding them. And, finally, we heard again and again about the importance of family and friends, what we call the informal support system.

Any new methods of financing and coordinating long-term care must maintain and support this informal support. I look forward to hearing from our witnesses today, and exploring with each of them the proposals before us.

Before I do, I would turn to my colleague from Oregon for any comment he might have.

Senator PACKWOOD. Mr. Chairman, I had a long opening statement at the last hearing, and I will not repeat it. I would emphasize only one point. No witnesses testifying at that hearing indicated that on a 1-for-1 basis home health care was more expensive than nursing homes or hospitalization. There is great fear about over-utilization. There is great fear that people who now get no nursing home care or no hospital care would get home health care, and that would make the program expand like a balloon and become very expensive.

But I don't think any witness testified that the home health care was in any way, shape or form more expensive per se than nursing home or hospital care. And I would very much appreciate it, assuming that presumption is correct, if the witnesses might help us in identifying how we could avoid over-utilization.

Thank you, Mr. Chairman.

Senator **DURENBERGER**. Thank you.

Senator Bradley.

Senator **BRADLEY**. Thank you, Mr. Chairman. Mr. Chairman, as you know, and as Senator Packwood knows, by the year 2000 the over 85 population will be 60 percent larger than it is today. The nursing home population can be expected to increase by 49 percent. And 15 million more individuals 65 years and older will suffer from limitations in their daily activities due to chronic disease.

A recent GAO report stated that in 1977 only 50 percent of the people classified as severely dependent lived in nursing homes. It is estimated that that number of chronically ill elderly living in the community may be up to three times as great as the number living in nursing homes. Many of these people are not receiving even the most rudimentary assistance. And of those who are living in nursing homes, many live in an isolated and sterile environments and are deprived of their personal independence and dignity.

I'm convinced that in many cases, as we heard in the hearing just last week, life would be a lot better for elderly people if this country developed a more extensive program to provide long-term medical and social services in the home. There are humane reasons for supporting the development of long-term in-home care for the elderly, and there are cost reasons.

Between 1965 and 1985, the cost of nursing home care will have quadrupled. At least one-third of private payers become eligible for medicaid in less than 1 year after admission to nursing homes. Medicaid simply cannot keep pace with the growth in this country's elderly population and the rise in the cost of nursing care.

Mr. Chairman, I believe the bills before us do present us with at least a path to the future that we all want to reach. I look forward to this hearing which gives us an opportunity to clarify some of the specific components of the bills and inform us as to the most humane and the most cost efficient.

Senator **DURENBERGER**. Thank you very much.

We will call our first witnesses: Stan Wallack and Jay Greenberg from the Health Policy Center, The Heller School, Brandeis University in Waltham, Mass. Gentlemen, welcome. And we thank you for being here. We thank you for your efforts in this area. Your full statements will be made a part of the record, and you may summarize those before you respond to questions.

STATEMENT OF STANLEY WALLACK, PH.D., HEALTH POLICY CENTER, THE HELLER SCHOOL, BRANDEIS UNIVERSITY, WALTHAM, MASS.

Dr. WALLACK. Thank you, Senator.

We've been asked today to provide a framework for evaluating the three bills that we understood have been referred to the Senate Finance Committee: The Community Nursing Centers Act of 1983; the Senior Citizens Independent Community Care Act; and the Health Care Coordination Act of 1983.

What we are going to try to do is provide an overall framework by which the committee can then start to evaluate these bills.

In doing that, we thought it was important to first of all start off with the kinds of global issues that you are all facing when you start to think about long-term care. Often when this committee deliberates the issues about hospital or acute care reimbursement, over the last 10 years you have been very concerned with looking for the appropriate payment system. What are the kinds of rates we should set to get efficiency in the delivery system?

However, when you consider long-term care problems, the system and the issues you must consider are much broader. You must deal with the overall issues about how do we finance long-term care, because so few people have protection from that. You also must deal with what is an acceptable delivery system out there because today there are very few of them.

And so the issues you must face as you frame your questions are much broader than when you look at the acute care system.

In our testimony today we have provided to you in a table on page 6 the kinds of major issues we feel you must deal with in financing, delivery and services and reimbursement.

And those are the major issues. And let me sort of highlight why we think those are the issues that this committee should be addressing.

First of all, with regard to the financing of long-term care, as Senator Bradley has already said, right now that is a terrible problem for many people. When I was at the Congressional Budget Office and we did studies on long-term care expenses, we found out that long-term care was the major source of cash for the elderly. Right now, the people out of their own pockets pay a high proportion of long-term care costs—44 percent.

And basically what happens in our system now, we either have people paying privately or they get paid out of the welfare program out of medicaid. And what we have is an awful lot of people, in fact, who enter a nursing home as private pays and then spend down very fast. That creates tremendous social problems out there as families look to ways to divest their assets in order to save some of their resources that they have earned over all their lives. At the same time, States must look for ways to protect the welfare programs.

And we have got tremendous problems out there for a lot of individuals as these two forces collide.

We must find ways of developing a better financing system for long-term care. As we look at another financing problem of long-term care—is the fact that when we start including acute care—it includes institutional care; it includes social services. And right now the system out there is very fragmented. And it is fragmented because of the fact the dollars that flow into these programs are separate. And until we some way coordinate the financing flows, we will always have a fragmented delivery system. I think it's almost that simple.

As we start to think about long-term care, we also need to start to think about what are the kinds of services that make some sense out there. And the set of services one must have must be very broad. We have learned through a lot of research and observing of the long-term care system that the elderly population of the chronically ill—they need chronic care services, social services; they also need acute care services. It is the chronically ill elderly person that is the real user of a lot of services in the acute care system as well.

Therefore, the delivery system that we start putting together must be very broad. And we also must have a delivery system that, in fact, treats people in such a way that there isn't a bias toward institutionalization as there is today.

So, therefore, I think we need to have some integration of the financing system; we need to have financial protection for individuals; and we need to have a very different delivery system, one that has a broad array of services as well as, in fact, a delivery system that takes responsibility for people as, in fact, they pass from a healthy status to a more disabled status.

When we start to put this system together, we also have to understand the incentives that are out there. And we have learned a lot about what is efficient delivery system from our earlier demonstrations. Senator Packwood has talked about the fact that we know that home health care can substitute for nursing home care and for hospital care. We know that.

But one of the problems we found out in our previous demonstrations is that if you just do that separately, it becomes an add-on. It doesn't really lead to the appropriate kinds of substitution. If we develop a delivery system that, in fact, encompasses a wide array of services and also one that puts providers within a budget, we think we can accomplish some of the goals of getting appropriate substitution for our services.

So on page 6 of the testimony we have outlined the kinds of major issues in financing and delivery and services and reimbursement that you must consider in developing a long-term care system.

Rather than go through the parts of each of bill—of S. 410, of S. 20, S. 1244 and S. 1614—with regards to whether or not they address all the issues, I would like to make a few overall statements. First of all with regard to S. 1614, it addresses many of the questions we are concerned with. The one major problem that it does not deal with is the financing of care. For a lot of people it does not provide additional financial protection.

Rather than go through the yes and no's because we don't have time, let me mention three of the problems that result because in fact certain bills don't incorporate certain kinds of the issues that we are talking about.

With regard to the integrating of medicare and medicaid, as you can see, S. 1614 includes that. By not including within a State the incentive of tying together medicare and medicaid what we often end up with is an individual that is in a hospital who is staying for too long a period of time. Well, from a State's perspective medicare pays that bill, and, in fact, since the State pays the medicaid there is, in fact, no incentive to get people out of the hospital. By integrating those flows of dollars you then provide the kinds of appropriate incentives.

With regard to having one organization responsible for the chronically ill, if, in fact, you don't include and don't make one institution responsible, what you may end up with is an individual gets chronically ill and needs nursing home care—that provider who is responsible for that system may, in fact, put that person in a nursing home prematurely. And, in fact, you have set up incentives for nursing home utilization, and increased institutionalization, by not, in fact, making that agency responsible for the same individual.

Finally, with regard to the risk sharing. And all your bills, I think, have some risk sharing involved either with the States or with the providers. It's very important to set up some incentive that leads to the appropriate use of resources. If, in fact, under S. 1244 the States, in fact, have an awful lot of responsibility for the administration of the system, for running that system—yet there, in fact, is no financial risk. One of the real cost problems that may result is that States may, in fact, have an incentive under that system to keep people out of the nursing homes, keep them at home, and therefore, in fact, reduce their costs, but so high a cost, and tacked onto medicare.

In evaluating all these three bills, I think you need to, in fact, look at the kinds of incentives that are incorporated. All three bills, in fact, start to address some of the major problems. And that was really, I think, the purpose of that graph on page 6.

Let me take 30 seconds, if I may, to describe to you a project we have at Brandeis which in many ways is small scaled, but really tries to do many of the same things that this committee is considering. That is what we call the social HMO. The social HMO takes a broad perspective on a set of services, includes hospitalization care, long-term care, as well as social services; makes one agency responsible for it and does it under a capitated system when, in fact—with the providers at risk.

The one difference in this small experiment we are doing, this national demonstration project we are running, than all these other bills is that we are trying to incorporate the notion of insurance or private financing. The population that we want eligible for these social HMO's cuts across, includes the frail elderly as well as the healthy elderly; includes those on medicaid as well as those who aren't on medicaid.

What we were attempting to do was to recognize the fact that public financing for long-term care is limited, and we need to develop private financing—increases in private financing. And what we were trying to do was, is have individuals join this system, in fact, pay premiums, and in that way pay for the cost of the sicker individuals, the more chronically ill.

The bills you have before you would in some way facilitate things like the social HMO's. S. 1614 would make it easier for other States to, in fact, join if it is successful. In fact, with S. 1244 it would provide for additional financing which would make it more possible for us to offer an unextended long-term care benefit.

These would be helpful. The last point I would like to make is that as you sort of look at these bills, there are differences with regard to what should be the role of the States and what should be the role of the Federal Government; they talk to differences perhaps in how it should be financed through Federal Government versus State government. Those are major issues which this committee is going to have to grapple with over the next couple of years.

For what all these bills can do and what we are trying to do in the social HMO is to try and develop out there now, today as we discuss these issues, a delivery system that we trust. Whether we are financing it from public dollars or from private dollars, one that we think is efficient, one that we think that we want to enter as we get older.

And I think that's very important to accomplish now. We are accomplishing it through the support of HCFA, with waivers and some of the legislation here today would also facilitate that. And that's something we can do today. We don't have to wait for the next 10 years to settle these other issues.

Thank you.

Senator DURENBERGER. Thank you very much, Dr. Wallack. That was a very helpful statement.

[The prepared statement of Dr. Wallack and Mr. Greenberg follows:]

TESTIMONY

OF

STANLEY S. WALLACK AND JAY N. GREENBERG

University Health Policy Consortium
Brandeis University
Waltham, Mass.

Read before

The Health Subcommittee of the Senate Finance Committee
U.S. Senate
November 14, 1983

My name is Stanley Wallack. I am with Brandeis University and direct the University Health Policy Consortium, which is composed of faculty and staff from Boston University, Brandeis University and M.I.T. With me is Dr. Jay Greenberg, also from Brandeis. Dr. Greenberg directs our Social/HMO demonstration project. As you may know, the Social/HMO will soon be tested in California, Minnesota, New York, and Oregon. Since the Social/HMO is in many ways a composite of the bills we are discussing today, I hope Dr. Greenberg and myself will be able to discuss some of the issues and obstacles we have faced, and still confront, in establishing a coordinated, prepaid system that integrates funding sources as well as services.

We have been asked today to provide a framework for evaluating the three bills that have been referred to the Senate Finance Committee. They are S.410, the "Community Nursing Centers Act of 1983;" S.1244, the "Senior-Citizens Independent Community Care Act;" and S.1614, the "Health Care Coordination Act of 1983." It is our view that these three bills, and others that the committee may eventually consider, should be evaluated according to their ability to accomplish the following major changes:

- increase financial protection to individuals;
- integrate the flow of funding;
- integrate delivery systems and provider responsibility; and
- provide incentives for efficient behavior.

It is important to stress that the long-term care system, unlike the acute care system, requires major change in each of these areas. When this committee deliberates the problems in acute care, their attention is often focussed on the fourth point - the need to reform reimbursement or payment mechanisms to give incentives for efficient behavior. In long-term care, improving payment systems will not be enough. Unlike acute care, few people have financial protection against the cost of long-term care; for the most part, acceptable delivery systems don't exist and access to community-based services is limited. Because these first three problems are unique to long-term care, they deserve additional discussion.

The most basic problem with long-term care financing is the lack of financial protection for individuals. In contrast to the acute care sector, where in 1981 public insurance (Medicare) and private insurance covered nearly 92 percent of the elderly's hospital bill, insurance covered only 3 percent of the nursing home bill in the same year, 2 percent by Medicare and 1 percent by private insurance. The lack of insurance creates catastrophic costs for individuals who become dependent because of chronic illness and leads to the impoverishment of many elderly people and their spouses. Individuals paid over 44 percent of the nursing home bill directly in 1981 - more than $10 billion. Again, this contrasts with hospital costs, where only 3 percent of total spending was paid out-of-pocket by individuals.

This pattern of private spending creates a problem for Medicaid, which becomes responsible not only for the poor (as with AFDC, AB, and AD), but also for people who were not poor before they became chronically ill. About half of the people on Medicaid in nursing homes were not on Medicaid when they entered, but they later became eligible by "spending down" to the point where their resources were no longer sufficient to meet their costs.

This spend-down provision in Medicaid has created one of the most problematic processes in health policy. Faced with long-term care costs that could wipe out a life's savings, individuals and families have incentives to transfer and shelter assets in such a way that they qualify for Medicaid support. Faced with rising spending, state Medicaid programs seek harsher and broader authority to attach assets and require families to support their impaired elders. It is difficult to blame either side - the states for trying to protect the integrity of a means-tested welfare program, or the individuals and families for trying to avoid impoverishment by using the one "insurance" program available to them. Both Medicaid and the beneficiaries face a problem, but the problem is not really so much in the actions of either side as it is in the nature of the underlying problem: the lack of any alternatives between catastrophic spending and welfare for paying the costs of severe chronic illness. Thus, new public or private financing mechanisms are needed to give older persons financial protection.

Characteristics of the delivery system are not unrelated to the characteristics of the financing system. First, there is a separation among the delivery systems for acute care, institutional chronic care, and community-based social support. Separate funding and regulatory systems have inhibited related professionals and agencies from managing and coordinating the interfaces of their services. Second, and related to this, it is often the responsibility of the individual in need of care of their families to find and put together the services needed to keep the individual out of an institution. This is a challenging job for a professional trained in case management and knowledgeable about financing and service availability. It can be an overwhelming task for a family in crisis. Thus, an integration of financing is required to allow for an integration of service delivery and proper case management.

The 1970s saw the development of a number of demonstration projects aimed at solving "the long-term care problem." Generally, these demonstration projects consisted of the infusion of new service dollars for a variety of home and community-based case management services. For the most part, evaluation of these demonstrations does not reveal cost savings. Critics of these demonstrations have argued that the combination of conflicting goals, lack of authority over resources, and lack of financial incentives resulted in these programs being rather weak interventions in the delivery system. They suggest that integrated systems that give the provider financial incentives to make efficient resource allocation decisions could lead to improved system outcomes. This lack of demonstrated cost savings has resulted in policy makers at all levels being very cautious about the expansion of long-term care benefits. It should be noted that this cautious attitude predates the current administration and current economic conditions.

In this way, financing and service delivery characteristics feed on one another to create a "Catch-22" phenomenon in long-term care. Promising steps have been taken in demonstrating integrated and adequate service delivery systems, but better financing is need to test out more powerful and, hopefully, more efficient systems. But adequate financing can be obtained only if the government and/or private insurers are shown that the systems for delivering services and managing access to them can be created such that costs can be predicted and controlled.... But, without continued and probably broader financing of more consolidated long-term care systems, no assurances can be given that costs can be predicted and controlled... and so on.

Thus, the goal of any piece of long-term care legislation should be aimed at breaking this Catch-22. It is for this reason that <u>we believe that these</u>

bills should be judged against the criteria of increased financial protection, integration of financing, and integration of delivery systems. Furthermore, we believe that this must be accomplished in the context of reimbursement systems that provide incentives for efficient behavior.

Although the main objective of our testimony was to provide the above framework for evaluation, and not actually to evaluate the bills, it would be instructive to briefly examine these bills to see which of the potential major changes were incorporated into them and how their structure and incentives might impact upon who is served, what delivery entities evolve, and how costs are affected and distributed.

We have provided in our testimony, Table 1, a checklist of the possible solutions that are incorporated in each bill. But, rather than go through each item for each bill, we would like to make a few general observations regarding similarities and differences among them.

Two characteristics common to all three bills are a strong case management component and, from the federal perspective, capitation payment. However, with regard to the former, S.410 is far more prescriptive than S.1244 or S.1614 regarding the form and structure that case management should take. Indeed, it may be the case that it goes too far in that direction to allow for the necessary flexibility at the local level. S.410 is more prescriptive than the other two bills in another aspect that is not displayed in Table 1. S.410 calls for the development of only one provider agency per catchment area unless it can be documented that one agency cannot adequately serve all individuals in that area. Thus, it precludes the use of competition as a device to improve efficiency.

S.410 differs from the other two bills in another important way. Both S.1244 and S.1614 integrate the responsibility for both acute and chronic

TABLE 1

EVALUATING ALTERNATIVE LONG-TERM CARE BILLS

Possible Solution	Senate Bill		
	S.410	S.1244	S.1614
Financing:			
Integrate Medicare/ Medicaid Funds	No	No	Yes
Financial Protection for Individuals not Eligible for Medicaid	Yes	Yes	No
Delivery/Services:			
Case Management	Yes	Yes	Yes
Same Agency Responsible for Both Acute and Chronic Care	No	Yes	Yes
Same Organization Responsible for Care Regardless of Change in Health Status	No	No	Yes
Reimbursement Incentives:			
Capitation (from Federal Perspective)	Yes	Yes	Yes
Risk-Sharing with:			
State	No	No	Yes
Providers	Yes	Yes	Determined by State

care. They do this by making the same provider entity responsible for the full spectrum of acute and chronic benefits. S.410 does not do this. As such, it does not fully address the issue of service fragmentation and may result in less efficient resource allocation than the other two bills.

Another aspect of service integration has to do with whom the provider is responsible for serving. In this regard, S.1614 differs from S.410 and S.1244. In S.1614, the same provider organization is responsible for care regardless of a change in the health status of an enrollee. That is not true of the other bills. In the cases of both S.410 and S.1244, if an enrollee's condition either improves such that they no longer require chronic care or it deteriorates to the point to which they require nursing home care, the provider is no longer financially responsible for their care. Thus, under both S.410 and S.1244, there is both the incentive and potential for providers to "dump" heavy care patients.

With respect to both aspects of financing, S.1614 differs from the other two bills. Both S.410 and S.1244 provide some financial protection to chronically-ill and disabled Medicare recipients who are not eligible for Medicaid; S.1614 does not. However, because neither bill protects the recipient against nursing home expenditures, they should be viewed as partial solutions. While S.1614 does not assess financial protection, it is the only bill which directly addresses the need to pool Medicare and Medicaid funding so that care can be efficiently delivered. It should go a long way in providing states the additional flexibility they will need if they are to continue to be the level of government primarily responsible for long-term care.

In terms of payment, all the bills recognize the value of capitation. But only S.1614 tries to place risk-sharing on the state. However, it is for this reason that some states may not be attracted to that bill. We suspect that states will be attracted to S.1244 because it gives them organizational and administrative control over resources that will prevent or delay people from Medicaid eligibility, and it does it without putting the state at any financial risk. For these same reasons, it will be particularly difficult to make accurate cost projections for S.1244 and S.410. Another aspect of S.1614 that might cause states some difficulty is its prohibiition on lock-in or requiring a recipient to participate. This may result in both providers and recipients "gaming the system" to the detriment of the program.

All three bills have the potential for significant provider risk-sharing. While S.410 and S.1244 build it in explicitly, S.1614 leaves it as a state option. We would suspect that if a state decides to participate in S.1614, they will require substantial provider risk-sharing.

As the above discussion suggests, each of the above bills proposes solutions to one or more of the four major problems that plague the long-term care system in this country. However, none of the bills address all of the major problems and they each emphasize a different solution. In this context, it would be useful to briefly compare them to the National Social/HMO demonstration project that is currently underway.

The Social/Health Maintenance Organization (Social/HMO) is a managed system of health and long-term care services geared toward an elderly client population. The Social/HMO will enroll a representative mix of people - from well to significantly impaired. Under this model, a single provider entity assumes responsibility for a full range of acute inpatient, ambulatory, rehabilitative, nursing home care, home health, and personal care services under a fixed budget which is prospectively determined. The Social/HMO is financed through monthly premiums paid by Medicare and by individual enrollees. For Medicaid eligibles, Medicare and state Medicaid agencies share the premium payments. Enrollees, providers, and public third-party payers share risk under the Social/HMO model. Elderly persons who reside in the target service area are voluntarily enrolled through the marketing efforts of the Social/HMO provider entity. Once enrolled, clients are obligated to receive all Social/HMO-covered services through Social/HMO providers, similar to the operations of a medical model health maintenance organization. Thus, the Social/HMO proposes solutions to all four major system problems. However, because of the limited size of the risk pool and the specter of adverse selection, the long-term care benefit for non-Medicaid enrollees will not initially be unlimited. Thus, it will not fully address the problem of financial protection. Nevertheless, the protection that the Social/HMO offers is substantial. At one site, the chronic care benefit will be up to $1000 per month. In no case is it less than $6000 per year.

Because the Social/HMO attempts to change the system in so many ways, its development has required much time and effort. We at Brandeis fully recognize that the Social/HMO concept could not have become a reality without the hard work and dedication of HCFA research and demonstration staff, staffs at the four state Medicaid agencies, and the pioneering efforts of our four sites: SCAN Health Plan (Long Beach, California); Ebenezer Society/Group Health Plan (Minneapolis, Minnesota); Elderplan (Brooklyn, New York); and the Kaiser Health Plan (Portland, Oregon). In addition, the project has received much financial support from several national and local foundations. It is anticipated that three of the sites will begin marketing in January or February 1984 and the other sites will begin in early spring of 1984.

The Social/HMO should provide all levels of government, providers, and potential private insurers with valuable information regarding the feasibility of integrated systems of care that are financed on insurance principles. In addition, because of the large number of continuously enrolled elderly (over 16,000), clinicians and epidemiologists will be able to learn much about improving care to the elderly and the management of chronic conditions.

Neither the Social/HMO nor any of the bills before you fully addresses all of the problems of the current system, nor is any single bill likely to do that. Thus, in your deliberations, it is imperative that you know where you want to go. Do you desire a system that is financed primarily from public dollars, or do you wnat to move it towards private financing via insurance mechanisms or an income strategy? Do you want to shape the nature of the delivery system, or do you want to leave that up to states or the marketplace? What role do you want states to play in managing the system? While you may not have clear answers to all of these questions now, you can and must proceed.

Long-term care for the elderly is fast becoming one of the most important health policy issues of our day. Something must be done. While the choices you face are difficult ones, they are not impossible. Regardless of which methods we ultimately choose to finance long-term care, we know that effective and efficient delivery systems will be required. We know that delivery systems that reduce fragmentation, coupled with risk-sharing, lead to more efficient solutions. As a society, we must break out of the Catch-22 of long-term care. We can begin by supporting and fostering efforts to develop and implement innovative delivery systems. We hope that the framework provided here will be helpful to you in these important and difficult deliberations.

Senator **Durenberger**. Senator Bradley.

Senator **Bradley**. Mr. Chairman, I wondered whether we want to ask both questions simultaneously or direct questions only to Dr. Wallack.

Senator **Durenberger**. Well, I take it you are here together and that was the statement for both of you, right?

Dr. **Wallack**. Well, this is Jay Greenberg. Jay directs our social HMO project. And I think he would be the right one to address to ask any questions regarding social HMO's or a whole host of other questions.

Senator **Bradley**. Do you have any sense of how many people who are now in nursing homes would prefer a home health care setting if they had that option?

Mr. **Greenberg**. Senator, I don't have any information on the numbers that would prefer it. Some circumstantial evidence would suggest that substantial numbers would have preferred having the alternative prior to going in, but I don't have any numbers.

Senator **Bradley**. The recent GAO study talked about the great number of people who need care but are not in nursing homes. Do you have any sense of what kind of care they need and how many they are?

Mr. **Greenberg**. Senator, it's estimated that between 3 and 5 percent are frail, between 1 and 3 percent are extremely frail, and as many as 11 percent would have some need of some type of social service or health-related service. However, I haven't seen any accurate estimates of the net numbers. That is, the difference between those who are getting their needs met either through formal or informal care and those that aren't receiving it, those that are currently falling through the net.

Senator **Bradley**. Would you agree that on average, home health care is less costly than is maintaining an individual in a nursing home?

Mr. **Greenberg**. Again, I think the distinction has to be between for the individual versus the system, and for the individual it also depends on how disabled they are. If somebody requires 24-hour nursing care and 24-hour supervision, I really can't see how it would be less expensive to care for them in the home if there was not informal care that was willing and able to take care of them on a substantial amount of time.

Senator **Bradley**. In 1244, we have a capitation method of payment. Do you feel that is a proper way to go?

Mr. **Greenberg**. Having lived in Minnesota for about 10 years and having been on the board of directors of an HMO for 6 of those 10 years, it would be heresy for me to say anything other than that. [Laughter.]

And, indeed, I believe it's the way to go. I think it's very important that all of the actors have something at financial stake—private payers, providers, and Government.

Senator **Bradley**. Do you see any problems that might flow from that?

Mr. **Greenberg**. I think the problems become technical problems. And that is in terms of the methodologies, because the data are not as good as we would like them, there may be some problems in getting the exact correct payment. You don't want a payment that is too high, and you also don't want a payment that is too low. And so I think we are going to have to all recognize that it isn't the science; that you are not going to be able to start out at the third decimal point. But that I think it is possible to perceive to monitor those systems and to take corrective action as we go along.

Dr. WALLACK. I was just really going to support what Jay said. Not only from what we have learned about HMO's and their ability to use less expensive services. It's also then we start to consider all the kinds of services we want and are appropriate long-term care package. There really are substitutions. We have learned you can keep people in nursing homes—out of the hospital. You can keep people at home, out of the nursing home. Those are very effective substitutions.

However, in fact, unless you really have the ability to somehow cap some of these home services, I think we are all fearful that the thing is just going to explode on us. So I think we can get the kinds of substitutions and still do it in an appropriate way with a capitation system.

Senator BRADLEY. So that would argue for targeting very clearly the population that would be eligible for home health care?

Dr. WALLACK. I don't know if it means targeting the population very early. I think you do want, in fact, to have a caseman system which in fact looks at the chronically ill people and strives, in fact, to manage their care perhaps more than other individuals' care.

But you also have to have a system, it seems to me, that encompasses everyone, much like an HMO. I think largely because of the insurance reason, because, in fact, you get some individuals in there who are healthy to start to support those who are, in fact, sicker.

But there are those substitutions. We don't have a clear progress all the time when someone, in fact, obtains a chronic illness. It's a gradual process. And, therefore, it seems to me that if you wait too long what you are likely to do is only have a very small percentage when, in fact, maybe it's too late to do anything preventive about them.

Senator BRADLEY. We attempted in 1244 to design a coordinated system of care for the elderly, as opposed to having it fragmented all over. Do you think we succeeded?

Mr. GREENBERG. Senator, I think if there was a slight change in that bill that you will have succeeded. And the thing that concerns me about the bill is the fact that if an individual becomes healthy so that they don't require these services, that entity you have developed, in fact, no longer gets payments for these individuals so it takes away the incentive to keep them healthy.

And also if they get very disabled and have to go into a nursing home after 20 days, then that entity is no longer responsible for it. That's the part of the bill I'm concerned about.

Senator BRADLEY. I mean coordination between the home health care agency and the nursing home permit system.

Mr. GREENBERG. Well, this agency, the agency that you will be giving the capitated payment to, as I understand the bill, is no longer a financial risk for an individual that requires more than 20 days of continuous stay in a nursing home. If that's the case, then there's the possibility. I'm not suggesting that the agency would do so. But there is the possibility, and it would be in their financial best interest if a patient is very, very heavy care to try to get them certified into a nursing home. And then, in essence, be rid of that heavy care patient.

Senator DURENBERGER. Senator Packwood.

Senator PACKWOOD. How soon would you expect some definitive results out of the social HMO test?

Mr. GREENBERG. Three out of the four social HMO's will be, hopefully, marketing in January. And the fourth one will be begin marketing, hopefully, in the spring.

I would guess that it will be 2 years before we have good evidence with regard to the cost-effectiveness, if you will, of it. However, I think that we have a certain amount of evidence already, difference kinds of evidence. That is, whether or not organizations are willing to participate in this; whether or not consumers and consumer groups are excited about it; whether or not States are getting interested in the concept. And all of that evidence suggests that people feel that the concept is right. But in terms of cost-effectiveness, I would venture at least 2 years.

Senator PACKWOOD. Thank you.

Senator DURENBERGER. John Heinz, do you want to take time for an opening statement?

Senator HEINZ. No, Mr. Chairman. I ask unanimous consent that the text of my statement be put in the record.

[Statement of Senator John Heinz follows:]

OPENING STATEMENT BY SENATOR JOHN HEINZ

Good morning. I would like to begin by thanking my distinguished colleague from ~~Minnesota,~~ Senator Durenburger, for chairing this second in a series of long-term care hearings. I am very pleased that the Senate Finance Health Subcommittee is beginning to respond to the nation-wide demand for long-term care reform.

Just two weeks ago, at the first of our hearings, members of this subcommittee heard some sobering testimony. Witnesses appearing before us reviewed the major problems in the delivery of long-term care. First, we were told that the delivery of long-term care is marred by the absence of careful planning: Persons who are not eligible for public welfare may purchase, at great cost, individual health and social services—if such services are available. For individuals whose frail or disabled condition and income level have made them eligible for public welfare, services may be provided and financed through a variety of public welfare programs. In either case, however, there seems to be no comprehensive design or coordination to the delivery of their care.

Second, the number of persons requiring long-term care services has increased significantly and will continue to increase over the next few decades, intensifying the current demand for services. The demand for services resulting from projected increases in the numbers of persons older than 75 will be compounded by two significant factors. Many States are limiting the supply of nursing home beds in order to restrain Medicaid program costs. With fewer nursing home beds available, the demand for alternative services will grow. And, more home and community-based services will be needed if Medicare's new DRG payment plan successfully shortens hospital stays, discharging patients who are still in need of some level of care.

The third and inescapable problem is cost. Current financing mechanisms largely determine the ways in which services are delivered and which services are provided. The Medicare and Medicaid programs encourage overutilization of hospitals and nursing homes. The General Accounting Office told the committee that persons requiring long-term care services and their families prefer to avoid institutional care and would rather rely on a variety of home and community-based services—if such services were available and affordable. We seem to be encouraging older Americans to use the most costly, less appropriate and least preferred form of care.

As is often the case, those witnesses who came to the Finance Committee bearing bad news, came with few solutions.

We are here today to look at legislative proposals that make an honest attempt to achieve real reform in long-term care. Both of the bills offered by Senators Packwood, Bradley and myself, S. 1614 the Health Care Coordination Act of 1983 and S. 1244, the Senior Citizen Independent Community Care Act, address some if not all of the problems described in the last hearing. S. 1244 would provide home and community-based services to frail Medicare beneficiaries. The bill would not only help to keep the frail elderly at home and out of nursing homes, but also help slow down the devastating "spend down" problem—by that I mean the ways in which middle income familes are forced to impoverish themselves in order to become eligible for long-term care services.

The Health Care Coordination Act of 1983, S. 1614 allows States to provide coordinated health and community-based services, both acute and long-term care, to persons eligible for benefits under both the medicare and medicaid programs. The bill encourages States to manage the entire spectrum of health services to persons who often have the greatest trouble gaining access to the services they need most.

These dually eligible persons are, in large part, the poorest, oldest, and frailest in our country. These are the people who are falling between the gaps. They are sicker than the medicare-only population. They have a greater need for ongoing custodial and personal care. Even when institutional placement is appropriate, many cannot find an available nursing home bed. Yet, at the same time, they are unable to get the support services they need to remain in the community.

The bills that we will hear about today are by no means redundant or mutually exclusive. In combination, they incorporate what I believe to be the 6 key principals of long-term care reform: First, reimbursement should cover the entire range of long-term care services, including individual assessment and case management. Second, acute and long-term care services should be better coordinated. Third, savings should be captured by reducing unnecessary hospital utilization. Fourth, prepaid capitated plans, that provide incentives for cost-effective care should be encouraged. Fifth, States and local governments should have maximum flexibility to structure programs appropriate to local conditions and needs. And sixth, services should be targeted first to those most in need of care.

Mr. Chairman, I look forward to an interesting and productive hearing.

Senator DURENBERGER. Without objection, it is so ordered.

Senator HEINZ. Thank you. Mr. Greenberg, Mr. Wallack, each of the bills that you mentioned and were looking at uses capitated payments of finance benefits, but none of the financing methods are exactly alike. What do you use in the way of a financing method for the social HMO at least for experiments?

Mr. GREENBERG. We use the payment system that medicare currently uses, or a modification of the payment system that medicare currently uses to pay HMO's that are on a risk concept. The so-called AAPCC. There is one very important adjustment. And the adjustment is that we will be—for individuals that would be certified as requiring institutional care but remain in the community, we will be reimbursed at the higher institutional rate for those individuals.

Senator HEINZ. In S. 1614 we use the AAPCC. For those dually eligible enrollees who aren't frail, we pay 95 percent of the AAPCC. For those who are frail, medicare will pay 95 percent of the institutional AAPCC. Do you want to comment on that?

Mr. GREENBERG. Well, since it mirrors somewhat what we are doing in the social HMO, I think it's a reasonable way to approach it.

Senator HEINZ. Good; now in the bills before the committee today, one of the things that we are trying to do is reduce excessive hospital utilization stays. In S. 1614 we think we are trying to do that, to reduce hospital stays, and achieve medicare part A savings. Do you think it is reasonable for us to assume that in fact we will achieve part A savings?

Dr. WALLACK. I think there is already some evidence that suggests for the elderly the comprehensive kinds of care can significantly reduce hospitalization. There again have been small studies at looking at the very frail elderly in nursing homes that have shown reductions in hospitalization approaching 50 percent. There have been other studies that have looked at—there are now a number of HMO's participating and have elderly enrolled in them. And they are also showing large savings with regard to hospitalization.

The answer is "Yes." That is a real possibility. And the real question will be the size of those kinds of savings.

Senator HEINZ. One of the things we have been trying to get from both the Health Care Financing Administration and from CBO is a cost estimate on S. 1614. They have been trying. They haven't been uncooperative, but they have told us that there is not enough information in our bill for them to make such an estimate. They apparently need some help on the assumptions underlying the legislation.

Would it be possible based on your experience with the Health Care Financing Administration and the social HMO's to assist them and us in helping to specify necessary assumptions?

Dr. WALLACK. I think we could probably assist them if we find out sort of some of their issues that they are dealing with. There are some real conceptual problems that one would have to deal with in terms of structuring this rate. And to try to figure out particularly what would be the participation rate. How many States? How many individuals? You have got a voluntary system.

There are some calls one would have to make. And we could certainly deliberate over those as well as, in fact, how to appropriately deal with the reimbursement rate.

Senator HEINZ. We would really welcome that kind of help. I think all of us would.

Finally, in page 8 of your testimony you indicate that because of S. 1614's prohibition on beneficiary lock in the bill may allow providers and recipients to game the system to the detriment of the program. What could we do about that?

Mr. GREENBERG. Well, what some State medicaid programs are involved now, particularly in their medicaid competition demonstrations, and through section 2175 waivers, is requiring them to participate with or through particular providers and particular provider structures, so it would seem to me that it if a State desired it that if they felt that these programs that they were developing through your legislation were, in fact, cost effective to require participation through them.

Senator HEINZ. Thank you.

Senator DURENBERGER. I have a couple of questions on this social HMO. You talked about the high-low problems. You talked about the AAPCC problems. Are there any other difficulties we ought to get on the record in coming up with a capitation payment?

Mr. GREENBERG. I think there are a couple of things about the social HMO that make the payments trickier, if you will. And that has to do with the fact that since this has to be sold in a somewhat competitive environment that we don't know how much adverse selection we are going to entail and how much we are going to underestimate the true need in our population.

One of the advantages of the social HMO is that it is a broader benefit package that anybody can purchase today. One of the problems in a place like Minnesota where there are five or six HMO's selling more traditional service packages and HMO's and having been allowed to health screen on part of those is that there may well be a lot of people out there who are very, very frail, and the social HMO, which will not be health screening as such, may wind up with more than its fair share of disabled individuals. So that's going to be a difficulty.

Senator DURENBERGER. What will be the range in monthly premiums for the medicare only enrollees across your demonstration?

Mr. GREENBERG. Well, again, we have four sights. And three of them we have hard numbers on. One of them is in its—the one in California we don't have hard numbers. Of the three sides of the Brooklyn, the Minneapolis, and the Portland, Oreg., the lowest is the Minneapolis. The monthly payment of the medicare combined is around $221 a month, $29 of that is private premium. The highest is the Kaiser-Portland with a total of $259, and $40 of that is private premium.

Senator DURENBERGER. I guess I can understand why it might be, in the beginning, necessary to limit the long-term care benefits for nonmedicaid enrollees. But why will the different sights have different levels of protection? Is it just a matter of chronic care benefits being more expensive at one place than it is another?

Mr. GREENBERG. No; I think if you look across them and you look at who has the highest chronic care benefit and who has the lowest, it has a lot to do with the marketplace, and with competition in the marketplace, and the fear of adverse selection as a result of that. So what we see is that the Minneapolis one is coming in with the lowest chronic care benefit and Portland, Oreg., the Kaiser, coming in with the highest chronic care benefit. I guess while one can deliberate or argue over the virtues of competition. The real question is if we have a fledgling or a baby when it grows up, we think, can compete, how early do we put it into the wilderness to fend for itself.

Senator DURENBERGER. Let me finish with a general question on the Federal role. In my opening statement and you in your comments talked about some of the problems with the Federal involvement in the financing and the provision of long-term care. Would you tell us why the Federal involvement is important and what are the things that we should be careful to avoid as we involve ourselves, and then maybe some comments on the private sector insurance side? Why haven't we seen more, and what will it take? Is it just a matter of our having to decide where we are going before the private sector steps in?

Dr. WALLACK. I think the Federal involvement is terribly important. And I think a good case in point is the kind of model we are developing for insurance from the social HMO. It's really built upon medicare. And it's extending medicare, and trying to, in fact, incorporate private premiums. There is no question with the money you are spending on medicare, the money you are spending on medicaid that that is instrumental in developing any kind of a benefit package for the elderly, and that, in fact, includes insurance.

I think the other point I made before. And I don't know whether that means you pay all of it. I think that is really a question. And with the constraints on the budget, I think at this point that is unrealistic to consider that. However, the dollar is the key. And the ability to leverage those dollars or allow those dollars to be used in an effective way and appropriate way for an innovative system is very important.

The other part of the Federal role that I mentioned is that we have got an awful lot to learn about the delivery system. And it seems to me that that is only going to happen to some extent with this thing being facilitated perhaps by the Federal Government.

With regard to private insurance, I suspect we are going to see a little bit more of it. We are now seeing some smaller insurance companies like Firemen's Fund and some others start to offer insurance for long-term care. I suspect though in the long run it may come more from the delivery side, much like health insurance came from the providers, the hospitals in the 1930's.

As these deliverers of care, as these providers see the need to finance this care, they may, in fact, become innovative. And part of it goes back to why private insurance hasn't grown and why it hasn't happened. I mean I sit there sort of sometimes amazed that it is clearly a market. There are a lot of elderly. And we are finding in our marketing studies that these people want that protection. They start to realize it. Why, in fact, hasn't it happened? I think there are probably a number of reasons for it. Insurance companies are conservative about getting into new areas. They are run by actuaries. They, in fact, are very concerned about the adverse selection issue and don't know necessarily how to deal with that. But also in fact the major ones don't market to that population. They market to employers. And employers right now are concerned with health care costs and disabilities. They are not concerned with their employees 20 years down the road. And they are not thinking, therefore, about long-term care insurance.

So, in fact, given the reaction in the marketplace, I think it's unlikely that it will come from the traditional insurance company. I do, however, think it may come from the providers of care. You may know about the life care community. It's a retirement community. They have, in fact, proven insurance can really work in those systems. They can be actuarially sound. So it's clear to me you can do insurance in those models.

I think we will see more innovation. And I think to the extent this committee and others can encourage it, I think we will learn something.

Senator DURENBERGER. Thank you.

Any other questions?

[No response.]

Senator DURENBERGER. Thank you very much for your testimony. We appreciated it a great deal.

Our next witness is Larry Oday, Director of Bureau of Eligibility, Reimbursement and Coverage for the Health Care Financing Administration of the Department of Health and Human Services, along with trusty aides.

Larry, your full statement will be made part of the record. And you may proceed to summarize it.

[The prepared statement of Mr. Oday follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

LARRY ODAY

DIRECTOR, BUREAU OF ELIGIBILITY,

REIMBURSEMENT AND COVERAGE

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

NOVEMBER 14, 1983

I AM PLEASED TO BE ABLE TO SHARE WITH YOU THE ADMINISTRATION'S VIEWS ON THREE BILLS--S. 1244, S. 1540 AND S. 1614--AIMED AT BROADENING HOME AND COMMUNITY CARE SERVICES AVAILABLE TO THE MEDICARE AND MEDICAID POPULATIONS. WITH ME IS MR. ROBERT STREIMER, DIRECTOR OF THE OFFICE OF COVERAGE POLICY, AND DR. THOMAS KICKHAM, CHIEF OF THE LONG TERM CARE REIMBURSEMENT BRANCH OF THE OFFICE OF RESEARCH AND DEMONSTRATIONS. WHILE EACH BILL HAS ITS UNIQUE FEATURES AND ADDRESSES DIFFERENT GROUPS, THEY ALSO HAVE SEVERAL COMMON FEATURES. THESE MAY BE DESCRIBED AS FOLLOWS:

1. A COMMON PERCEPTION OF THE PROBLEM. EACH IS CONCERNED WITH THE INCREASED AGING OF THE POPULATION AND THE ACUTE CARE BIAS OF MEDICARE, AND EACH PRESUMES THAT MANY OF OUR ELDERLY HAVE UNMET PERSONAL CARE NEEDS.

2. AN ASSUMPTION THAT INCREASED HOME AND COMMUNITY-BASED CARE IS THE MOST COST-EFFECTIVE WAY TO ADDRESS THESE NEEDS AS OUR POPULATION AGES. WHILE THE PARTICULAR APPROACHES TO CARE DELIVERY AND PAYMENT DIFFER IN EACH BILL, THEY ALL EMPHASIZE NON-INSTITUTIONAL COMMUNITY-BASED CARE.

3. AN ASSUMPTION THAT STATE ADMINISTRATION IS THE PREFERRED COURSE FOR BOTH MEDICARE AND MEDICAID BENEFICIARIES TO BE SERVED THROUGH THESE AUTHORIZATIONS.

We too recognize the fact that there will be increasing numbers of the elderly and that they will be living longer than has been the case in the past. We recognize that this phenomenon, while a credit to our society and its health care system, will create new stresses on society's imagination and ability to finance and meet the needs of the elderly. Nor have we been idle. We have underway a number of research and demonstration projects to help us develop ideas and insights on how to proceed. I will discuss these projects at a later point in my statement.

We have serious reservations about the three bills under consideration and their long-term care and cost implications for the Medicare and Medicaid programs. Specifically,

-- The eligibility requirements are complex, liable to considerable subjectivity in determining whether an individual might use institutional care, and could lead to a much larger service population.

-- The scope of benefits is broader than in either the Medicare or Medicaid programs today. These expanded services may be more expensive than our existing care structure, and increase costs.

- THE ADMINISTRATION OF THE PROGRAMS THROUGH STATES IS FETTERED WITH MANY PROCESS REQUIREMENTS WHICH DETRACT FROM FOCUSING ON THE APPROPRIATENESS AND QUALITY OF CARE PROVIDED, CREATE UNNECESSARY REPORTING REQUIREMENTS AND RED TAPE, AND ARBITRARILY DECREASE THE FLEXIBILITY NEEDED TO ADMINISTER SUCH PROGRAMS WELL. IN ADDITION, SOME ASPECTS OF THE BILLS DUPLICATE EXISTING MEDICAID AND MEDICARE COVERAGE.

- NO NEW REVENUE RAISING SOURCES ARE SUGGESTED TO FINANCE ANY INCREASED PROGRAM EXPENDITURES BECAUSE MORE SERVICES ARE BEING PROVIDED. THIS IS PARTICULARLY CRITICAL GIVEN THE LOOMING INSOLVENCY OF THE MEDICARE TRUST FUND, AND STATE AND FEDERAL CONCERNS TO CONTAIN MEDICAID COSTS.

FOR THE REASONS JUST MENTIONED, OUR ACTUARIES HAVE BEEN UNABLE TO MAKE EVEN ROUGH ESTIMATES OF THE SIZE OF THE COST OF ANY OF THESE BILLS. WE OPPOSE THE PASSAGE OF LEGISLATION WITH SUCH UNKNOWN FINANCIAL CONSEQUENCES FOR OUR PROGRAMS.

I WOULD NOW LIKE TO BRIEFLY COMMENT ON EACH BILL IN THE ORDER IT WAS INTRODUCED IN THE SENATE. MY COMMENTS WILL REFLECT THE TRULY COMPLEX NATURE OF THE PROBLEMS WE FACE.

S. 1244, SENIOR CITIZENS INDEPENDENT COMMUNITY CARE ACT

THIS BILL WOULD ESTABLISH STATE MEDICARE PROGRAMS (IN FOUR STATES FOR THE FIRST FOUR YEARS) OF HOME AND COMMUNITY-BASED CARE FOR PURPOSES OF AVOIDING OR REDUCING INSTITUTIONALIZATION. FINANCING WOULD BE ON A PREPAID CAPITATED BASIS AND WOULD BE ADMINISTERED BY THE STATE.

TO BE ELIGIBILE, AN INDIVIDUAL MUST BE 65 OR OLDER, ELIGIBLE FOR MEDICARE PART A AND ENROLLED IN PART B, NOT INSTITUTIONALIZED OR SCHEDULED FOR DISCHARGE WITHIN 90 DAYS, EVALUATED ON AN ONGOING BASIS THROUGH A DETAILED SET OF CRITERIA BY A "PREADMISSION AND SCREENING TEAM" WHICH DEVELOPS AND UPDATES A WRITTEN PLAN OF CARE, AND HAVE A SPECIFIED DEGREE OF PHYSICAL OR MENTAL IMPAIRMENT.

THE SCOPE OF BENEFITS CONSISTS OF ALL MEDICARE PART A AND B SERVICES PLUS PERSONAL CARE SERVICES INCLUDING ADULT DAY CARE AND RESPITE CARE. A NUMBER OF SERVICES AND BENEFIT COORDINATION REQUIREMENTS ARE ALSO SPECIFIED.

WE HAVE A NUMBER OF PROBLEMS WITH THIS BILL. FOR EXAMPLE, WE CANNOT EVEN PROJECT AN ELIGIBLE POPULATION BECAUSE OF SEVERAL ISSUES, NOT THE LEAST OF WHICH IS THE COMPLEXITY OF THIS BILL.

-- UNMET NEEDS ARE NOT CLEARLY DEFINED. FOR INSTANCE, IF HOMEMAKER SERVICES ARE BEING PROVIDED BY A FRIEND OR A RELATIVE, DO THEY CONSTITUTE AN UNMET NEED?

-- UNMET NEEDS CAN BE SINGULAR OR A COMBINATION OF CONDITIONS. WITH SUCH A SITUATION, ELIGIBILITY MAY QUICKLY CHANGE, DEPENDING ON THE MOST RECENT COMBINATION OF FACTORS. PROGRAM CONTROL IN TERMS OF COSTS AND ADMINISTRATION WOULD BE DIFFICULT.

THERE ARE OTHER ISSUES AS WELL. THE BILL CALLS FOR A CAPITATED RATE AT 60 PERCENT OF THE AVERAGE SKILLED NURSING FACILITY (SNF) RATE IN THE STATE, BUT IT DOES NOT SPECIFY HOW THE BASIC RATE SHOULD BE ESTABLISHED OR WHICH SNF RATE (COST/CHARGES/MEDICARE/MEDICAID) SHOULD BE USED IN ANY SUCH COMPUTATIONS.

S.1540, COMMUNITY HOME CARE SERVICES ACT OF 1983

THIS BILL WOULD ALLOW STATES TO IMPLEMENT PROGRAMS OF COMMUNITY BASED CARE, WHEN MEDICALLY APPROPRIATE AND COST EFFECTIVE. IT WOULD ALSO REQUIRE PERIODIC ASSESSMENTS OF A MEDICAID PATIENT'S NEED FOR LONG TERM CARE SERVICES AND THE DEVELOPMENT OF A PLAN OF CARE TO MEET THOSE NEEDS. UNDER THESE PROGRAMS, A COMPREHENSIVE RANGE OF MEDICAL AND SOCIAL SERVICES WOULD BE PROVIDED IN THE HOME TO MEDICAID PATIENTS

WHO WOULD OTHERWISE REQUIRE INSTITUTIONAL CARE. STATES WOULD ALSO RECEIVE AN ADDITIONAL 10 PERCENT ABOVE THEIR CURRENT MEDICAID REIMBURSEMENT LEVEL AS AN INCENTIVE TO IMPLEMENT THESE PROGRAMS.

WE VIEW THIS BILL AS AN EXPANDED, MORE COMPLICATED, AND MUCH MORE COSTLY VERSION OF EXISTING AUTHORITY FOR STATE PROGRAMS OF HOME AND COMMUNITY-BASED CARE. UNDER EXISTING WAIVER AUTHORITY, PROVIDED BY SECTION 2176 OF THE OMNIBUS RECONCILIATION ACT OF 1981, STATES MAY OFFER SERVICES SUCH AS CASE MANAGEMENT, HOMEMAKER, HOME HEALTH AIDE, PERSONAL CARE, ADULT DAY CARE, HABILITATION CARE, RESPITE CARE, AND/OR OTHER SERVICES THAT WILL RESULT IN THE COST-EFFECTIVE AVOIDANCE OF INSTITUTIONAL CARE. AS OF OCTOBER 1, 38 STATES HAVE BEEN APPROVED TO OPERATE 51 PROGRAMS OF HOME AND COMMUNITY-BASED CARE. THIS RESPONSE TO THE WAIVER PROVISION DEMONSTRATES THAT THE MAJORITY OF STATES HAVE ALREADY INITIATED MEDICAID PROGRAMS OF HOME AND COMMUNITY BASED CARE TAILORED TO THE UNIQUE SERVICE NEEDS AND PROVIDER CAPABILITIES EXISTING IN THEIR COMMUNITIES. THUS, WITHOUT THE DETAILED LEGISLATIVE SPECIFICATIONS AND INCREASED FEDERAL COSTS IN S. 1540, ITS INTENT MAY ALREADY BE REALIZED AND WE SEE NO NEED AT THIS TIME FOR ITS PASSAGE. ONCE INFORMATION IS AVAILABLE ON THE RESULTS OF THESE PROJECTS, WE WILL BE IN A BETTER POSITION TO ASSESS IF CHANGES ARE NEEDED.

S. 1614. HEALTH CARE COORDINATION ACT OF 1983

THIS PROPOSAL WOULD ALLOW STATES TO IMPLEMENT COMPREHENSIVE AND COORDINATED PROGRAMS OF ACUTE AND LONG TERM CARE FOR PERSONS ELIGIBLE FOR BOTH MEDICARE AND MEDICAID. THESE PROGRAMS WOULD BE ALTERNATIVES TO CURRENT MEDICARE/MEDICAID BENEFITS WITH AN EMPHASIS ON EXPANDED HOME CARE TO REDUCE UTILIZATION. WITHIN CERTAIN SPECIFIED CONDITIONS AND RESTRICTIONS, ENROLLMENT WOULD BE VOLUNTARY. THE MEDICARE CONTRIBUTION TO STATES FOR EACH ENROLLEE WOULD BE AT 95 PERCENT OF THE INSTITUTIONAL ADJUSTED AVERAGE PER CAPITA COST FOR SNF AND INTERMEDIATE CARE FACILITY (ICF) PATIENTS AS DETERMINED FOR HMO REIMBURSEMENT.

STATES WOULD PAY THE MEDICARE PART B PREMIUM FOR EACH ENROLLEE AND WOULD BE PAID FOR PREMIUM COSTS UNDER EXISTING MEDICAID PROVISIONS. STATES WOULD HAVE THE DISCRETION TO CHOOSE AMONG THE VARIETY OF PAYMENT MECHANISMS FOR PROVIDERS.

OUR PROBLEMS WITH THIS BILL ARE SIMILAR TO THOSE WE HAVE WITH S. 1244. ELIGIBILITY IS SO LOOSELY DEFINED THAT WE ARE UNABLE, WITHIN THE DUALLY ENTITLED POPULATION TO IDENTIFY OR

TO ESTIMATE THE NUMBER OF PEOPLE WHO MIGHT MEET THE REQUIREMENTS OF DEPENDENCE ON PERSONAL ASSISTANCE. NOR DO WE HAVE THE ABILITY TO IDENTIFY OR ESTIMATE THOSE "WHO WOULD OTHERWISE BE INSTITUTIONALIZED" OR THE "FRAIL ELDERLY." CONSEQUENTLY, WE CANNOT ESTIMATE THE PROGRAM'S COSTS IN A WAY THAT WOULD ALLOW US TO KNOW THE MAGNITUDE OF THE COST OF THE PROGRAM MUCH LESS WHETHER IT WOULD BE COST EFFECTIVE. HERE, TOO, THE POTENTIAL DIVERSITY OF SERVICE ALTERNATIVES AND THEIR LOOSELY DEFINED RELATIONSHIP TO EXISTING MEDICARE/MEDICAID BENEFITS MAKE IT IMPOSSIBLE FOR US TO ASSESS THE CONSEQUENCES OF IMPLEMENTATION.

HAVING BRIEFLY OUTLINED SOME OF OUR COMMENTS ON AND OBJECTIONS TO THESE THREE BILLS, I WOULD NOW LIKE TO REVIEW OUR CURRENT ACTIVITIES THAT WE ANTICIPATE WILL PROVIDE US WITH DATA FOR DECISION MAKING ON THIS SUBJECT.

RESEARCH AND DEMONSTRATION ACTIVITY

RECOGNIZING THE TREND TOWARDS EXPANDED HOME HEALTH CARE AND THE DILEMMA IT COULD POSE FOR PROGRAM COSTS, THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND OTHER AGENCIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAVE UNDERTAKEN A NUMBER OF RESEARCH AND DEMONSTRATION ACTIVITIES. THESE EFFORTS ARE FOCUSED PRIMARILY ON COMMUNITY-BASED CARE AND

TRAINING RECIPIENTS UNDER THE AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM TO PROVIDE HOMEMAKER AND HOME HEALTH AIDE SERVICES. LET ME SUMMARIZE WHAT WE ARE DOING IN THESE DEMONSTRATIONS.

COMMUNITY-BASED CARE

THE HEALTH CARE FINANCING ADMINISTRATION AND THE OFFICE OF HUMAN DEVELOPMENT SERVICES HAVE INITIATED A NUMBER OF COMMUNITY-BASED CARE PROJECTS TO TEST WHETHER THE PROVISION AND MANAGEMENT OF AN APPROPRIATE MIX OF IN-HOME HEALTH AND SOCIAL SERVICES DIRECTED AT INDIVIDUAL CLIENT NEEDS WILL REDUCE BOTH TOTAL CARE COSTS AND INSTITUTIONAL CARE COSTS WITHOUT SACRIFICING QUALITY OF CARE. FINDINGS FROM SEVERAL EARLIER DEMONSTRATIONS HAVE BEEN MIXED. SOME PROJECTS HAVE SHOWN SIGNIFICANT REDUCTIONS IN MORTALITY AND HIGHER LEVELS OF SELF-MAINTENANCE AND SATISFACTION FOR DEMONSTRATION PARTICIPANTS VERSUS COMPARISON GROUP MEMBERS. HOWEVER, OTHER STUDIES CONDUCTED BY HCFA AND THE GENERAL ACCOUNTING OFFICE (GAO) INDICATE THAT AN EXPANSION OF HOME HEALTH SERVICES CAN BE MORE COSTLY THAN NURSING HOME CARE IF THERE IS A LACK OF TARGETING, THAT IS, IF THE INDIVIDUALS SERVED ARE NOT TRULY AT RISK OF INSTITUTIONALIZATION.

AN EVALUATION OF THE COMMUNITY CARE DEMONSTRATIONS IS NOW BEING PERFORMED UNDER CONTRACT, AND WE WILL RECEIVE A FINAL REPORT IN EARLY 1984.

THE FINDINGS FROM OUR COMMUNITY CARE DEMONSTRATIONS ARE SIMILAR TO THOSE REPORTED TO YOU, MR. CHAIRMAN, BY THE GAO IN ITS 1982 REPORT ON EXPANDING HOME HEALTH CARE. THE GAO FOUND THAT EXPANDED HOME HEALTH SERVICES INCREASED THE LONGEVITY AND SATISFACTION OF CHRONICALLY ILL, ELDERLY PATIENTS. HOWEVER, THESE SERVICES DID NOT REDUCE NURSING HOME OR HOSPITAL USE OR TOTAL SERVICE COSTS. THE GAO RECOMMENDED FURTHER EVALUATION OF THE EFFECTS OF EXPANDED HOME HEALTH CARE ON INDIVIDUALS WHO ARE MOST AT RISK OF INSTITUTIONAL CARE, AND OF HOW HOME CARE SHOULD BE ORGANIZED FOR MAXIMUM EFFICIENCY AND EFFECTIVENESS.

PARTIALLY AS A RESULT OF THE FINDINGS FROM THE COMMUNITY-BASED CARE DEMONSTRATIONS, HCFA AND THE DEPARTMENT HAVE IMPLEMENTED A MAJOR RESEARCH PROJECT, THE NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION, IN TEN PROJECT SITES (LYNN, MASSACHUSETTS; CLEVELAND, OHIO; RENSSELAER COUNTY, NEW YORK; PHILADELPHIA, PENNSYLVANIA; MIAMI, FLORIDA; MIDDLESEX COUNTY, NEW JERSEY; BALTIMORE, MARYLAND; HOUSTON, TEXAS; PORTLAND, MAINE; AND EASTERN KENTUCKY). THIS DEMONSTRATION BUILDS UPON OUR PREVIOUS EFFORTS BY TARGETING THE POPULATION

MOST AT RISK OF INSTITUTIONAL CARE AND BY PROVIDING SUFFICIENT ATTENTION TO MAINTAINING AND STRENGTHENING INFORMAL PROVIDERS OF CARE, PARTICULARLY FAMILIES, FRIENDS, AND VOLUNTEERS.

THE CHANNELING DEMONSTRATION IS DESIGNED TO DETERMINE WHETHER THE LONG-TERM CARE NEEDS OF ELDERLY IMPAIRED PERSONS CAN BE MET IN A COST-EFFECTIVE WAY THROUGH A COMMUNITY-BASED SYSTEM OF COMPREHENSIVE NEEDS ASSESSMENT, CARE PLANNING AND CASE MANAGEMENT. THE PROJECTS GENERALLY COMBINE INNOVATIVE APPROACHES TO THE ORGANIZATION AND DELIVERY OF SERVICES WITH BROADER SERVICE PACKAGES. THE FINAL REPORT ON THIS DEMONSTRATION WILL BE AVAILABLE IN SEPTEMBER 1985.

AFDC HOME HEALTH AIDE PROJECTS

ON JANUARY 1, 1983, THE AFDC HOME HEALTH AIDE DEMONSTRATION BEGAN ITS OPERATIONAL PHASE IN THE STATES OF ARKANSAS, KENTUCKY, NEW JERSEY, NEW YORK, OHIO, SOUTH CAROLINA AND TEXAS. UNDER THIS DEMONSTRATION, ELIGIBLE AFDC RECIPIENTS WILL BE TRAINED AND EMPLOYED AS HOMEMAKERS AND/OR HOME HEALTH AIDES. EACH STATE WILL TRAIN UP TO 500 AFDC RECIPIENTS TO PROVIDE LONG-TERM CARE SERVICES TO ELDERLY AND DISABLED INDIVIDUALS WHO WOULD LIKELY BE INSTITUTIONALIZED WITHOUT THESE SERVICES.

THE MAJOR ISSUES TO BE EXAMINED IN THE DEMONSTRATION ARE: (1) THE EXTENT TO WHICH TRAINING AFDC RECIPIENTS AS HOMEMAKERS AND HOME HEALTH AIDES IS FEASIBLE AND RESULTS IN EVENTUAL NON-SUBSIDIZED, PRODUCTIVE EMPLOYMENT FOR THE TRAINEES; AND (2) WHETHER THE PROVISION OF HOMEMAKER AND HOME HEALTH AIDE SERVICES TO ELDERLY OR DISABLED INDIVIDUALS, WHO WOULD NOT OTHERWISE RECEIVE THOSE SERVICES, RESULTS IN A LOWER USE OF INSTITUTIONAL CARE. THE EVALUATION OF THIS DEMONSTRATION WILL BE CONDUCTED UNDER SEPARATE CONTRACTS WITH THE SEVEN PARTICIPATING STATES AND IS SCHEDULED FOR COMPLETION IN JUNE 1986.

OTHER STUDIES

IN NEW YORK, A DEMONSTRATION PROJECT IS DEVELOPING A SYSTEM OF FINANCIAL INCENTIVES TO ENCOURAGE THE MOST COST-EFFECTIVE CARE FOR MEDICAID PATIENTS REQUIRING POST HOSPITAL SKILLED NURSING SERVICES. THE PURPOSE OF THIS DEMONSTRATION IS TO REDUCE THE BACK UP OF HOSPITALIZED MEDICAID PATIENTS AWAITING PLACEMENT TO SUBACUTE LEVELS OF CARE.

THE SYSTEM TO BE DEVELOPED WILL INVOLVE THE PAYMENT OF A CAPITATION RATE BY MEDICAID, FOR ELIGIBLE PATIENTS, TO COVER THE COST OF POST-HOSPITAL LONG TERM CARE. THE CAPITATION RATE IS INTENDED TO COVER THE HOSPITALS' COSTS FOR THE

PATIENTS' ALTERNATE CARE STAY TO THE EXTENT THAT THEY EXCEED THE AVERAGE SKILLED NURSING FACILITY PER DIEM FOR THE AREA. THE BALANCE OF THE CAPITATION PAYMENT WILL CONSTITUTE THE FINANCIAL INCENTIVE.

CONCLUSION

HOME HEALTH CARE IS NOW ENTERING A PERIOD OF RAPID EVOLUTION. IN RESPONSE TO THE DESIRE OF MANY ELDERLY AND DISABLED PATIENTS TO REMAIN IN THEIR HOMES, RATHER THAN BEING ADMITTED TO INSTITUTIONS FOR MEDICAL CARE, MORE PEOPLE VIEW HOME CARE AS A FUNDAMENTAL COMPONENT OF THE HEALTH CARE CONTINUUM NECESSARY TO MEET LONG-TERM MEDICAL AND SOCIAL NEEDS. HOWEVER, THE IMPLICATIONS OF THIS EMERGING CONCEPT NEED CAREFUL EXAMINATION. JUST THE AGING OF THE AMERICAN POPULATION CAN CAUSE US TO EXPECT INCREASED DEMAND FOR HOME CARE AND INCREASED DEMAND WILL CERTAINLY MEAN INCREASED COSTS.

MOREOVER, EXPERIENCE HAS TAUGHT US THAT WE SHOULD NOT RUSH INTO NEW BENEFIT PROGRAMS OR SIGNIFICANT MODIFICATIONS TO EXISTING PROGRAMS WITHOUT FIRST WEIGHING CAREFULLY THE EFFECTS ON QUALITY AND COST. AT A TIME WHEN COST CONTROL IS AN ABSOLUTE REQUIREMENT FOR THE PRESERVATION OF THE MEDICARE

AND MEDICAID PROGRAMS, WE NEED TO BE VERY PRECISE ABOUT HOW WE STRUCTURE THESE PROGRAMS TO MEET PATIENT NEEDS. DATA AND INFORMATION ARE JUST BEGINNING TO COME IN ON THE HOME AND COMMUNITY-BASED CARE WAIVER PROGRAMS. IN ADDITION, OUR DEMONSTRATIONS AND EVALUATIONS ARE JUST BEGINNING TO PROVIDE DATA, WITH MUCH VALUABLE INFORMATION DUE TO BE REPORTED DURING THE NEXT FEW YEARS.

MR. CHAIRMAN, I BELIEVE WE HAVE A MUTUAL OBJECTIVE: TO ASSURE THE DELIVERY OF GOOD QUALITY CARE IN THE MOST APPROPRIATE SETTING WITHOUT CONTRIBUTING TO THE ALARMING GROWTH IN COSTS WHICH I MENTIONED EARLIER.

I AM SURE YOU CAN UNDERSTAND WHY IT IS CRITICALLY IMPORTANT THAT WE EXAMINE THE DATA FROM THE WAIVER PROGRAMS AND FROM OUR DEMONSTRATIONS. ONLY THEN CAN WE BE IN A POSITION TO CONSIDER DESIGNING IMPROVED HOME HEALTH COVERAGE THAT WILL SUPPORT THE CONTINUED VIABILITY OF THE MEDICAID AND MEDICARE PROGRAMS AS WELL AS FEDERALLY FINANCED SOCIAL SERVICES FOR FRAIL ADULTS. TO ACT PREMATURELY AND WITHOUT ADEQUATE KNOWLEDGE WOULD PROVE DETRIMENTAL TO THEIR FINANCIAL VIABILITY.

I WOULD BE PLEASED TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

STATEMENT OF LARRY ODAY, DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT, AND COVERAGE, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ODAY. Thank you, Mr. Chairman. I will present a condensed version of my prepared statement, and then will be pleased to answer your questions.

I am pleased to be able to share with you the administration's views on three bills—S. 1244, S. 1540, and S. 1614.

With me on my left is Mr. Robert Streimer, Director of the Office of Coverage Policy. And on my right is Dr. Thomas Kickham, the Chief of the Long-Term Care Reimbursement Branch, Office of Research and Demonstrations.

While each of these bills has its unique features and addresses different groups, they also have several common features. These may be described as follows:

One, a common perception of the problem. Each is concerned with the increased aging of the population and the acute care nature of medicare, and each presumes that many of our elderly have unmet personal care needs.

Two, an assumption that increased home and community-based care is the most cost effective way to address these needs of our population.

Three, an assumption that State administration is the preferred course for both medicare and medicaid beneficiaries to be served through these authorizations.

We have serious reservations about all three bills. For example, the eligibility requirements are complex, susceptible to considerable subjectivity in determining whether an individual might use institutional care, and could lead to a much larger service population. The scope of benefits is broader than in either the medicare or medicaid programs today. These expanded services may be more expensive than our existing care structure, and increase costs.

For the reasons just mentioned, as well as others, our actuaries have been unable to make even rough estimates of the size of the cost of any of these bills. We oppose the passage of legislation with such unknown financial consequences for our programs.

I would like now to briefly comment on each in the order it was introduced in the Senate.

S. 1244. This bill would establish State medicare programs—in four States for the first 4 years—of home and community-based care for purposes of avoiding or reducing institutionalization. Financing would be on a prepaid capitated basis and the program would be administered by the State.

We have a number of problems with this bill. For example, we cannot even project an eligible population. Unmet needs are not clearly defined. For instance, if homemaker services are being provided by a friend or a relative, do they constitute an unmet need? Unmet needs can be singular or a combination of conditions. With such a situation, eligibility may quickly change depending on the most recent combination of factors.

There are other issues as well. The bill calls for a capitated rate at 60 percent of the average skilled nursing facility rate in the

State, but it does not specify how the basic rate should be established or which SNF rate—cost charges, medicare, or medicaid—should be used in any such computations.

S. 1540. We realize that this bill is not pending before this committee. However, since the bill has medicare and medicaid implications, we would like to make a few comments. This bill would allow States to implement programs of community-based care when medically appropriate and cost effective. It would also require periodic assessments of a medicaid patient's needs for long-term care services and the development of a plan of care to meet those needs.

We view this bill as an expanded, more complicated and much more costly version of existing authority for State programs of home and community-based care. Under existing waiver authority provided by section 2176 of the Omnibus Reconciliation Act of 1981, States already have the ability to offer a wide range of services that will result in the cost effective avoidance of institutional care.

With respect to S. 1614, this proposal would allow States to implement comprehensive and coordinated programs of long-term and acute care for persons eligible for both medicare and medicaid. These programs would be alternatives to current medicare/medicaid benefits with an emphasis on expanded home care to reduce institutionalization. Within certain specified conditions and restrictions, enrollment would be voluntary. The medicare contribution to States for each enrollee would be at 95 percent of the institutional adjusted average per capita cost for SNF and intermediate care facility patients as determined for HMO reimbursement.

Our problems with this bill are similar to those we have with S. 1244. Eligibility is so loosely defined that we are unable, within the dually entitled population, to identify or to estimate the number of people who might meet the requirements of dependence on personal assistance.

Nor do we have the ability to identify or estimate those who would be otherwise institutionalized or the frail elderly. Consequently, we cannot estimate the program's costs in a way that would allow us to know the magnitude of the cost of the program, much less whether it would be cost effective. Here, too, the potential diversity of service alternatives and their loosely defined relationship to existing medicare/medicaid benefits makes it impossible for us to assess the consequences of implementation.

Mr. Chairman, I believe that we share a common goal and that is to assure the delivery of good quality care in the most appropriate setting without contributing to the alarming growth in costs which I mentioned earlier. Nevertheless, if experience has taught us anything, it is that we should not rush into new benefit programs or significant modifications to existing programs without first weighing carefully the effects on quality and costs. At a time when cost control is an absolute requirement for the preservation of the medicare and medicaid programs, we need to be very precise about how we structure these programs to meet patient needs.

Data and information are just beginning to come in on the home and community-based care waiver programs. In addition, our demonstrations and evaluations are just beginning to provide data with much valuable information due to be reported within the next few years.

With that, I would be pleased to respond to any questions you may have.

Senator DURENBERGER. Thank you. We will start with Senator Packwood.

Senator PACKWOOD. How long will you need to gather data? The problem is not new. I don't think we are surprised by the sudden revelation that care at home is cheaper than care in a nursing home or care in a hospital. We have had a variety of pilot programs going now for a number of years.

I sometimes sense that studies are a dodge to undertake any program. How much more do you think you need to study? What more information do you need?

Mr. ODAY. Senator Packwood, sometimes I can share your frustration with that. The bureau for which I am responsible is very much involved with the problems of here and now. And sometimes we get frustrated internally with the answer that we need to research that more or we need to collect the data when we have a problem that requires immediate attention.

Nevertheless, if I have learned anything since I have been there it is that the data really does become important. The research must be done because otherwise you run a terrible risk of doing it wrong simply as the expedient to get some sort of answer out quickly. I think we need to avoid that sort of situation.

In terms of how much longer do we need to collect data, I think we will begin to see answers coming in early next year. But it will take 3 to 4 years beyond that, depending on which particular demonstration or which particular research project is involved. Maybe Dr. Kickham would like to add something to that.

Dr. KICKHAM. I think, Senator, that two types of data can come out of the demonstrations. I think the one set that we have got some information on—for instance from the demonstration program in Oregon and several other HCFA-sponsored community care demonstrations—indicates clearly that this sort of organization can be put together so that you can case manage a frail population. The second set is hard data on costs and whether the demonstrations are effective or not. We expect to be getting those sorts of things shortly from the HCFA-sponsored community care demonstrations. The evaluation report will be coming in at the first of the year. We should have something on the 2176 waiver program evaluation in the national channeling both in 1984 and 1986.

Senator PACKWOOD. Now while all that studying is done isn't it likely the conclusion will be that there is a problem of overutilization but care at home is cheaper than care in an institution?

Dr. KICKHAM. Actually, I'm not sure what it will show. I think it will show though, for instance on eligibility similar to Senate bill 1244, whether you can determine which individuals are most at risk of institutional care. I think the national channeling demonstration which has similar eligibility criteria as your bill should make some statement about that.

I'm not sure how the cost information, is going to come out.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator DURENBERGER. Senator Bradley.

Senator BRADLEY. Thank you, Mr. Chairman.

Mr. Oday, is the administration opposed to any home health care bill before 1984?

Mr. ODAY. Senator Bradley, the administration will be opposed to any bill that will increase program outlays at this time. I think that's the best I could answer that kind of a question. To say any home health care bill seems to me to be somewhat different from a bill that simply provides a new benefit or expands eligibility or otherwise increases program outlays.

Senator BRADLEY. Will the home health care bills before the committee today increase outlays?

Mr. ODAY. Well, as Senator Heinz noted earlier and as I mentioned in my testimony, the actuaries are having a great deal of difficulty in coming up with cost estimates for these bills. We are working on it. We would be happy to work with the staff of this committee. We would even accept the help from Brandeis in terms of constructing the assumptions necessary in order to come up with a meaningful cost estimate for these bills.

Senator BRADLEY. In your opening statement, you said in reference to each of the bills, each presumes that many of our elderly have unmet personal care needs. Do you not presume that?

Mr. ODAY. I think a presumption is just that. It is a statement of belief. But like many other things, a presumption can be rebutted.

Senator BRADLEY. But do you believe that now?

Mr. ODAY. Do I believe that the elderly——

Senator BRADLEY. Do you believe that many of our elderly have unmet personal care needs?

Mr. ODAY. I think that's a safe presumption.

Senator BRADLEY. And do you feel that any form of home health care might meet those needs more cost effectively than institutionalization?

Mr. ODAY. Only if it is a substitution for some sort of institutional care and not an add-on to institutionalization.

Senator BRADLEY. So you would oppose any home health care bill that resulted in any more dollars being spent than is presently being spent on medicaid and medicare?

Mr. ODAY. That's correct.

Senator BRADLEY. Thank you very much.

Senator DURENBERGER. Senator Heinz.

Senator HEINZ. I don't have a question per se for Mr. Oday and HCFA, but I would like to make this observation. It is true that studies take a lot of time. And it is probably also true that no matter how carefully you study and come up with an estimate, the estimate may prove to be wrong, and by a fairly substantial margin. Which way it is wrong, we don't know. But generally, the Government has successfully underestimated just about everything. The Pentagon underestimates. There is no reason why HCFA shouldn't underestimate.

We sometimes even underestimate the good that we do as well. And I guess my only comment is this, Mr. Chairman. I said at our previous hearing and I would have said it again today except that I abbreviated my statement. These hearings are very important but not just for the technical reasons of looking at these bills. They are important because although we all know there are many people who need home health care services, access to different kinds of care, alternatives to institutionalization; we know of excess utilization of hospitals, it is my judgment that there is not a real constituency as yet at the grassroots level that is really demanding that the Congress act to do something on long-term care.

I was a member of the House of Representatives about 9 years ago and introduced a bill that some brilliant Senator—I don't think in this case it was Senator Packwood, but it could just as easily have been—had introduced. It had many similarities to Bob's bill. And that was a long time ago. And we are just about as far along today as we were then. Our concepts are getting better. Our approach is more refined.

But the American people are going to have to make up their mind that they really do care about people who are becoming older and frailer. And I don't think we really have a lot of time. There are roughly 8 million Americans who are between ages 75 and 84. That number will increase by 70 percent by the year 2000.

And the number of Americans 85 years of age and older, those most in need of long-term care services, will increase by 150 percent in that same timeframe. The combined over 75 age group will increase from over 10 million to well over 17 million within the next 15 years. This suggests that there will be a substantial number of persons needing some form of long-term care, but there is currently no design to expand services adequately to meet this demand. And, I would observe that even though we had 10 or 12 million unemployed Americans and their families who lost their health insurance earlier this year, something that they had come to depend upon, that Congress, as we sit here today at least, has not acted—I am concerned that we could still be sitting here another 17 years from now without any solution because this constituency of some 17 million people will somehow or another not be thought to be big enough or relevant enough.

Senator **Durenberger**. Thank you.

What is HCFA's view or the administration's view on prepaid capitation for acute and long-term care services? Does it hold some promise for managing and controlling long-term care expenditures as an example?

Mr. **Oday**. Let me make a number of observations about that, Mr. Chairman. I think, yes, intuitively we find it very intriguing. The incentives are correct in of capitation system.

But capitation is, after all, only the reimbursement mechanism. If there are other kinds of services outside of the capitated rate, then you are going to lose something. Furthermore, you have the whole question of the population and the ability to opt in or out of the capitation system and back into fee for service or what have you. We would run a terrible risk in that kind of a situation of, in effect paying twice. We've paid a capitated rate for a presumed block of services, and yet we wind up paying for those services all over again when somebody opts out of the capitated arrangement.

I would also make the observation that a capitated system assumes that there are entities out there that are willing to go at risk. At this point, I don't think that we know the answer to that question entirely. Certainly when you are talking about adding in some sort of long-term care component to the acute care part. I would also observe that I think it's necessary—I think history has taught us from 10 years ago—that some sort of financial safeguards are necessary with respect to that entity at risk. Otherwise, you runing a chance of them, in effect, taking the money and running, if you will. That's not to say that those kinds of things are likely to happen again. But, again, the incentive would be there.

But in general the notion of capitation is one that we certainly find very intriguing and one that we are exploring further.

Senator DURENBERGER. At our last hearing Mr. Meiners talked to us a little bit about the research that he is doing on the feasibility of private health insurance coverage for long-term care service. Is HCFA conducting or thinking of beginning any research in this area? Do you think it's a fruitful area of research?

Mr. ODAY. I think in answer to your latter question, yes. I think it is a fruitful area for research. Having said that, I think you can appreciate that the Office of Research and Demonstrations these days has a very full agenda, and it's a question of trying to establish the priorities. Nevertheless because of our belief that it is a fruitful area, we are beginning exploratory talks with the national center in terms of how we can build off some of its work and go forward.

Senator DURENBERGER. Let me say that I finally got hold of the red book, HCFA's status report on the demonstration projects, and read it in an airplane going home. I think you are doing too much. And you can sense from the testimony today some of the frustration with these projects. I think we as a subcommittee are going to have a hearing on that whole big red book of all the research projects going on out there and see if we can't help you narrow some of that down.

The last question I have is, isn't it true that there are some preliminary analyses now available on your channeling project? And I wonder if you could share some of those findings with us. Maybe it will encourage some of my colleagues to believe that some good does come out of all this research.

Mr. ODAY. My understanding is that the answer is, no, we do not yet have any data from the long-term care channeling demonstration.

Dr. KICKHAM. Senators, there is no analysis of the data that is being gathered by our evaluator.

Senator DURENBERGER. But that is going to be here when? January? February?

Dr. KICKHAM. Well, there's a preliminary impact analysis that will look at the differences between the treatment and control group. That should be out in the middle of 1984. The final report won't be until January of 1986.

Senator DURENBERGER. OK. Senator Bradley.

Senator BRADLEY. No information until January 1986?

Dr. KICKHAM. The information from the national channeling in 1986 will be the information on cost. The September 1984 preliminary impact will say something about whether there are differences between the two groups.

Senator BRADLEY. If S. 1244 was passed by the Congress this year would the data developed from several years of testing this program in several States be valuable to developing a nationwide home health care bill?

Dr. KICKHAM. I think it certainly can say some things about the elements of the bill. The patient assessment team; we've had quite a bit of experience on that. I think the idea of individuals at risk—those that have a fragile support system, those that are impaired in several activities of daily living—I think we can get something out of that from the earlier demonstrations.

I might point out that that evaluation report is due in the beginning of this coming year.

Senator BRADLEY. Would you be supportive of S. 1244 as a research document?

Dr. KICKHAM. As a research document? I'm not sure I understand what you mean.

Senator BRADLEY. Was information gathered to help you design a better national home health care system.

Dr. KICKHAM. I think the demonstration that we have underway with Brandeis that you heard quite a bit about in many ways permits us to get at the sorts of questions I think everyone has in terms of capitated approach to acute and long-term care. S. 1244, as I understand, has the first several years as a demonstration, but then turns into a regular program after that. And I'm not sure what our position is on that.

Mr. ODAY. I guess I would just note an irony here. If we were to go ahead and do S. 1244 as additional demonstration project, it will be just that much longer before the results of all of those new demonstrations are in. And so we would suddenly be talking about, be 5 years before the evaluation is completed or what have you.

I don't think there is, at this point any further kinds of research questions that would be addressed in S. 1244 that we aren't already addressing in one way or another in the demonstrations. And for that reason I wouldn't think that it is necessary. Certainly we don't need the authority to do it that way. We have the authority now to do these kinds of demonstrations and as previously mentioned, we are doing that.

Senator BRADLEY. Mr. Chairman, if I could, the question is, what level of commitment exists at the administration level for a home-health-care bill. Mr. Oday has put a very stringent no new costs lid on the bill, on the whole concept. And at the same time in his own testimony and in his statement to the committee he presumes that many of our elderly have unmet personal care needs. And, in fact, GAO says that there are three times more chronically ill senior citizens living in home settings than in nursing homes, which means that their families are struggling to make the payments to keep them in some state of minimum health.

Now what we are saying here is that we want to test a concept to reach that population. Yes; it might be a new population. It might involve some increase in costs. We think there will be a very serious tradeoff with some reduction in costs, but we want to test the concept. If we are dealing with a lid that says no new costs, you are saying to a large percentage of the population that is now receiving no health care that you are not going to provide them with any health care.

Mr. ODAY. I don't believe my statement presumed that they were receiving no health care. And the question was unmet needs. And, of course, that's a very subjective kind of term. It could be social services that they need. And I think to a very large extent that is what some of these bills address.

Let me just observe that after all the Governments, both State and Federal, are not powerless in this matter. There is the 2176 program, and that is to a very large extent what that program was designed to address. The States have responded very positively but cautiously to that program. And I think that's appropriate. This is an evolutionary kind of process. And you add maybe one service at a time as you learn from the services that you have now.

Senator BRADLEY. But you continue to state that if it increases costs above their present levels you could not support any kind of home health care program directed at the recipient population that is presently; not in nursing homes?

Mr. ODAY. That is our position.

Senator DURENBERGER. Any other questions?

Senator HEINZ. One more question, Mr. Chairman.

Senator DURENBERGER. Senator Heinz.

Senator HEINZ. Mr. Oday, you said that the demonstration of the waiver projects will give us all the information we need on all these bills, including what they will cost. Did you include S. 1614 in that?

Mr. ODAY. In terms of the kinds of demonstrations that are similar to S. 1614, I would include it in that.

Senator HEINZ. I just want to know whether the blanket statement made by Mr. Oday—at least I took it to be a blanket statement—that we have all the experiments in place or at least committed that we will need to answer questions concerning these bills, including S. 1614.

Mr. ODAY. Well, I think the most similar thing to S. 1614 would be the social HMO demonstrations. And it may be that we could find out that there are other research questions that were not addressed in the social HMO demonstrations that would be addressed in S. 1614. However, at this point I'm not aware of them.

Senator HEINZ. Well, it seems to me that 2 years from now when we get some data from the social HMO project, that you are going to come back and say, well, we still have some questions that need to be researched on S. 1614. So I would like for you to give us, for the record, what information you think we will not get from the demonstration projects that is relevant to 1614, together with your recommendations on how we might get it.

Mr. ODAY. I would be happy to submit that for the record, Mr. Chairman.

[The information from Mr. Oday follows:]

INFORMATION NOT AVAILABLE FROM SOCIAL HMO DEMONSTRATION RELEVANT TO S. 1614

- To a great extent, the elements of S. 1614 and the Health Care Financing Administration's (HCFA) Social Health Maintenance Organization (S/HMO) demonstration are similar. In terms of services and eligibility, S. 1614 and S/HMO are virtually identical.

- There are, however, differences relative to provider types, reimbursement, and program administration.

  - Under S. 1614, State Medicaid programs would be responsible for implementing the S/HMO concept and could establish social HMOs in a number of ways (i.e., contract with existing HMOs, designate county departments of health or social services as S/HMO providers, enter into agreements with community care providers, or any combination of the above). Under the S/HMO demonstration, only HMOs and local community care providers are participating.

  - Under S. 1614, the State would receive a capitation payment for each eligible enrollee, but could reimburse the provider of social HMO services using one or more payment methods, as the State finds appropriate. Under HCFA's Social HMO experiment, payment for all providers is made on a capitated basis.

  - Under S. 1614, the State will administer the provision of both Medicare and Medicaid benefits for enrolled individuals. The Social HMO demonstration is administered solely by HCFA.

- To the extent that S. 1614 differs in provider and payment arrangements and administration, the S/HMO demonstration would not provide information on quality, use, costs, and the issues involved in State administration of Medicare benefits as proposed in S. 1614.

- In addition, the S/HMO demonstration is not designed to estimate fully the demand for S/HMO services. We would be unable to determine the increase (if any) in S/HMO enrollment if greater numbers of S/HMOs existed in a given area as permitted under S. 1614. We will be able, however, especially in our Portland, Oregon and Minneapolis, Minnesota sites, to estimate the demand for S/HMO services for those persons who already have expressed an interest in enrolling in an HMO.

- Further, we will not be able to estimate the supply of providers willing to serve as a social HMO. Given the novelty of the S/HMO concept, we had a difficult time identifying potential organizations to serve as demonstration sites. Because of the uncertainty surrounding the volume of health and medical services used by chronically ill elderly persons, many providers were unwilling to assume the risk of serving these patients on a capitation basis.

- The S/HMO demonstration is designed to determine primarily the feasibility of combining within one organization the delivery of both acute and long-term care services through a case-managed capitation approach. We will not be able to make national inferences using demonstration data from the four sites. S. 1614 permits an unspecified number of S/HMOs in 20 States for the first three years following enactment. Using our demonstration data, national estimates on the impact of the bill would not be reliable, given the difficulties in estimating enrollment demand and supply of social HMOs.

Senator **Durenberger**. Thank you, gentlemen, very much. We appreciate your testimony.

Next we have a panel consisting of Brian T. Baxter, executive deputy secretary, Pennsylvania Department of Public Welfare; and Barbara Matula, chair, State Medicaid Directors' Association of the American Public Welfare Association and director, Division of Medical Assistance, North Carolina Department of Health and Human Resources.

While they are coming up let me say that there are other representatives of State and local government that indicated an interest in testifying today, and we indicated to them that they would have plenty of opportunity as we moved farther into the area in probably in January of the States' role in long-term care and in care for the indigent. That they will then be provided additional opportunities to testify on this and related subjects.

Your statements will be made part of the record. You may proceed to summarize them.

STATEMENT OF BRIAN T. BAXTER, EXECUTIVE DEPUTY SECRETARY, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, HARRISBURG, PA.

Mr. **Baxter**. I appreciate very much the opportunity to testify today relative to S. 1614. The Commonwealth of Pennsylvania views long-term care as a continuum of both needs and services. We feel we must insure that each person receives the specific level and type of care that he or she needs, when they need it. Such a system must include a full range of both medical and social services in both community and institutional settings.

In many States, including Pennsylvania, the Older Americans Act has helped to create community-based social services which are planned and administered at the local level within State and Federal guidelines. However, at the same time, the Federal Government is financing several major long-term care programs which are administratively unrelated at all levels of Government, and are usually not coordinated with local service delivery systems. These programs include the medicaid nursing home program, the SSI special supplement for residential services, and the title XX social services block grant.

In fact, in a recent Pennsylvania analysis, we identified 15 major funding sources being used for some 38 different long-term care services. The lack of coordination, uneven distribution, and often conflicting requirements between the different funding streams compounds the problem and frustrates the local service delivery system.

Unless a redirection in long-term care policy occurs soon, States will have major problems meeting the growing demand for these services, because of the current concentration on expensive, medically intensive institutional care and the fiscal realities at all levels of Government.

During the past several years we have witnessed a growing nursing home industry, while community care alternatives have not received adequate public support. We must now respond with initiatives which enable policymakers and our communities to develop a spectrum of services within available resources. We must also identify ways of linking public investment with private sector resources. Further and most importantly, our long-term care system must be able to identify and respond to the special needs of an extremely diverse population. And, lastly, we must clarify Federal/State relationships and reconcile the problems which result from these separate categorical funding streams which carry differing recipient eligibility levels.

Over the years, a long list of health care experts has come before you detailing many of these easily identified problems and pessimistically predicting that this nonsystem cannot be salvaged into any comprehensive, workable system. I disagree.

S. 1614 gives all of us the opportunity to create local laboratories which can help us to learn how we can most effectively address long-term care issues in the future. I would like to share with the committee six features of the bill which we feel are very positive.

The first is that it requires case management, which is vital in assisting people to identify and locate necessary and appropriate care, and to avoid possible exploitation by providers.

Second, prepaid capitation, which as a financing mechanism will encourage States and localities to use the most efficient and effective means possible to meet the needs of this population group.

Third, the comprehensive scope of mandated services, which will allow local delivery sites to blend social and medical services, and institutional and community based care.

Fourth, the pooling of resources, which will remove current incentives to shift costs between programs, and will help to insure that the appropriate level of care is provided.

Fifth, dual eligibility, which will enable States to provide coordinated services to the vulnerable population who retain both medicare and medicaid eligibility and who, in some cases, currently receive inappropriate care.

And, sixth, local control coming from a representative of a State, which in my view is the most important feature of the bill. The long-term care needs of dependent people are closely related to individual, family, and community circumstances. We must push long-term-care decisionmaking as close to the local level as possible in order to respond appropriately to the recipient needs and delivery networks.

With the help of Senator Heinz and other members of our congressional delegation, Philadelphia and Pennsylvania were awarded a channeling demonstration grant for long-term care for the elderly. And we have found at this point, while we cannot as earlier speakers indicated, provide the committee with final results, we are able at this point to make some informal observations. To date, the care provided generally cost only 30 percent of the cost of institutional alternatives. Services provided average 3 hours a day, 5 days a week. And expenditures average only $13 per day.

As a result, we are convinced that many of the aspects of the bill introduced by Senator Heinz and his colleagues will have the positive result of providing the dependent elderly with appropriate care within budgetary constraints.

The bill will allow us to build on what we have learned and develop new opportunities to create a coordinated and effective long-term care system. We call for this bill's prompt enactment.

We welcome your questions.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Mr. Baxter follows:]

TESTIMONY

OF

BRIAN T. BAXTER

EXECUTIVE DEPUTY SECRETARY

DEPARTMENT OF PUBLIC WELFARE

COMMONWEALTH OF PENNSYLVANIA

SUBCOMMITTEE ON HEALTH
FINANCE COMMITTEE
November 14, 1983

Thank you for giving me the opportunity to testify today in support of S 1614, "The Health Care Coordination Act of 1983".

Long term care is a growing concern. How we can best provide and pay for long term care services for the elderly, mentally retarded, mentally ill, mentally alert/physically disabled people in our nation is a question that must be addressed in a coordinated fashion at federal, state, and local levels of government.

We estimate the current long term care population in Pennsylvania to be about 400,000 people. This includes 160,000 persons aged 18-64, or 2.5% of that age group, and 240,000 elderly, or about 16% of our citizens age 65 and over.

The Commonwealth views long term care as a continuum of both needs and services. We must ensure that each person receives the specific level and type of care he or she needs, when they need it. Such a system must also include a full range of medical and social services in both community and institutional settings.

In many states, including Pennsylvania, the Older Americans Act has helped to create community-based social services which are planned and administered at the local level within State and Federal guidelines. However, at the same time, the Federal government is financing several major long term care programs which are administratively unrelated at all levels of government, and are usually not coordinated with local service delivery systems. These programs include the Medicaid nursing home program, the SSI special supplement for residential services, and the Title XX Social Services Block Grant. In fact, in a recent Pennsylvania analysis, we identified 15 major funding sources being used for some 38 different long term care services. The lack of coordination, uneven distribution, and often conflicting requirements between the different funding streams compounds the problem and frustrates the local service delivery system.

Unless a redirection in long term care policy occurs soon, states will have major problems meeting the growing demand for these services, because of the current concentration on expensive, medically-intensive institutional care and the fiscal realities at all levels of government. During the past several years, we have witnessed a growing nursing home industry, while community care alternatives have not received adequate public support. We must now respond with initiatives which enable policymakers and our communities to develop a spectrum of services within available resources. We must also identify ways of linking public investment with private sector resources. Further and most importantly, our long term care system must be able to identify and respond to the special needs of an extremely diverse population. Lastly, we must clarify federal/state relationships and reconcile the problems which result from these separate categorical funding streams which carry differing recipient eligibility levels.

Over the years, a long list of health care experts has come before you detailing many of these easily identified problems and pessimistically predicting that this "non-system" cannot be salvaged into any comprehensive, workable system. I disagree.

Through experimentation we must find solutions to this major social problem.

S 1614 gives all of us the opportunity to create local laboratories which can help us to learn how we can most effectively address long term care issues in the future. The positive features of this bill include:

1. Case management, which is vital in assisting people to identify and locate necessary and appropriate care, and to avoid possible exploitation by providers;

2. Prepaid capitation, which as a financing mechanism will encourage states and localities to use the most efficient and effective means possible to meet the needs of this population group;

3. The comprehensive scope of mandated services, which will allow local delivery sites to blend social and medical services, and institutional and community-based care;

4. The pooling of resources, which will remove current incentives to shift costs between programs, and will help to ensure that the appropriate level of care is provided;

5. Dual eligibility, which will enable states to provide coordinated services to the vulnerable population who retain both medicare and medicaid eligibility and who, in some cases, currently receive inappropriate care; and,

6. Local control, which in my view is the most important feature of the bill. The long term care needs of dependent people are closely related to individual, family, and community circumstances. We must push long term care decision-making as close to the local level as possible in order to respond appropriately to recipient needs and delivery networks.

With the help of Senator Heinz and other members of our Congressional delegation, Philadelphia and Pennsylvania were awarded a Channeling Demonstration Grant for long term care for the elderly, which includes a control group for research purposes, and requires a highly structured case management process. Appropriate care ranging from institutional to community-based services is available. While the demonstration results will not be available in final form for a few years, some informal observations can now be made. To date, the care provided generally costs only 45 percent of the cost of institutional alternatives. Services provided average three hours a day, five days a week, and expenditures average only $13 per day.

As a result, we are convinced that many of the aspects of the bill introduced by Senator Heinz and his colleagues will have the positive result of providing the dependent elderly with appropriate care within budgetary constraints. The bill will allow us to build on what we have learned and develop new opportunities to create a coordinated and effective long term care system. We call for this bill's prompt enactment.

I welcome your questions.

STATEMENT OF BARBARA MATULA, CHAIR, STATE MEDICAID DIRECTORS' ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION AND DIRECTOR, DIVISION OF MEDICAL ASSISTANCE, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, RALEIGH, N.C.

Senator DURENBERGER. Ms. Matula.

Ms. MATULA. I am Barbara Matula, and I chair the State Medicaid Directors' Association.

Senator DURENBERGER. How did you get to Matula? Up in northern Minnesota, it's——

Ms. MATULA. It's a Czechoslovakian name. I'm a Yankee hiding out in North Carolina, and now you have blown my cover. [Laughter.]

I can't talk as fast as my northern colleagues because of 10 years in North Carolina, but I'm just going to skim over some of the points in my testimony, if I could.

Senator HEINZ. Senator Bradley isn't really from New Jersey at all. [Laughter.]

Ms. MATULA. I don't know what I have started here.

We are very grateful to be represented here—the State Medicaid Directors' Association. And while we haven't had a chance to take a formal position on the bills, we hope that we can share with you some of the concerns we have in this area, and hopefully point to some of the areas within the bills where with a little strengthening we could be very supportive.

The issue of long-term care is an issue that we feel has not really received the attention of the Federal level that it warrants. And please do not be misled by our caution in moving slowly that there is not a ground swell of support for bills such as this. It's just that we have been burned many times in the past, and we want to move in the way that is beneficial and not subject to great criticism for costs.

We feel this national dialog is necessary. And I will say this many times representing the States because we feel a national commitment is needed. And when you talk about putting States at risk, I would ask you not to compromise that national commitment and think also about how we can keep the Federal Government sharing in that risk.

Medicaid pays for much more of the long-term care bill than was ever originally designed. When medicare came into being we believed that that was the program of health care for the elderly and for the disabled, and that medicaid was for the poor families and other individuals—children.

Very quickly we are seeing that the medicaid program is becoming an institutional program for the elderly and for the disabled. So what we are doing here is at the expense really of many families and children who, when budget cuts are made, suffer first while the institutional budget continues to swallow up a large portion of our funds.

We are very happy to have been a part of the Omnibus Budget Reconciliation Act provisions for home and community-based services. The States have been enthusiastic in getting into it although in a limited scale. And their limits, again, are so that we can learn and not make mistakes on the statewide basis, but rather make our mistakes in a limited way and learn from them; put something positive in place.

We have targeted eligibility. We have targeted geographical locations. We have targeted services. We are testing. We feel that we are a laboratory. And we are looking forward to the data that comes from this and we hope that it is soon in coming so that we can learn from each other and not have to waste a great deal of time reinventing the wheel.

I think that the issue we hear the most about is that the needs are there, but how can we develop a program that does not erode the natural commitment that family and friends and community have. And that will be something that your bills, both 1244 and 1614, at least in being demonstration programs will enable us to test them.

We don't have all the answers. We do have a few questions on the bills you have proposed, or a few statements to make. While the States do feel strongly that they should serve as the primary administrator in any long-term care program, we don't want you to forget that these long-term care programs must exist within the overall Federal policy framework. And that there be a sufficient Federal financial commitment to meet these needs.

Second, we hope that you will continue to develop the long-term care policies in an incremental fashion by allowing demonstration programs in a variety of ways. Again, I say we don't want to repeat the mistakes we have made in the past, very expensive mistakes. And this will enable us to move ahead cautiously, carefully, and, we hope, effectively.

We would appreciate a bit more flexibility than you have provided in some of the bills. In the sense that what States were given some flexibility to control costs in medicaid, they were quite effective in doing so. We feel that we may have some different ways to design packages of services and eligibility and setting reimbursement rates, and we would like to work with your staff in giving you some ideas not to box us in.

We applaud the pooling of medicare and medicaid funds. It's a great step in the right direction of getting all of these programs together, and eliminating that fragmentation.

Again, I have some comments that are quite technical. If I could work with your staff to insure that the formulas are such that they are based on sound data.

We do support the development of this national long-term care policy. We appreciate the opportunity to be here today, and we extend to you our help in designing some bills that will get this moving.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Ms. Matula and answers to questions from Senator Durenberger follow:]

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TESTIMONY OF

BARBARA D. MATULA

CHAIR, STATE MEDICAID DIRECTORS' ASSOCIATION

OF THE

AMERICAN PUBLIC WELFARE ASSOCIATION

AND

DIRECTOR, NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

FOR THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

U.S. SENATE

HEARINGS ON LONG-TERM CARE LEGISLATION

November 14, 1983

Mr. Chairman, members of the Subcommittee, good afternoon. I am Barbara D. Matula, Director of the North Carolina Division of Medical Assistance and current Chair of the State Medicaid Directors' Association of the American Public Welfare Association.

The State Medicaid Directors' Association consists of the people responsible for administering the Medicaid program on a daily basis. I am here to present our views on long-term care policy in general and some thoughts on the relevant bills now before your Subcommittee.

Let me begin by commending the Subcommittee for holding this series of hearings on the issue of long-term care. On the whole, it is an issue that has not received the attention at the federal level that it warrants. A number of witnesses, including those from the General Accounting Office and the Administration, have outlined to you the extent of the problem in long-term care, both with regard to the large commitment of public funds by each level of government and the increasing demand for long-term care services the entire country faces in the coming years. It is appropriate that a national dialogue occur, since solutions to the difficult problems we confront require a national commitment.

As you know, the Medicaid program pays for a large part of all the long-term care services provided in this country. About half of all nursing home expenditures are paid for by the Medicaid. This accounted for $13 billion in spending during FY 82. Medicare, on the other hand, reimburses only a small portion of the long-term care costs in the country.

I do not believe that when the Medicare and Medicaid programs were created anyone could have anticipated the current situation we face. Originally, Medicare was to provide care for the elderly, and Medicaid was to provide care for the poor. Medicaid has become the program for institutional long-term care costs for the elderly, disabled, and the poor. Both the federal and state levels of government are up against a dilemma. The demand for the Medicaid program continues to grow, while program resources are constrained.

The states believe that a national long term care policy--a national commitment--is needed to deal with this dilemma in order to satisfy society's needs. We must pursue a policy of sufficient care for those in need, while maintaining control over the cost of any answers we develop.

Given the fact that many of the problems the program now contends with were not foreseen by the original architects of Medicare and Medicaid, it is understandable that incremental changes have begun to occur. The states believe that the most significant program change to date to deal with the issue of long-term care is the home and community-based care waiver program contained in the Omnibus Budget Reconciliation Act of 1981. What this provision provided the states was more flexibility to explore alternatives to the nursing home method of providing long-term care. While it is a waiver program, it goes beyond the limits of research projects. It gives the states a tool to test ways to reduce the demand for nursing homes and reduce program costs.

The states response, as you know, has been quite enthusiastic. Forty-six states have applied for 100 waivers for services provided to the aged, and disabled, including the mentally retarded and mentally ill. While approval of the waivers has been slower than originally promised, states have put about half of them into effect anyway. I believe this shows the strong interest on the part of states to work out new, more effective and rational ways to provide long-term care.

At the same time, however, it is important to realize that this is one incremental phase in developing an understanding of long term care. If you examine the types of waivers the states have applied for, they are limited in scope. States have entered the non-institutional area of long-term care cautiously. Nearly all of the waivers have been targeted to specific geographical regions within the state. States on the whole have used their waivers for specific population groups, to provide limited services. The average waiver applies to about 500 people. The reason for this targeting is quite clear. States are not sure how to pursue long-term care alternatives in an effective and productive manner. They are concerned about controlling costs. They are concerned about how to most effectively focus the care being provided. They are learning what screening mechanisms are most effective in determining what level of care a recipient needs. They are not certain now government can provide care where it previously did not, without unnecessarily eroding the natural commitment family and friends currently show towards the elderly and disabled in our society.

So the states have demonstrated, through their pursuit of the home and community-based care waivers, the interest they have in developing the strategies necessary to provide good quality long-term care while controlling costs. By no means do we have all the answers yet, but the home and community-based care waivers have provided us with a logical, incremental step inacquiring the knowledge needed.

The question facing the Subcommittee now, and the Congress as a whole for the next few years, is what can further be done to continue to develop the necessary knowledge for a long-term care policy, particularly in determining who should be eligible. This leads to the bills currently being considered by the Subcommittee on the issue of long-term care.

First, let me say that the State Medicaid Directors' Association has not taken a position on any of the bills before the Subcommittee, but the states have some ideas and thoughts on them, particularly the Senior Citizens Independent Community Care Act (S. 1244), and the Health Care Coordination Act of 1983 (S. 1614). These points are as follows:

- <u>First, the states should serve as the primary administrator of any long-term care program.</u> Both S. 1244 and S. 1614 would do this. It is clear the states have the experience, knowledge, and access to information about needs that are required for an efficient and effective program. Local entities are also essential, but we believe the states are best prepared to serve as the focal point in developing alternatives in long-term care. However, long-term care programs should exist within an overall federal policy framework backed by a sufficient federal financial commitment.
- <u>Second, development of long-term care policy should continue to be incremental.</u> Both S. 1244 and S. 1614 recognize this factor by providing demonstrations by a limited number of states during the

first few years. While progress is important, progress only occurs based on sound knowledge. If programs advance too quickly, they run the risk of being regressive because they do not adequately provide services to the appropriate population, or because they cost too much.

- Third, states should be provided maximum flexibility to develop alternatives. One of the advantages of having states take the lead in the development of long-term care policy alternatives, as opposed to one federal program, is that you have as many different approaches being examined as there are states involved. In addition, the states believe that general flexibility in the Medicaid program has produced a more efficient and effective program overall in the last two years. We believe the same is true for the area of long-term care.
- Fourth, the pooling of Medicare and Medicaid funds could prove productive. The idea of linking the Medicare and Medicaid programs as proposed in S. 1614 generally moves towards the coordination of all government programs for long-term care. The states would, however, have reservations regarding being put at risk for the cost of the program by Medicare setting a cap based on an "average adjusted per capita cost." How would such a measure be determined given the limited knowledge of the home care expense of Medicare eligibles? Similarly, the cap on reimbursement to providers set at 60 percent of the monthly fee for skilled nursing facility care included in S. 1244 could be unnecessarily restraining.
- Fifth, eligibility determintion would be of concern to states. Both S. 1244 and S. 1614 would present difficulties for the states in

determining and limiting eligibility. Eligibility under S. 1244 would be determined based on certain criteria regarding level of needed care, about which states are still learning. We would recommend that states be given more flexibility to target. In S. 1614 the states are asked to distinguish between "frail" and "non-frail" Medicare beneficiaries. Again, states are still learning about how to screen persons and make level of care determinations outside of an institutional setting. Further, while statewideness can be waived under S. 1614, the bill requires that the percentage of individuals enrolled in the program who are disabled or frail elderly must be approximately equal to or greater than the same percentage in the general population of the area served by the program. This measure is required to prevent states from ignoring those in most need of the program, but it is likely that in most areas of the country, states do not know how the general population breaks down across this dichotomy.

In conclusion, let me reiterate that the states support the development of a national policy for long-term care. We believe the bills now before the Subcommittee are a step in that direction. As the discussions and development of legislation in long-term care continue, the State Medicaid Directors' Association stands ready to assist both the Subcommittee members and their staffs in any way we can.

Thank you for this opportunity to present the states' views. I would be happy to answer any questions you might have.

QUESTIONS FROM SENATOR DURENBERGER

1. Do States know how to target community-based services to those who really would otherwise go into a nursing home? Do they know what alternative services actually prevent institutionalization?

One of the major concerns states face is that of expanding home and community based services without reducing the demand for nursing home care. Unfortunately this cannot be a quid-pro-quo measurement because many states do not have sufficient nursing home beds and experience not only a high occupancy rate in the existing homes, but also are pressured to build additional facilities, regardless of their activities to expand community based-services.

A better measure of effectiveness is to test the clients served in the community for their abilities to meet "activities of daily living" standards and see how these compare to the institutionalized clients.

Clearly the pre-screening tools are the most valuable device in assuring that clients served in the community are those who in all other aspects would meet nursing-home criteria.

States have to learn how to avoid "gaming" this device, however, so that screening instruments are not falsely completed or exaggerated in an attempt to provide services in the home for a client who does not truly need them to avoid institutionalization.

One of the products of the waivers would be to examine the frequency and utility of the various health and social support services offered and to determine which services or combination of services are rated as most useful or essential to the client or to the client's family.

2. How are answers to be "teased" out of State experimental activites? Is this a State or Federal responsibility? Is the Federal Government doing all that it can?

You are asking me to answer a question which I consider most provocative, i.e., what is the federal role in long term care?

In my opinion the federal role has been, in the past, minuscule to non-existent, or worse, obstructive; however, by Congress' actions to authorize these waivers and require an evaluation of these efforts, the federal role has been defined (at least for Medicaid), although still on a very limited basis.

The key now is how the evaluation of these waivers will be conducted. Questions of timeliness, objectivity, dissemination of findings and technical assistance to the states must be addressed, perhaps by your committee. I have some serious reservations about the "objectivity" issue which I would be willing to discuss with you later.

The absence of a federal role in long term care for the elderly is a direct product of the lack of attention to the Medicare population's needs for the full continuum of care services.

It is not only the poor who need these services. Persons of modest means also may require them but face the same barriers that the Medicaid population did before the waivers were granted, i.e., fragmentation of services, lack of coordination/case management, lack of availability of services, differing eligibility requirements, etc.

There should be available to this population coverage of the same services on a fee-for-service basis, perhaps on a sliding scale. Otherwise these persons will exhaust their resources and become Medicaid eligible upon institutionalization which could have been avoided or delayed.

States view themselves as experimental laboratories in this venture. I believe they have done so only because the federal government has not taken the lead.

I do not think that the design or the delivery of community-based care systems is the exclusive responsibility of either the states or the federal government but instead should be shared. The Older Americans Act was successful without the involvement of state agencies, per se, so I do not think it is appropriate for the federal government to excuse itself from all responsibility in this new area.

As long as Administration officials in OMB make known their distaste for these waivered programs and their convictions that these are not cost-effective - but costly, then the federal role will continue to be played out in the shadows.

3. <u>What are States doing to encourage private sector involvement in the coverage of long-term care services?</u>

In the interest of responding to this quickly, I will not poll the states for their specific experiences, but rather will describe in general terms what states <u>can</u> do.

It is not in the interest of state or local governments to expand their staffs to provide care and/or services which already exist in the community. Not only are we under severe fiscal constraints which require us to keep governmental hiring to a minimum, but none of us feels strongly that public agencies, with all the restrictions placed on us, can compete with most private agencies in delivering services in a cost-effective, efficient manner.

To avoid duplication and overlap, it is in our best interest to contract with those providers for their services.

Perhaps the most difficult role for states to relinquish is that of case manager, and this is an area which is predominantly public because the vast majority of clients are public assistance clients. (This is another reason why I believe the services must be available to clients of all income levels, so that these programs do not become identified with welfare programs).

Two efforts that I have personally been interested and involved in are:

(1) Encouraging nursing homes to become community-based service centers (adult day care, etc.) and deliverers of home-care (nurses, dietary services, etc.). This makes sense because of their experience in this area and also eliminates some of the devisiveness generated by the Community Care vs Institutional Care foes.

(2) Encouraging the private insurance sector to provide coverage for the full continuum of care services. This would "legitimize" these services and contribute to their stability.

Barbara D. Matula
April 24, 1984

Senator DURENBERGER. Senator Packwood.

Senator PACKWOOD. Ms. Matula, I have read the five points that you have stated that would be desirable in the bills. But give me the benefit of your experience beyond those five points. You say the question facing the subcommittee now and the Congress as a whole for the next few years is what can be further done to continue development and so forth, and then you list the five points.

But you have been in this business long enough to have some pretty good intuitive knowledge of what we ought to be doing. And I share the same fear you do and everybody else does about expecting a universe of 100,000 and it turns out it is 500,000 and we didn't know it. The Federal Government is not going to fund that. States can't afford to fund it. But assuming we can keep it to a controllable universe, what are some of the steps that you would take? Or do we just wait until we finish these other studies that you heard the previous witnesses talk about?

Ms. MATULA. I think it isn't necessary to wait forever. I think there are some things we are doing now. We have funds in social services programs. We have funds in medicaid and medicare. Moneys are being spent but they are not being pooled, put together and put to the best use.

We know that we can't afford at this time to provide a universe of services for a universal population of eligible. It would probably have to be phased in for those who are in financial need first. That would be a step toward taking moneys currently spent, putting them together, knowing that you are already providing in some shotgun fashion services out in the community. Try and set some priorities for the funds you have.

Looking at the benefit of the experiments that are currently underway, freeing up more funds to increase that population of eligibles to be served. We don't want to promise more than we can deliver.

Senator PACKWOOD. In your judgment, do we have enough money and experience to go ahead now with the pooling of these funds thus giving the States some degree of latitude within the total available amount of money? Are we at that stage yet or do you still need more information?

Ms. MATULA. I would be nervous about making a statement that we are at that stage now. We do know that we can prevent some institutionalization. We can delay some. But it would take the medical experts to tell us how many hospital days could actually be eliminated. There are chronic illnesses. We know how much in medicare is being spent in terminal illnesses in the last year of life. And to promise that we could handle that at less cost, I think, is a promise that would be prematurely made.

Senator PACKWOOD. Thank you.

Thank you, Mr. Chairman.

Senator DURENBERGER. Senator Bradley.

Senator BRADLEY. A question of Ms. Matula. In S. 1244 we have a four-State demonstration. Is four States sufficient? Could we learn what we need to know with fewer than four States? Or should it be more than four States? Do you have any idea?

Ms. MATULA. I don't know if the absolute number "four" is a good or a bad one, but it would be nice if you had a mix of States, a mix of rural States and urban States and Sunbelt States where the population of elderly is growing and so on. It isn't the number so much as the makeup.

Senator BRADLEY. And, Mr. Baxter, you say that you are delivering services at 45 percent the cost of institutional alternatives.

Mr. BAXTER. Actually, Senator, I corrected my testimony; it's 30 percent at this point.

Senator BRADLEY. Oh.

Ms. MATULA. Even better.

Mr. BAXTER. As Senator Packwood was saying, it doesn't take a lot of geniuses to know that it cost a lot less to provide care at home in those cases where you don't need round the clock nursing care. And that's what we are proving in the channeling projects.

Senator BRADLEY. That's quite an impressive number. You can back that up, I suppose, with what kinds of services were provided?

Mr. BAXTER. Yes.

Senator BRADLEY. Would you do that for the record?

Mr. BAXTER. Yes, we will.

Senator DURENBERGER. Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

For a variety of reasons, Pennsylvania has been reluctant to apply for a 2176 waiver. Is that right?

Mr. BAXTER. Well, we have, Senator, applied for several waivers. We've received approval for one, and have two waivers presently in Washington with HCFA. And we are developing at least one other that I am aware of.

Senator HEINZ. That's mostly for the aged and disabled?

Mr. BAXTER. No. For the mentally retarded, for the physically handicapped, mentally alert populations.

Senator HEINZ. What about the aged and disabled under medicaid?

Mr. BAXTER. So far we haven't done that because the biggest problem there is that one has to have control of the expenditures and be able to shift moneys from one source, and, in effect, to close beds in one place, and then redirect the money to the community. In the case of our institutional areas for the mentally retarded, we are able to do that because we think we can provide better care. In the case of frail elderly in nursing homes, the need is so great at this point that we haven't felt it appropriate to start closing nursing home beds for us to shift the moneys over.

Senator HEINZ. Now you have said some very fine things about S. 1614. That would help you deal with that problem, wouldn't it?

Mr. BAXTER. I think that the pooling of the resources of medicare and medicaid and the capitation approach is something that we would like to tackle, although, of course, as Barbara said, it's not easy.

Senator HEINZ. In further response to Senator Bradley's notation of the 30 percent lower cost of the institutional alternatives, is there any other information you can give us about that other than it meets Senator Packwood's commonsense test of doing the necessary things in the home?

Mr. BAXTER. We have been very closely following the Philadelphia project for our own purposes, and I'm sure that we could provide you with additional information on how that is going. That's part of the national channeling project. We are proud to be a part of it.

Senator HEINZ. I am told that about one-third of the enrollees in the Philadelphia channeling project are dually eligible medicare/medicaid beneficiaries, and that those dually eligible persons are more sick and more in need of home- and community-based care than the medicare-only beneficiaries. Would S. 1614 therefore help States provide more humane care?

Mr. BAXTER. I think that depends upon the particular way that we set up the experiments. But it should be able to do that.

Senator HEINZ. I'm talking about the dually eligible.

Mr. BAXTER. Clearly serving people that need care and haven't been served would respond to that kind of concern.

Senator HEINZ. Thank you.

Senator DURENBERGER. Any other questions?

[No response.]

Senator DURENBERGER. I have half a dozen for each of you which I am going to submit to you and ask you to respond for the record.

Senator DURENBERGER. We appreciate your being here and we appreciate your efforts in preparing for today's testimony. Thank you very much.

Mr. BAXTER. Thank you.

Senator DURENBERGER. We have another panel: Ralph Hazelbaker, president and chairman of the board of Americare Corp. of Columbus, Ohio, on behalf of the American Health Care Association and the National Council of Health Centers; and Charles H. Edwards, general counsel and director of government affairs, American Association of Homes for the Aging, Washington, D.C. If there is any possibility for Eunice Cole to come up at this time, we might move things along a little bit. Is Eunice here? She is representing the American Nurses' Association in Kansas City, Mo.

We have written statements from all of you which will be made a part of the record. And you may proceed to summarize them, and we will start with Ralph.

STATEMENT OF RALPH HAZELBAKER, PRESIDENT AND CHAIRMAN OF THE BOARD OF AMERICARE CORP. OF COLUMBUS, OHIO, COLUMBUS, OHIO, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION AND THE NATIONAL COUNCIL OF HEALTH CENTERS

Mr. HAZELBAKER. Thank you, sir.

Mr. Chairman, and members of the subcommittee, I am Ralph Hazelbaker. And accompanying me is Gary Capastran of the American Health Care Association staff.

Each of my organizations has submitted a written statement for the record. And I am president of Americare Corp., which operates 21 skilled nursing facilities serving over 2,300 patients.

As you have heard, the problems of financing and delivering long-term health care are staggering. There seems to be five root problems.

No. 1, demographics. The elderly population is increasing rapidly, especially among the oldest age groups who are most in need of long-term health care.

Health status—extended life span means more chronic disabilities, more difficult recovery, and deteriorated mental function.

Cost—long-term health care is expensive, primarily because of the intensive hands-on care required.

Knowledge—the magnitude and complexity of a long-term health care demand is without precedent. All the rhetoric about solutions aside, the growth of knowledge of critical information lags the increasing needs.

Infrastructure—service capacity also lags the increasing need. For example, the growth of nursing home beds is not keeping pace with the population. Just to maintain the existing level of service, a new 100-bed facility would have to open each day for the foreseeable future. A worse situation is the shortage of health and related professionals trained in long-term care.

The written statements of both organizations recommend a wide range of actions Congress can take to improve the public benefit programs and to strengthen the private capabilities of individuals and their families for caregiving and financial involvement.

I would like to specifically identify three priority areas for short-term congressional consideration.

One, industrial development bonds. It is possible you will soon have to react to House provisions to severely restrict the use of industrial development bonds. IDB's are practically the only form of financing available for nursing home construction and rehabilitation. Conventional financing is virtually unavailable and prohibitively expensive if offered. Unlike the use of IDB's for most purposes, Government directly benefits from their use for nursing homes because of significantly lower capital cost reimbursement under medicare and medicaid.

Two, prospective payment for medicare SNF's. I hope that early next year you will approve a medicare prospective payment plan for skilled nursing facilities. Such a plan, long overdue to provide incentives for efficient care delivery, is needed now more than ever to accommodate the incentives for rapid discharge under the new medicare DRG payments to hospitals. SNF prospective payments would attract more provider participation in medicare to meet the increased demand for posthospital care.

Point three, demonstrations of comprehensive long-term care. Congress should also approve early next year the next step to the development of long-term care. Small, cautious steps must be taken to build on the positive experiences of such previous steps as the medicaid home and community-based service waivers and the medicare prepaid capitation methods. We support and encourage the types of focused demonstration projects as proposed in S. 1614, the Health Care Coordination Act, and S. 1244, the Senior Citizens Independent Community Care Act. We must oppose bills such as S. 1539 and S. 1540 which would greatly increase spending and distort the long-term care delivery system before sufficient knowledge and capacity is achieved.

A comprehensive chart of our evaluation of these bills is in our written testimony.

For longer term congressional consideration we suggest three priorities:

Capital financing—one of the most crucial issues for long-term care for the rest of the century will be the availability of capital to develop the needed infrastructure. For nursing homes alone, an increase in beds of 54 percent, some 700,000 beds, from 1977 to the year 2000 and 132 percent, or an additional 1 million beds, by the year 2030 will be needed just to maintain the present service capacity according to HCFA projects of age specific utilization rates.

While there has been growth in home health, residential care, congregate housing, adult day care, et cetera, an adequate supply of home and community-based services does not now exist and will take years to develop. The present dilemma is that medicare and medicaid reimbursements are not sufficiently adequate and stable to attract ample private capital, yet the public sector has been unwilling to make a direct financial commitment.

Individual and family responsibility—the magnitude of the long-term-care challenge is such that public policies must encourage the maximum effort of individuals and their families by strengthening their financial ability to do so. Examples include expanding State flexibility to pursue family contributions for the medicaid cost of care, when appropriate, and eliminating barriers to charitable contributions to nursing homes. Several tax policies could be modified to accommodate private financing of long-term-care costs, notably individual retirement accounts, medical expense deductions, and dependent care credit.

And, lastly, medicare coverage—medicare provides scant coverage of the long-term care needs of its beneficiaries. Priorities for improvement should be expanding the restrictive definition of covered nursing home services, reducing the excessive patient cost sharing, and waiving the minimum three-day prior hospitalization requirement.

The American Health Care Association and the National Council of Health Centers believe that these factors should be addressed to assure that elderly Americans will be able to get the care they need. We look forward to working with Congress, the administration, the States, and consumers and their families to meet this challenge.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Mr. Hazelbaker follows:]

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STATEMENT BY

Ralph E. Haxelbaker

BEFORE THE

Subcommittee on Health

Committee on Finance

U.S. Senate

Monday, November 14, 1983

Summary of AHCA Recommendations

- Oppose action to prevent a full restoration of normal federal-state financing of Medicaid services.
- Develop state reimbursement policies that will result in reasonable long-term financing arrangements which can effectively reduce program costs, place renewed emphasis on quality care for program beneficiaries, and provide for rational growth in capital expenditure levels.
- Develop and implement a Medicare prospective payment system for SNFs.
- Improve Medicare long term care benefits by expanding Medicare nursing home coverage, reducing SNF patient cost sharing, and eliminating the three-day prior hospitalization requirement.
- Adopt policies that encourage equity formation and financing for health care institutions as a means of controlling Medicare and Medicaid costs.
- Encourage individuals and families to contribute to the cost of long term care or to assume the role of caregivers by developing a "block time" policy, expanding state flexibility to implement a family responsibility law, eliminating barriers to charitable contributions to long term care facilities.
- Develop incentives to encourage individuals and families to financially support long term care by modifying provisions related to IRAs, allowing tax deductions for itemized medical expenses paid on behalf of elderly family members without regard to the support requirement, eliminating support requirements for tax deductions for partial care of the elderly, and modifying provisions regarding parental and handicapped relative trusts.
- Support the Health Care Coordination Act (S. 1614) as the most constructive and feasible proposal pending to improve the delivery of long term care in a way which increases effectiveness and administrative efficiency.

Mr. Chairman and Members of the Subcommittee:

My name is Ralph E. Hazelbaker and I am representing the American Health Care Association. AHCA is the largest organization of nursing home providers and I am Chairman of its Payment Committee. I am also President of Americare Corp., operating 21 facilities in 3 states and serving over 2200 patients.

First, I want to express our appreciation to you for having this valuable set of hearings and encourage your consideration of this emerging, dynamic, and challenging area.

My statement today will focus on issues related to the jurisdiction of this Committee. There are important public policy issues and private sector activities which cannot be overlooked, but must remain for another occasion. I will also focus on short-term and longer range solutions, and try to minimize hand wringing about problems which have been quite thoroughly discussed.

How to pay for nursing home care has become a dilemma confronting many of our aged and their families. It is also a problem faced by public officials responsible for the Medicare and Medicaid programs. The problem will not go away; it will rapidly get worse if ignored. The facts substantiating this claim are staggering:

- The number of Americans age 85 and older will double in the next 18 years.
- Of the approximately 6 million people who form the core of the long term care population, less than one-third are currently in a long term care facility.

A range of services has been developed to meet the diverse needs of the long term care population in the community, but for many of our aged and disabled there are no alternatives to nursing home care. Half of our chronically ill elderly have no spouse or other family member who can provide informal health care and maintenance. Even with the support of informal caregivers, a significant proportion of these individuals would still require nursing home care at some point because of their degree of debilitation. A recent GAO study indicates that patients being admitted to nursing homes are getting sicker and older and the trend will likely continue.

AHCA believes that new and creative financing options for long term care services must be developed for the future. Public policies must deal with the complexities of financing long term care and commit adequate resources to assure quality long term care services can be provided. AHCA also believes it is time that public policies acknowledge the heavy financial burdens placed upon individuals and their families in providing in-home care or financial support for institutional services. Thus, public policies must assure that nursing homes can continue to provide high quality long term care services, while assisting and encouraging individuals and their families to provide or help pay for such services in the future.

FEDERAL MEDICAID FINANCING

As a result of provisions in the 1981 Omnibus Budget Reconciliation Act, federal payments to the states for Medicaid were reduced by 3, 4, and 4.5 percent in 1982, 1983 and 1984, respectively. The Administration proposed in its 1984 budget a continuing three percent reduction of federal Medicaid matching payments to the states in fiscal 1985 and beyond. The proposed reduction would shift financial responsibility for Medicaid costs from the federal government to the states by over $500 million in fiscal 1985 and $3.3 billion over 5 years.

AHCA is opposed to congressional action which would prevent a full restoration of normal federal-state financing of Medicaid services. Current budget restrictions provide states with a strong incentive to contain Medicaid costs; further federal reductions at this time would be punitive. Because most states are unable to cover the financial short fall, the cut would be passed on to Medicaid beneficiaries, directly or indirectly.

STATE MEDICAID REIMBURSEMENT

Many state Medicaid reimbursement programs are driven by budgetary concerns. The result is a program of inadequate reimbursement that tacitly encourages a lessened level of quality care to Medicaid beneficiaries. Many state payment systems are developed for short-term budgetary reasons without any long-term or strategic planning objective (i.e., a comprehensive goal directed toward long run savings, quality care, and pricing efficiency in the wake of a growing demand for long term care services). State reimbursement policies must be developed that will result in reasonable long-term financing arrangements which can effectively reduce program costs, place renewed emphasis on quality care for program beneficiaries, and provide for rational growth in capital expenditure levels (including replacement and renovation costs).

States should be encouraged to consider patient needs in the development of Medicaid reimbursement rates. Currently, many states utilize rate structures that ignore differences in patient needs. Such systems encourage nursing homes to accept light care patients and avoid heavy care patients, since the costs of care are different, while reimbursement levels are the same. Consequently, heavy care patients often remain in hospitals and increase Medicaid costs.

In addition, the Medicare statewide class limitation on Medicaid rates should be eliminated as a restriction on the Medicaid rate establishment process. An examination of interstate variations in Medicare long term care costs shows that Medicaid long term care reimbursement practices explain the differences. In the long term care industry, Medicaid is the driving force, not Medicare. Moreover, an innovative Medicaid reimbursement system that induces significant efficiencies and causes Medicaid cost reductions will also lead to reductions in Medicare reimbursements. Because of these interrelated phenomena, states with inefficient Medicaid reimbursement systems find the Medicare limitation rather high and easily met, while states with effective Medicaid reimbursement systems find the Medicare limitation to be difficult to meet. In both cases, the limitation reduces incentives for efficiency.

State cost containment efforts generally have taken three forms: providing incentives for the facilities to introduce efficiencies and economies into their operations (often through the profit motive), defining costs out of existence (most often by refusing to recognize legitimate capital costs), and artificially restricting the supply of beds and thus denying access to care for a part of the patient population. Only the first of these approaches to cost containment can be justified; however, it is the approach least often utilized because it requires more effort and reimbursement design expertise than most states have. If current budgetary pressures continue, and the latter two cost containment approaches continue to be used, the quality of long term care will decline, capital investment will flow from the industry, and any cost containment will actually represent cost shifting to other parts of the Medicaid system. Short-term cost savings are likely to be achieved by having the industry subsidize the cost of patient care, but in the long run state costs to revive the industry will outweigh this short-term saving. In the meantime, our nation's elderly will suffer, both those who gain access to the system and those who do not. They will be the victims of short-sighted cost containment efforts of states which do not understand the nature, dynamics, and incentives of a for-profit industry.

MEDICARE REIMBURSEMENT

A serious problem confronting policymakers relates to the reluctance of nursing homes to participate in Medicare. As a result, many Medicare beneficiaries in need of skilled nursing facility (SNF) care are "backed-up" in expensive hospitals awaiting SNF placement. Medicare's inappropriate payment system is one of the major reasons for the reluctance of SNFs to participate in Medicare.

AHCA recommends that a prospective reimbursement system for SNFs under Medicare be implemented to achieve significant savings and enable beneficiaries to receive the appropriate services in the least costly setting. AHCA is actively pursuing the development of a Medicare SNF prospective reimbursement system with HCFA. While the mechanics have yet to be worked out, it is clear that certain basic principles must be incorporated into the system. These principles include:

- <u>Recognition of patient needs</u>-- Separate reimbursement rates should be provided for a limited number of classes of patients which require different levels of basic nursing services (i.e., assistance in activities of daily living). These classes should be based on the number and types of activity of daily living dependencies, and a good proxy for these dependencies in the Medicare population is likely to be the hospital discharge DRG.
- <u>Bundling of services where appropriate</u>--Reimbursement for special

services and ancillary services which are provided to most of the patients of a given class should be folded into the basic payment for that class. On the other hand, special services (e.g., tube feeding, decubitus ulcer care) and ancillary services (e.g., physical therapy, inhalation therapy) needed by only a part of the patient class should be reimbursed on a per unit of service basis so that patients needing these services are not financially unattractive to the facility.

- Monitoring of unbundled services--To prevent excessive use of services remaining unbundled, standards should be developed for use by the fiscal intermediary and/or prior approval should be made necessary for the utilization of the service.
- Inclusion of profit and capital costs--Because it is undesirable to make a special provision for profit, capital, return on equity, etc., or to utilize a pass-through mechanism for these items, capital costs or allowances should be folded into each of the basic patient class rates. Since the use of charges automatically folds such costs into the base, the system would be simpler than if cost-based.
- Regional variation--Because wages vary significantly by region, separate rates should be established by major geographic region, with consideration given to urban-rural location. No distinction should be made by ownership, size, or hospital affiliation, however. Only differences due to factor prices and patient needs should be recognized for reimbursement purposes.

The new hospital prospective payment system provides a strong incentive for early hospital discharge of Medicare patients. Although the effects of the hospital payment system has not been fully studied, long term care providers expect a large number of hospital patients to be moved quickly to a lower level of care. These patient transfers are expected to be more numerous and to involve patients who require more intensive service. A prospective payment system for SNFs would attract more provider participation in the Medicare program and alleviate some of the anticipated nursing home bed shortage that would result from increased hospital dischaxge. The coordination of these two initiatives is necessary to avoid a hospital "back-up" crisis and to facilitate the continuity of post-hospital care.

MEDICARE BENEFITS

Medicare provides scant coverage for nursing home services and other long term care. Medicare only covers up to 100 days in a SNF. This small benefit is further diminished by Medicare's restrictive medical eligibility criteria, excessive patient cost sharing, and a minimum three-day prior hospitalization requirement.

Skilled Nursing Care Definition

The most significant problem faced by a Medicare beneficiary seeking SNF care is the narrow definition of covered services. Beneficiaries must require "on a daily basis skilled nursing care provided directly by or requiring the supervision of skilled nursing personnel or other skilled rehabilitation services, which as a practical matter can only be provided in a SNF on an inpatient basis..." However, the Medicare program has not adapted its coverage to take advantage of the services which can be provided in today's long term health care facilities. Medicare provides no coverage of the most utilized nursing home service — intermediate care. Medicaid, on the other hand, is a heavy user of ICF services, which are less intensive than skilled nursing. Although not one of the mandatory

Medicaid services, ICF services are utilized by each state program.

Under the Medicare SNF definition of covered services, patients who need skilled nursing or rehabilitative services regularly, but not necessarily daily, would not meet eligibility requirements. For example, a cancer patient, receiving chemotherapy or radiation treatments in a hospital and requiring close observation and intermittant nursing supervision, would not be covered by Medicare for SNF services. Similarly, a patient needing general health supervision and personal care (as might be provided in an ICF or a Medicaid SNF) as well as physical therapy or another rehabilitative service less than daily would not qualify for the SNF Medicare benefit but might remain in a hospital or be discharged home where a wide array of home delivered services would be covered by Medicare and other public programs. Although the patient might be better served at a lower overall cost in an SNF, such care would not be covered by Medicare.

Congress should consider cost-effective opportunities to restructure Medicare nursing home coverage. Based on the experience of Medicaid and prepaid health plans, a less restrictive definition of covered nursing home services should be developed. Medicare should provide coverage for care between SNF services and home health care. An example of a recent change which is expected to be cost-effective and lead to patient well-being is the inclusion of ICF services in the new Medicare hospice benefit.

SNF Patient Cost Sharing

Present cost sharing for SNF patients is excessive, especially relative to other Medicare services. In 1984, a SNF patient, after already having paid the hospital deductible and possibly coinsurance for the required prior hospitalization, will pay $44.50 per day from the 21st day to the maximum 100th day of care. In many areas of the country, a $44.50 fee approaches 100 percent of the facility's reimbursement. In contrast, home health recipients pay nothing and hospital patients pay a deductible of $356 for the first 60 days. According to current practices, a Medicare patient in a SNF for the same number of days would be faced with 5 times that amount in copayments: $1780.

President Reagan, recognizing the unfairness of present SNF cost sharing, proposed the rate be reduced to five percent of the hospital deductible--$17.80 in 1984. AHCA supports the President's intention to reduce the SNF patient's cost sharing. However, when a SNF prospective payment is implemented, SNF coinsurance should be set at a percentage of the SNF payment rate and not be artificially linked to hospital costs.

Prior Hospitalization Requirement

To qualify for SNF services, Medicare beneficiaries must spend at least three days in a hospital. Although a provision in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) gave the HHS Secretary authority to waive the three-day prior hospitalization requirement if such a waiver would not lead to an increase in costs, HHS has taken no action on this issue to date.

Although HHS contends that elimination of the three-day stay requirement would increase Medicare costs, it should be waived when specific patient conditions can be identified for which the prior hospital requirement is neither cost-effective nor necessary to control inappropriate utilization. Examples of such situations include patients receiving Medicare home health services who develop an intensified nursing need and beneficiaries whose "spell of illness" has not ended because 60 days have not lapsed since their earlier hospital or SNF care.

Congress should urge HHS to implement expeditiously the cost saving provision included in the 1982 TEFRA and seek a timetable for HHS action. With the strong incentive for hospital admission and earlier transfer of hospital patients as a result of the new Medicare hospital prospective payment system, reform of the prior hospitalization requirement takes on added importance.

CAPITAL FINANCING AND CAPITAL FORMATION

One of the most crucial issues for long term care for the rest of the century will be the availability of capital financing for nursing homes. An increase in nursing home bed of 54 percent from 1977 to the year 2000 and 132 percent by the year 2030 would be needed just to maintain present age-specific level of service. Dramatically stated, a 100 bed nursing home would need to be opened each day to the year 2000 just to meet that projected demand. Capital costs of at least $10 billion can be expected.

Tax exempt bonds are the main source of capital financing for the nursing home industry and over the last few years have been essentially the only viable source of capital. Since health care providers are being squeezed between higher construction costs and tightened government reimbursement, conventional lenders are even more reluctant to finance new facilities. When conventional financing is offered, it is generally at interest rates higher than most providers can afford due to Medicaid and Medicare payment policies, which fail to provide a fair recognition of property costs.

Congressional considerations to restrict severely the use of tax exempt bonds, notably industrial development bonds (IDBs), are a major concern to nursing home providers. AHCA recommends that no restrictions on the use of IDBs by nursing homes, beyond the 1982 actions, should be approved at this time. Nursing homes financed through IDBs have not abused the program and the reasons cited for restricting the use of IDBs do not apply to long term care facilities. Restrictions on their use will only lead to higher capital financing costs and thus increase Medicare and Medicaid spending.

Equity financing can also lead to lower capital financing expenditures in both the Medicare and Medicaid program, if reimbursement policies are enacted to encourage this type of capital financing. A recent HHS Inspector General report, recommending reduction in the return on equity capital (ROE) allowance for SNFs under Medicare, raises serious questions over the Administration's long range health policies aimed at controlling expenditure levels. Such policies are shortsighted, and while they may reap some short-term savings, will only lead to an erosion of equity capital in an already heavily debt leveraged industry. Congress should seek policies that encourage equity formation and equity financing for health care facilities as a means to control Medicare and Medicaid costs.

INDIVIDUAL AND FAMILY INVOLVEMENT

AHCA believes that policymakers should create an environment that encourages and strengthens the financial ability of individuals and their families to provide home care or to pay for institutional care when necessary.

Purchase of Block Time

The 1977 National Nursing Home Survey indicates that more than one-half of nursing home residents at the time of admission had a remaining spouse, child, or other relative. In many cases, these family members are willing to care for their relatives, but require periodic and temporary respite from caregiving. However, current Medicaid eligibility and coverage requirements discourage family involvement in the care of patients. Medicaid policies should be changed to encourage family members to assume the role of informal caregivers, even on a part-time basis.

Once institutionalized, many individuals quickly exhaust their financial resources paying for care and become financially dependent on Medicaid. In addition, such individuals are rarely returned to the community after conversion to Medicaid, even if the person's condition improves, not only because of the lack of personal financial resources, but also because of the general difficulty associated with readmitting a Medicaid patient to a nursing home. The block time concept offers a solution to this problem.

Block time would allow flexible financing alternatives under the Medicaid program that would offer limited duration nursing home care in lieu of permanent institutionalization. Medicaid could purchase extended inpatient respite care under restrictive circumstances when such arrangements could be shown to be cost effective to the program. Block time would be periodic, but extended respite care designed to prolong the involvement of informal caregivers. As a result, families could continue sharing in the care of Medicaid or potential Medicaid recipients and thus share in the cost of delivering long term care services.

This block time approach would enable the Medicaid program to guarantee an individual admission to a specific long term care facility for a prearranged period of time, begining on a specific date, in two situations:

- when families of currently institutionalized and eligible individuals are willing to participate in a home care program, and
- when individuals, who are ineligible for Medicaid benefits because of their personal financial resources and who are currently being cared for by families, can be targeted as high risk candidates for Medicaid-supported nursing home care.

The first situation can be accomplished under existing federal statute, but the creative financing arrangements necessary to accomplish this objective need to be encouraged at the state level. However, the second situation will require changes in the federal and state eligibility requirements. To address the second situation, federal and state laws need to be modified to enable the Medicaid program to assist in the payment of temporary nursing home care (block time) rendered to a targeted high risk population of aged and severely disabled individuals who are not currently eligible for Medicaid program benefits. This high risk group would be defined as being both:

- Medically necessary
  - 65 years of age or older, and
  - physically or mentally unable to care for themselves (i.e., targeted population having a dependency in at least four basic personal care services of bathing, dressing, eating, and toiletry as measured by the Katz Index of Activities of Daily Living).
- Financially necessary
  - personal financial net worth of $50,000 or less, and
  - excessive medical expenses that would exceed annual income if institutionalized in a skilled or intermediate care nursing facility.

Specifically, this proposal would apply on a progressive scale depending on individual net worth, if all other criteria are met (i.e., age, functional disability, and annual personal income). In addition to the age/functional disability and net worth criteria that must be met, this program could be further restricted through a Medicaid cost sharing provision. Medicaid payment to a nursing home for the block time purchase could be reduced by the amount of the eligible individual's personal monthly income.

The proposal can be modified to accommodate any one of several other viable financing options. For example, the eligible individual could be required to pay the nursing home the difference between the private pay daily charge and the amount of the Medicaid payment as an inducement to secure nursing home participation in such a program. In addition, the Medicaid agency could arrange to purchase, on an annual basis, a prearranged number of nursing home beds to accommodate, coordinate, and effectively target the block time program to nursing homes that are willing to participate.

Family Responsibility

Because of pressures to better target Medicaid spending, interest has grown in having patients' families assume, when possible, some of the financial esponsibility for Medicaid-provided nursing home care. Responding to this interest, HHS issued a policy guideline which indicated that states may require families to contribute to the cost of care under certain circumstances. The adopted policy neither prescribes a specific family responsibility formula, nor requires states to adopt any such system; it merely provides states flexibility to explore this approach and to adopt a family responsibility system if a state deems one necessary and practical. AHCA believes state flexibility on this issue, within broad federal parameters, is essential.

Increasingly unable to pay for the care needed by their many recipients, states continue to adopt measures which limit available services and restrict the number of individuals eligible for care. Family responsibility approaches become critical because they reduce the need for states to adopt more objectionable cutbacks and enable states to target Medicaid funds for those most in need.

Presently, the Medicaid program essentially prohibits families from making any contribution for the care of their elders. Some families have felt so strongly about their desire to pay for additional services or higher quality care for their elders that the families have gone to court, unsuccessfully, to assert their desire. Family involvement in the financing of care also has positive consequences for the family being more involved in monitoring the care provided and searching for appropriate, less costly arrangements. Furthermore, public acceptability of the entire Medicaid program would be enhanced by family responsibility provisons. Criticism has been voiced about Medicaid patients who have wealthy sons or daughters. However rare such situations may be, states should have some ability when they do occur to seek a modest family contribution.

Critics of the concept focus on the problems of implementing a family responsibility program. While states would have practical problems to overcome in devising a system, it is not justification for rejecting the family responsibility concept.

AHCA believes Congress should enact a provision providing states with flexibility in pursuing family responsibility programs. Specifically, we suggest the HHS Secretary be allowed to waive Medicaid requirements for meritorious state initiatives for family participation. The waiver mechanism has been successful for fostering other reasonable Medicaid cost-saving efforts, such as restricting patient freedom of choice of providers, without the concern and uncertainity of blanket authorization.

An alternative approach would be to allow states to delineate the specific types and extent of Medicaid-covered services for nursing home patients and permit families to purchase any uncovered ancillaries. This approach would achieve two important objectives: first, the patient would receive some demonstrable gain from the family participation and therefore families would be more willing to participate than if the gain accrues only to the state; and second, this approach recognizes the increasing difficulty of states to make "payment in full" for all services of all Medicaid patients.

However, to avoid some of the pitfalls of the supplementation methods used in the early years of Medicaid, family responsibility programs should not affect Medicaid eligibility or payment to providers. Specifically, an individual's eligibility for Medicaid must not be contingent upon the family making contributions nor should the ability or inability of a patient's family to contribute affect the patient's eligibility. In addition, facilities should not be responsible for collecting from the patient's family.

Charitable Contributions

A related area for Congress to facilitate improvements in nursing home care is by encouraging charitable contributions. Presently, there are two barriers which should be eliminated.

The first barrier prohibits contributions to nursing homes in which there is a Medicaid recipient related to the giver. In the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, Congress made it illegal to knowingly and willingly charge, solicit, accept or receive any gift, money, donation or other consideration, whenever Medicaid-covered services are involved. The only exception is when the consideration comes from an unrelated person or organization for a philanthropic or charitable purpose. In practice, the broad intrepretation of this provision goes beyond the target of eliminating blatantly fraudulent or abusive practices to preventing the use of private funds for care services. AHCA recommends Congress clarify the 1977 provision to allow again bona fide voluntary contributions from patient-related givers.

The second barrier is that "undesignated" nursing home philanthropy may be merely offsets to Medicare and Medicaid reimbursement. The 1980 Omnibus Reconcilitation Act addressed this issue in regard to protecting hospital philanthropy. AHCA recommends the 1980 provision be extended to include nursing homes.

TAX INCENTIVES

Nearly one-half of the elderly's health expenses are paid from private sources, usually personal savings. Because nursing home care is the number one health cost burden for the elderly and their families, and because the government has reduced budgets for public health programs such as Medicare and Medicaid, the financial impact of health expenses on the elderly and their families will worsen. Current federal income tax laws are ineffective and actually impose several financial disincentives to informal family caregivers. Several disincentives in the tax code can simply be modified to target their effectiveness towards caring for and supporting our aged and disabled.

Developing tax incentives may also serve to reduce the need for some individuals to rely on Medicaid and Medicare. Many people view Medicaid as a last resort and would not apply for coverage if their families were assisted by tax deductions for contributions to the cost of their long term health care.

Individual Retirement Accounts (IRAs)

One of the most significant advances in public policies that will positively affect the ability of individuals to privately finance future long term care needs has been the extension of IRA eligibility to all workers and their spouses.

There are two major drawbacks in the IRA statutory requirements, however, if this provision is to be considered a potential financial resource for paying for long term care services:

- no deduction is allowed individuals for contributions made after attaining age 70 1/2, and
- the individual must start drawing down on the IRA account upon reaching age 70 1/2.

These mandates fail to recognize the dynamics and demographics of the nursing home population. With the average admission age of a nursing home resident over 75 years (and approximately 80 years of age for widowed females who represent a majority of nursing home residents), the mandatory IRA distribution age is several years before the typical nursing home admission. Forcing individuals to draw upon IRA funds before these funds are necessary to pay for nursing home services is a self-defeating public policy.

AHCA recommends that these two barriers be eliminated. Individual IRA fund balances that are not distributed upon the death of the individual (or that of a spouse if joint life expectancies are considered) could be taxed as ordinary income to the decedent utilizing the special 10-year averaging rule.

Medical Expense Deduction

Presently, many families who help finance a private paying relative's stay in a nursing home or their other long term care cannot deduct the expense because of the support requirement for qualifying as a dependent. Dependents are defined as "individuals who receive over half of their support from the taxpayer and who meet one of the nine relationship tests." Requiring a taxpayer's contribution of more than one-half the support of the cared for individual to meet the definition of a dependent ignores the validity of situations when families contribute significantly to the care of an aged person but fall short of the high support requirement.

AHCA recommends the tax deduction for itemized medical expenses recognize long term care expenses paid on behalf of elderly family members, without regard to the support requirement.

Dependent Care Credit

The tax code allows a tax credit for up to 30 percent of qualifying child or dependent care expenses which are paid for the purpose of enabling the taxpayer to be employed. To be eligible for the credit, a taxpayer must maintain a household for certain qualifying individuals (including a spouse or any dependent who is physically or mentally incapable of caring for himself or herself) to whom the taxpayer contributes more than one-half the support. There are two drawbacks to this credit that do not make it conducive to caring for the aged or disabled, or, as an example, to utilize adult day care programs when necessary. First, for married taxpayers, the qualifying expenses are limited to the earned income of the spouse with the lesser income. Generally speaking, no credit is allowed if one spouse does not work. Second, the taxpayers must contribute more than one-half the support for the individual to qualify as a dependent. Furthermore, the support requirement dissuades multiple cooperative arrangements among family members, each of whom may be capable and willing to care for the individual, but only for a portion of the year.

AHCA recommends the dependent care credit be improved by eliminating 1) the limitation on qualifying expenses to the earned income of the spouse with the lesser income and 2) the primary support requirement for elderly relatives.

Parental and Handicapped Relative Care Trusts

Last Congress, Senators Jepsen and Laxalt introduced S. 1378 which would have enabled individuals to contribute up to $3,000 per year to a qualified parental or handicapped relative care trust. The objective of this type of long term care trust account is to support the accumulation of personal resources to help pay for future long term care services that may be needed by aged and disabled people. There are a few changes to the proposal, however, that would make it more effective.

First, the provision should allow trust distributions used for the care of the beneficiary to be tax-exempt. The incentive is to allow a tax sheltered vehicle to provide for the long term care of a beneficiary. The trust should be created to allow the full amount of trust corpus to be utilized for the beneficiary's care, not just the tax shield or after-tax amounts.

In addition, creation of a trust should be allowed at any time, not just at time of disability, so that sufficient corpus accumulation could be available to provide for the long term care of the beneficiary.

Finally, distribution of trust funds for other than the care of the intended trust beneficiary should result in taxable income to the recipient of such funds. While funds used to provide care for the beneficiary should not be taxable, funds distributed for other than the care of the beneficiary should be taxable to the recipient of such funds.

INTEGRATED LONG TERM CARE

In recent years Congress has enacted significant improvements in long term care coverage and a waiver program for Medicaid home and community-based services. Other farreaching demonstrations and innovations are being tried, such as social health maintenance organizations and multi-service "campuses" for the elderly.

There is much congressional interest to move ahead expeditiously, but also much concern about not acting hastily. There are several incremental provisons, as have been presented, which address specific problems in long term care. The long range is much more difficult to sketch.

Barriers to constructing the long range solutions are many. There is so much that is unknown about such basics as what services are really effective, how to target services so they are truly cost-efficient, and how to assess individual needs. Also much of the infrastructure is just being developed, notably home services and the training of health and allied professionals. There is a real danger in overloading the system, promoting more than can be delivered, and raising expectations which today cannot be met.

The Committee has before it some bills which attempt to make the next "big step." Only one is supportable at this time—the Health Care Coordination Act (S. 1614). AHCA finds S. 1614 the most constructive and feasible proposal pending to improve the delivery of long term care in a way which increases service effectiveness and administrative efficiency. S. 1614 would greatly reduce the Medicare-Medicaid and acute-chronic care fragmentation of health services to the frail elderly. AHCA recommends S. 1614 as the most innovative, doable next "big step" in long term care, building on such positive steps as Medicaid home and community-based services and Medicare prepaid group plans.

Following is a chart which lays out the features and our preliminary analysis of S. 1614 and three other comprehensive long term care proposals.

FEATURES AND AHCA'S VIEWS ON MAJOR COMPONENTS OF COMPREHENSIVE LONG TERM CARE BILLS

	S.1614	S.1244	S.1539	S.1540
Proposal Summary	o Demonstration — 20 projects o Combining of Medicare and Medicaid for dually eligible beneficiaries o Medicaid-operated with broad state flexibility	o Demonstration -- 4 states o Expands Medicare coverage of long term care	o Block grant to states for home and community based services o Does nothing for 3 years -- begins in FY 86	o Medicaid home and community based program would be expanded and waiver safeguard removed o Nationwide
Costs	o Limits Federal and state cost to what would otherwise occur o Immediate Medicare savings because of fixed funding at 95% of average beneficiary cost o Facilitates savings because of integration of Medicare-Medicaid and acute-chronic care o Encourages incentive-based reimbursement of providers	o Needs overall cost limit -- Only limit on per capita costs o Requires provider payments to be fixed fee per capita despite the lack of knowledge and experience	o New expenditure of $2.25 billion for FY 86-88 o States may not use funds to reduce or reprogram existing spending o No limitation that per capita cost not exceed institutional cost	o No limit o Federal cost increase can be expected from increase in Federal matching rate for home care, esp. without HHS waiver approval safeguard o No limitation that per capita cost not exceed institutional cost
Coverage	o At least Medicare-Medicaid benefits o Opportunity to provide full range, within cost limit o Uses Medicare-Medicaid providers	o Entitlement for all elderly Medicare beneficiaries in state o Greatly expands home services, beyond present knowledge and capacity o Anti-institutional oriented and does little to improve Medicare's scant nursing home coverage o Means tested copayments o Greatly expands providers beyond present Medicare standards	o Greatly expands home and community based services, beyond present knowledge and capacity o Prohibit inpatient coverage (even inptient respite care) adding to problem to continity of care o Unnecessarily restricts participation of facilities in providing facilty-based services o Anti-institutional oriented to move patients out of facilities rather than most appropriate setting	o Greatly expands home services, beyond present knowledge and capacity o Unnecessarily restricts participation of facilities in providing facility-based services o State has unrestricted choice of providers, not the patient o Increased federal matching rate will reduce state diligence to target

FEATURES AND AHCA'S VIEWS ON MAJOR COMPONENTS OF COMPREHENSIVE LONG TERM CARE BILLS

	S.1614	S.1244	S.1539	S.1540
Administration	o Integrates care for dual Medicare-Medicaid beneficiaries o Permits targeting to local needs, capacities, and circumstances	o Unclear why a state would want to administer, esp with difficulty that the program be statewide o Builds on Medicare despite shortage of LTC experience, Federal inflexibility, etc. o Does nothing for Medicaid coordination, but study o State agency should not be open, but Medicaid agency designated because of expertise and provider relations o Creates new, cumbersome "patient assessment teams" to direct services	o Increased fragmentation with new program o Does not include usual block grant protections about recordkeeping, auditing, etc. o Prohibits proprietary providers from available financial assistance	o Medicaid-based o Distorts Medicaid to home care with 10 percentage point increase in Federal matching rate

GFC:cjw
November 10, 1983

SUMMARY

With a rapidly aging population, growing demand for nursing home and other long term care services, and mounting federal and state fiscal pressures, it becomes quite evident that quality long term care services cannot continue to be adequately financed through present financing approaches. Public policymakers cannot ignore on long term care issues; our nation's lawmakers and regulators must recognize the rapidly growing demand for long term care services and develop strategic policy objectives that will adequately address the issues. Of paramount importance is how to pay for these services in view the rapidly escalating demand.

The ideas presented here are intended to generate thought and debate over future financing options for long term care. These ideas emphasize the importance of utilizing private personal resources to pay for long term care services as opposed to continuing the substantial reliance on existing Medicare/Medicaid funding. The proposals highlight both public and private approaches to maximizing the interplay of private funding, informal caregiving and broad financial/insurance programs to meet the future long term care needs of our nation.

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STATEMENT
OF THE NATIONAL COUNCIL OF HEALTH CENTERS
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

ACCESS TO LONG TERM CARE SERVICES

November 14, 1983

STATEMENT
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TO THE
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UNITED STATES SENATE

ON

ACCESS TO LONG TERM CARE SERVICES
NOVEMBER 14, 1983

The National Council of Health Centers takes this opportunity to offer its views on providing access to long term care services for millions of elderly Americans.

Members of the National Council are investor-owned multifacility nursing home corporations which own or manage approximately 2,000 nursing centers in 48 states and the District of Columbia. Our members also provide other health related services such as home health, alcohol and drug rehabilitation, adult day care, retirement communities and hospice services.

Because our members are actually involved in providing health care for the elderly, we are acutely aware that the over-65 group is the fastest growing segment of the U.S. population and has the highest rate of institutionalization.

In terms of patient make-up, the median age of nursing home patients in 1982 was 81. Seventy percent are over 70 years of age. Five percent of the over 65 population live in nursing homes at any given time, and one out of five, or approximately 20 percent of the over-65 population, will reside in such a facility at some time during their lives. In total, the industry now serves more than 1.4 million Americans and experiences an occupancy rate in excess of 95 percent. Nursing home care is the fastest growing segment of our health care industry, with 1981 revenues totaling more than $24 billion. Over 70 percent of the facilities are owned and operated by proprietary firms, with approximately 17 percent of the industry homes being publicly-owned multifacility organizations.

National Council members have made great strides in developing and implementing innovative and cost effective long term care programs for our residents with an increasing emphasis on expansion of services along a continuum of care. We realize that only by having a complete array of health services available to the community can the elderly choose the services most appropriate to their needs.

As members of the health care industry, however, the National Council has grave concerns relating to the continued ability of our nation to provide appropriate long term services. We are alarmed by the country's current economic environment and several disturbing trends in long term care.

The increase in health care demand stemming from the tremendous growth in the size of the elderly population, with an increasing likelihood of disabilities, will greatly increase competition for the scarce health dollar. Our country no longer has limitless financial resources. We can no longer look to the federal and state governments for total direction and financing for our nation's long term care programs. While the federal government has made positive strides in restraining skyrocketing costs in various areas of our economy, many states have reached their financial limits in supporting Medicaid programs. Medicaid dominates the nursing home industry -- providing about one-half of our revenues for 60 percent of all patients.

Negative Impact of Current Trends in Long Term Care

In addition to these fiscal realities, we are concerned about several significant trends, that may adversely impact on the ability of our nation to continue to provide access to long term care services. First, a growing disabled and dependent elderly population will dramatically increase demand for more intensive nursing home services and greatly increase competition for the shrinking health dollars. Second, in an effort to reduce costs, states have limited nursing home reimbursement or the bed supply or both. Third, the Medicare prospective reimbursement payment system for hospitals may increase the growth of nursing home expenditures because hospitals are discharging more and sicker patients to nursing homes. In an effort to prepare for the impact of those individuals, the National Council is making efforts to expedite the implementation of a prospective payment system for SNFs. Fourth, expanded home health care for the elderly has been found to be beneficial. Such services, however, do not reduce nursing home or hospital total service costs. Fifth, and finally, two congressional initiatives are disturbing. Proposals to restrict the use of IDBs will severely curtail nursing home construction and the continued difference in rates for hospital-based and freestanding SNFs is an inappropriate and inefficient use of public funds, especially at a time when Medicare's Trust Fund faces a financial crisis.

A 1983 General Accounting Office (GAO) study of nursing homes conducted over the last several years found two conflicting and distressing tendencies. The elderly population now residing in nursing homes are becoming increasingly disabled and dependent, and the number who may need to enter a facility in the next decade is likely to increase. Unless major breakthroughs in the treatment of chronic diseases occur, extended life expectancies, with greater likelihood of chronic disabling diseases, will lead to an increase in demand for more intensive nursing home services.

A second trend found by the GAO involves the effort by most states to keep their Medicaid costs down by limiting nursing home beds despite high occupancy rates and growing demand for services.

Virtually all the states have had problems financing this service and their efforts to reduce costs tend to focus on ways of limiting nursing home reimbursement or the supply of beds or both. Such policies further reduce the number of available nursing home beds.

A 1982 GAO examination of expanded home health care found that the elderly should benefit from such services, but increasing home health care would not ensure cost reductions. The GAO found that when expanded home health care services were made available to the chronically ill elderly, their longevity and client-reported satisfaction improved. However, those services did not reduce nursing home or hospital use or total service costs.

An important finding was that community-based long term care services will continue to grow. This is because three-quarters of the long term care population resides in the community. Most individuals, prefering to avoid institutionalization are served largely by relatives or friends. Seventy-five percent of that group report they only get assistance from such informal sources, and seek numerous options in long term care in addition to nursing services. We fully support the GAO's contention that more research is needed in two areas: the effects of expanded home health care on the elderly highly at risk of placement in nursing homes, and how home care should be organized for maximum efficiency and effectiveness.

Prospective Payment System for Hospitals and SNFs

Recent legislative and regulatory changes in Medicare's hospital reimbursement system has resulted in a new diagnosis-related group (DRG) payment system for hospital care. With its built-in incentive to reduce lengths of stay in hospitals, the DRG system may place greater pressures on the limited nursing home bed supply. Already, hospitals are attempting to place more patients in nursing homes and in home health care as they try to discharge patients earlier than they have in the past. However, nursing home beds are not available to meet this new demand.

Unfortunately, the current Medicare payment system for SNFs is not geared to respond to the heavier care patient. Already our members are reporting that Medicare patients are exceeding the cap on routine services in nursing homes, which is currently about $60 per day.

Our concern that it will be many months before the Health Care Financing Administration (HCFA) completes its work in developing a prospective payment system for Medicare SNFs has led us to move in that direction. The question we asked is whether a DRG system similar, but less complex, than that of hospitals, could succeed in SNFs. To this end the National Council and the American Health Care Association has jointly commissioned a study to determine its feasibility.

We strongly believe that a well-designed prospective reimbursement system for Medicare SNFs that recognizes the needs for heavy care patients is absolutely critical in the new climate which encourages early release of hospital patients. The final results from our study are expected shortly. We will be pleased to share our data and recommendations with the Committee at the earliest opportunity.

Industrial Development Bonds Needed for Nursing Home Construction

The National Council is greatly concerned about proposals in the Congress to severely restrict the use of industrial development bonds (IDBs). Provisions in the House Ways and Means Committee's omnibus tax reform package, H.R. 4170, would impose a $40 million limit on IDB use by for-profit companies and a $150 per capita state cap for such organizations.

Few people, lawmakers and consumers alike, realize the crucial role that IDBs provide as a source of financing for the construction of our nation's nursing homes. The use of IDBs for the financing of new nursing home construction, and the improvement and expansion of existing facilities is practically the only form of financing available to construct new nursing homes. Conventional financing is not a viable alternative. The investment community reports that long-term taxable borrowing, even for a financially strong health care provider, is prohibitively expensive. Taxable long-term financing may not be available at all or only at an exhorbitant cost to most nursing home owners and operators.

Multifacility chain nursing home firms are the principal source of new facility construction in the industry. More than $10.6 billion in capital will be needed to meet the cost of constructing the 260,000 additional nursing home beds that will be required by 1990. It has been estimated that with an average facility size of 100 beds, one nursing home a day must be built in this country for a least the next 20 years to meet our needs.

Pending Legislative Proposals

As mentioned earlier, many members of the National Council are engaged in providing home health services in addition to nursing home care. One might assume that we would automatically favor any legislation which greatly expands the availability of these services. State and federal budget realities force us to do otherwise.

Our great concern rests with the thousands of patients already in our nursing homes who have seen their benefits and entitlements reduced as a result of budgetary cutbacks. We do not entertain much hope that this situation will greatly improve nor do we believe that there will be a savings in public monies by any expansion in benefits. Numerous studies have shown that:

- Families undertake heroic measures in order to maintain their loved one in their home.
- The patient population in nursing homes has become much sicker with greater deficiencies in activities of daily living then ever before.
- The nursing home bed shortage and hospital backlog problems are so great that by diverting a nursing home eligible patient to an in-home service, another patient in need will only take his place.
- Home health services cannot be a one-for-one substitute for nursing home care. Many other costs are involved in assessing the expense of maintaining someone in their home.
- The hospital DRG system will impose even greater burdens on nursing homes and home health agencies by creating a new class of patient whose needs are sub-acute with great demands for increased nursing care.

Regarding the pending legislation, we support and encourage the types of focused demonstration projects as proposed in S 1614, the Health Care Coordination Act, and S 1244, the Senior Citizens Independent Community Care Act. The importance of innovative programs and research in long term care cannot be overstated. We need experimentation to determine the appropriate mix of services and eligibility for the elderly in need of nursing home services which will encourage, but not supplant family support. At the same time. they should not strain budgets to the detriment of the patients who are in nursing homes or who will be there in the future. We are confident that nursing home care will remain the lower priced alternative when assessing the needs of the eligible patient population, particularly as we begin to see the impact of the more acutely ill DRG-released patients.

Our position with regard to proposals such as S 1540, which would expand home health services, is that we do not believe it is appropriate at this time to increase expenditures in this area when we are cutting back in almost every other health care program. This is especially true when the cost effectiveness of an additional home health benefit has not been demonstrated. We would prefer to see increased participation by states in

Section 2176 waivers. These waivers permit states to offer a whole host of non-institutional services to nursing-home eligible patients. The only caveat is that the services cannot cost more than comparable care in the nursing homes. We believe that such an approach would permit experimentation while at the same time assuring that the experimentation is cost effective.

No one should be deluded that the demand and need for additional nursing home beds will in any way diminish if home and community-based services are expanded. The enormous projected increase in the aged 80 and over population, which is the group most at risk of institutionalization, will assure a continuous heavy demand for nursing home beds on into the future. It is our hope that increased private resources available to this population, whether through Individual Retirement Accounts, Reverse Annuity Mortgages or private health insurance, will alleviate the pressure placed on public financing for long term care services.

We look forward to continuing the development of services in long term care. In representing investor-owned chain nursing home firms, we take pride in the efforts of our members to improve the quality of life for the elderly. The National Council believes that the numerous concerns highlighted in our statement should be addressed immediately if our nation is to assure that elderly Americans will not lack necessary care. We look forward to working with the Congress, the Administration, the states and consumers to meet these long term care challenges. By working together, we are confident that viable and responsible solutions can be found to the significant problems facing the nursing home industry and long term care.

STATEMENT OF CHARLES H. EDWARDS, GENERAL COUNSEL AND DIRECTOR OF GOVERNMENT AFFAIRS, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, WASHINGTON, D.C.

Senator DURENBERGER. Mr. Edwards.

Mr. EDWARDS. Mr. Chairman, and members of the subcommittee, I'm Charles Edwards, general counsel to the American Association of Homes for the Aging. I'm accompanied this morning by Tina Biondo and Howard Bedman, legislative analysts for AAHA.

We appreciate the opportunity to present AAHA's views on challenges facing our long-term care system and pending legislative proposals. Over the coming decade this Nation will undergo a demographic explosion which will swell the ranks of our elderly population. Unprecedented percentages of our Nation's citizens will live into the 8th, 9th and 10th decades of life, requiring unprecedented amounts of long-term care services. Yet even at the present time our long-term care system cannot be said to be fully meeting with success. Older persons too often find their health and ability to function as individuals compromised by their inability to obtain needed long-term care services by insufficient quality of services available and by massive problems in coping with the costs of long-term care.

Largely because of inadequate Government support, our current fragmented long-term care system is clearly not good enough to meet today's demands. And it is equally clear that it will in no way be fully able to answer tomorrow's challenges.

Long-term care services must be viewed as a continuum. Too often today the debate about appropriate provision of services seems to focus simply on the choice as to whether services are to be delivered in the institutional setting of the nursing home or in the individual's own home. Both types of services are essential and adequate funding needs to be available for both.

Our member homes are actively involved in the delivery of community services such as Meals on Wheels, adult day care and transportation, as well as various health services. AAHA believes that the definition of the long-term care system must also take into account facility-based settings other than nursing homes. AAHA members include many housing projects for the elderly and personal care homes which provide a variety of essential services in helping their aged residents to function with the maximum possible degree of independence.

Hospital prospective payment under medicare threatens to exacerbate problems currently facing the long-term care system. We believe prospective payment will create strong pressures for hospitals to discharge medicare patients substantiallv earlier than in the past, and perhaps earlier than their medical condition warrants. Nursing homes already have too few beds for those in need of skilled nursing care.

AAHA urges the subcommittee not only to fully review the impact on SNF's of the medicare hospital prospective payment system, but to examine with great caution the potential application of a prospective payment system to SNF's. If we are to adopt such a system to help control costs, we feel that it first needs to be studied and tested thoroughly to insure that it is viable for institutions and will not result in a deterioration in the quality of care provided residents. In fact, we believe that quality of care must be a major consideration in determining payment rates under any system.

AAHA is pleased that there are a number of long-term care initiatives pending in Congress which reflect a recognition of the need to address the long-term care needs of the elderly and disabled more fully. We hope that these proposals will stimulate debate and be further refined to better reflect current and future needs.

We must express concern that S. 1539, S. 1540 and S. 1244 focus too exclusively on noninstitutional long-term care services. While we recognize that this is the area of services which had been traditionally excluded from coverage under public programs, we would caution against creating any system of coordination of long-term care services which does not include facility-based care. This segmented approach strikes at the heart of our concern about developing a full continuum of care and services.

The long-term care and nonsystem is fragmented enough without institutionalizing a division between institutional and noninstitutional long-term care.

AAHA believes that S. 1614's proposed consolidation of medicare and medicaid funds to provide comprehensive health and long-term care benefits to the dually eligible is an interesting concept which deserves further study. Tapping acute care dollars for long-term care is appealing.

AAHA wants to stress, however, that this approach should not require the elderly to sacrifice their also needed acute care coverage in order for improvements to be made in the long-term care coverage.

Finally, AAHA urges that these legislative proposals be modified to enhance the participation of nonprofit facility based providers in the provision and coordination of the entire range of long-term care services. AAHA members are experienced leaders in the long-term care field and providers of a wide range of services. Our community based facilities have much to contribute in what we hope will be an emerging comprehensive long-term care system capable of meeting the needs of the elderly and disabled.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Mr. Edwards follows:]

Testimony of

Charles H. Edwards

General Counsel and Director of Government Affairs

of the

American Association of Homes for the Aging

Presented to the

Subcommittee on Health

of the

Senate Finance Committee

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The American Association of Homes for the Aging is pleased to have this opportunity to convey its views on meeting the long-term care needs of our nation's elderly and disabled.

AAHA is the national organization representing over 2,200 nonprofit homes, housing and health-related facilities for the aging. AAHA member homes have deep roots in the communities they serve through sponsorship by religious, fraternal, labor, private, and governmental organizations. While there is diversity among our member homes, they all have two things in common: they are all operated on a nonprofit basis as a service to the community in which each is located, and they are all committed to delivering the best possible services and care to each of the approximately 500,000 persons they serve.

Providers, today's and tomorrow's elderly, the disabled, and public policy decision-makers are all faced with long-term care challenges of immense proportions. The sheer demographics of aging makes the issue of assuring accessible, affordable long-term care critical. Even at the present time, we are not coming close to adequately meeting the long-term care needs of our older population (65 plus) which totals 26 million and comprises 11.4 percent of the population. Unless action is taken in the near term to address this unmet need, the problem may overwhelm us in the not so distant future; in 2030, 59 million Americans will be 65 or older, representing 18 percent of the population.

The urgent need for fashioning a comprehensive, well-designed national policy on long-term care is dramatized further when one considers that the fastest growing segment of the aged population is the one most vulnerable--those 85 and older. More than 20 percent of the 85-plus group are in nursing homes, and, even among those not residing in an institution, 40 percent need the assistance of another person in basic physical activities and/or home management activities. This age group will increase from one percent of the total population currently to 5.2 percent in 2050.

As we endeavor to develop innovative approaches for addressing the challenges which face us now and those which lie ahead, we must recognize the expansive nature of long-term care services. Having just returned from AAHA's Annual Meeting in Chicago, where over 3,000 health experts and AAHA members providing services to the elderly gathered to examine new perspectives in long term care, I want to emphasize that there are a vast number of long-term care services and a variety of settings in which those services are delivered. While generally long-term care no longer refers to only health-related services, the current perception of long-term care and, thus, strategies for assisting the aged, are commonly regarded too narrowly.

Although there is much talk about the need to develop a continuum of care and services, the current debate about services seems focused in such a way as to suggest that a choice must be made between institutional care and alternatives to institutionalization. As preoccupation with cost pervades discussion of this issue, this resulting dichotomy is not surprising, as the former has become equated with high cost and the latter has become associated with the promise of lower costs. The politics of austerity is a current reality and cost, of course, cannot be ignored when fashioning a long-term care system. Nevertheless, this dichotomy is dangerous. First, at a time when this nations's elderly increasingly need access to a full range of services, AAHA believes that this characterization could lead to the unfortunate result of "pitting one against the other," particularly regarding competition for public funding. The availability of the entire range of services is essential if we are to meet appropriately different levels of services needed by various individuals as well as by a single individual whose needs change over time.

This "either-or" approach seems to imply as well that the consumer's choice is limited to residing in a nursing home or being able to remain in one's own home--somehow pictured as a single-family dwelling where he, or more often she, has lived for the last 30 years--and receive community-based services. This distortion of the choices, whether intended or unintended, does a disservice to the elderly seeking appropriate long-term care services. Moreover, it does a disservice to all AAHA nonprofit members--nursing homes, housing, personal care homes and continuing care retirement providers alike.

For AAHA members providing SNF and/or ICF care in a facility setting, this approach incorrectly seems to exclude them from the community. Quite to the contrary, our member homes are intricately tied to and part of their respective communities; each has a local board of trustees and 75 percent of AAHA members have religious sponsors in the community. In addition, this dichotomy fails to recognize that many of these homes are providing community-based long-term care services such as meals on wheels, adult day care and transportation to the elderly residing outside their facilities. This artifical division currently in vogue in public policy debate must be erased so that these community-based programs run by experienced nonprofit facility-based long-term care providers can take their rightful place as part of the solution to our long-term care dilemma.

Perpetuating this characterization also tends to hide from view other key settings along the continuum of care and services which are also strongly represented among AAHA nonprofit providers. For instance, without a broader vision about long-term care, where does a housing project for the elderly which provides such services as congregate dining, recreational activities and an emergency response system fit? Similarly, are personal care homes which provide assistance with activities of daily living, supervision and a secure environment, destined to be excluded from the long-term care solution?

The unavoidable consideration of cost may, in the end, limit federal government involvement in many of these critical long-term care options, but they should remain clearly visible so that the elderly, who currently must fend mainly for themselves in the long-term care arena, know what the choices are.

Moreover, in the midst of budget cuts and new deficit reduction initiatives, we are deeply concerned that development of a national long-term care policy will become the cloak for efforts really targeted at reducing federal long-term care expenditures. We must come to grips with the realities of budget issues, but we must not allow cost issues to obscure our responsibility to meet human needs. A strong federal funding commitment is essential to assuring access to and quality of care for the nation's aged requiring long-term care service.

The recently implemented DRG payment system for hospitals is likely to have a profound impact on the demand for long-term care. The incentive which this system provides to discharge patients earlier is unquestionable and unprecedented. SNFs will be asked to admit Medicare patients as never before.

The problem lies, however, in the fact that, as this time, no one is able to ascertain whether lengths of hospital stays will decrease by five percent or 25 percent. Nursing homes already have too few beds for those in need of skilled nursing care. No one presently knows how many Medicare patients are backed up in hospitals awaiting admission into a SNF, costing the federal government four times as much in costs per day. As GAO recently reported, the number of patients involved could be anywhere from 250,000 to 2 million. Whatever the number, back-up could easily double or triple, as no preparations have been made for the upcoming dramatic rise in the demand for SNF care.

Many SNFs, particularly in the proprietary sector, are not going to be anxious to admit these patients because Medicare patients often have needs requiring complex and costly care, and they often quickly become Medicaid-eligible. SNFs are having enough problems treating most Medicaid patients at a reimbursement rate significantly below the actual cost of care (about a 15 percent difference on average), without admitting these high intensity Medicare patients. It is abundantly clear that severe access problems are going to result from the implementation of the Medicare prospective payment system for hospitals.

The federal government must take the lead in devising methods to increase incentives to admit these backed up Medicare patients without impacting those who need to remain in the nursing home. Such an initiative could, of course, save a significant amount of federal dollars. By encouraging construction for needed new nursing home beds, establishing a separate reimbursement mechanism for high care Medicaid patients who recently converted from Medicare, and ensuring that hospital residents are not discharged prematurely, the federal government can create an environment in which long term care facilities will be able to avoid a crisis and handle the significant new demand for services that will inevitably arise from the implementation of the DRG payment mechanism.

HFCA is also currently attempting to devise a Medicare prospective payment mechanism for SNFs. It is hoped that this will further increase incentives to contain costs in the health care system. While keeping the lid on rapidly escalating costs is certainly a laudable objective, such attempts cannot be allowed to sacrifice other priority concerns, such as quality of care and access to necessary services.

A problem that arises in this context, which comes up all too often in a variety of long-term care financing issues, is the absence of adequate data available on which to base an equitable, efficient Medicare prospective payment system for SNFs. No demonstration project has ever been funded to look at prospective payment for Medicare patients in SNFs until New York state received such a grant only several months ago. The results from this demonstration, however, will not be available for several years. While several studies have been conducted on case-mix measures for Medicaid, and some states have instituted prospective payment plans for Medicaid patients in SNFs, this population is significantly different from those treated under the Medicare program, and these efforts, therefore, have little application to the system being contemplated by HCFA. We fear that a payment mechanism will be recommended which is not based on adequate research and has never been tested or attempted elsewhere. Surely, if New Jersey had not previously used DRG's, no one would have been willing to take the risk of implementing such a system throughout the country.

There are several other critical concerns which we have with regard to Medicare prospective payments for SNFs. As several commentators have noted, unlike the hospital sector, quality of care varies widely in the nursing home industry. Prospective payment must not reward delivery of the lowest common denominator of care. Quality of care must be a major consideration in formulating a payment system, since the well-being of the patient has to be the primary goal underlying health care financing.

Access for patients with high care needs is an issue which also must be directly addressed by the payment proposal. The growing back-up problem articulated earlier cannot be ignored, and appropriately tested case-mix adjustments ought to be considered for incorporation into the system at some point.

Other areas which should be included in the payment system are a strong appeals process, a capital maintenance allowance and a rate structure which takes account of a facility's historical costs.

AAHA is pleased that there are several long-term care initiatives pending in Congress which reflect a recognition of the need to address the long-term care needs of the elderly and disabled more fully.

We must express concern that most of the bills (Senator Hatch's S. 1539 and S. 1540 and Senators Packwood and Bradley's S. 1244) focus exclusively on non-institutional long-term care services. While we recognize that this is the area of services which had been traditionally excluded from coverage under public programs, we would caution against creating any system of coordination of long-term care services which does not include facility-based care. This segmented approach strikes at the heart of our concern about developing a full continuum of care and services. The long-term care "non-system" is fragmented enough without "institutionalizing" a division between institutional and non-institutional long-term care.

AAHA believes that the proposed consolidation of Medicare and Medicaid funds (contained in Senator Heinz's S. 1614) to enhance the effort to provide comprehensive health and long-term care benefits to the dually eligible is an interesting concept which deserves further study. Clearly, tapping acute care dollars for long-term care is an appealing concept since the vast majority of public funding for the elderly's health and long-term care needs currently is funnelled in that direction. Again, however, we must express a concern. Since the proposal is designed to be cost neutral, we must assume that it is based on the premise that inappropriate utilization of acute care under the programs is occurring; that is, if coverage of long-term care services as well as access to services existed, these services could appropriately substitute for some acute care. If this premise is valid, then this proposed consolidation of funding could result in better meeting the real health and long-term care needs of the elderly. However, it would be unconscionable to ask or require the elderly to sacrifice their also needed acute care coverage in order for improvements to be made in their long-term care coverage.

Finally, AAHA urges that these legislative proposals be modified to enhance the participation of nonprofit facility-based providers in the provision and coordination of the entire range of long-term care services. AAHA members are experienced leaders in the long-term field and providers of a wide range of services. Our community-based facilities have much to contribute in what we hope will be an emerging comprehensive long-term care system capable of meeting the needs of the elderly and disabled.

In discussing approaches to meeting the long-term care needs of the elderly, it is important to remember that partial solutions can be found outside programs that directly provide coverage for long-term care services. Federal funding for research is an important investment in the future. Relatively small outlays now for research have the potential to reap major rewards--cost savings in long-term care expenditures--in the future.

In the case of long-term care, attention must be focused on unlocking the key to Alzheimer's disease. This tragic and prolonged but terminal disease is the fourth leading cause of death among the aged. AAHA is pleased that the recently enacted FY84 Labor-HHS Appropriations bill includes $3.5 million for up to five research centers to study Alzheimer's. However, more must be done.

Our long-term care system, part of a partnership between government and the private sector, should strive to deliver services at the highest level of excellence at the lowest possible costs to private individuals and the public.

These goals are threatened, however, by the rapidly-increasing incidence of concentration of control over nursing home beds in the United States. Recent years have witnessed a perilous phenomenon as for-profit, and particularly for-profit chain, nursing home beds have expanded sharply as a perentage of total nursing home beds.

AAHA is concerned about this development because we believe that it could possibly result in lower quality care--as well as higher prices.

As nonprofit homes, we obviously believe that homes who provide services to the aged solely out of a sense of mission regarding the restoration of health, rather than for the purpose of investor profit, provide the <u>best</u> possible care available.

Beyond that, however, if concentration of ownership results in market domination, we fear that decreased competition could bring about erosion of the quality of care provided in selected communities throughout the nation. And equally we fear that market domination could result in higher costs, whether to be borne by consumers or government.

We want to take note of the recently released report of the Seattle office of the Federal Trade Commission which concluded that there are "a number of unfair and deceptive business practices exist(ing) in some nursing homes today," particularly affecting private pay patients.

Private pay patients are to be found disproportionately in for-profit, rather than nonprofit nursing homes.

That FTC investigation also called for an anti-trust investigation focusing on the nursing home industry.

AAHA is pleased to note that the FTC is launching a new probe of for-profit nursing homes' business practices.

We remain convinced that an additional step needs to be taken: a comprehensive investigation of anti-trust issues related to the increasing concentration of ownership and market control within the industry.

Assuring the highest possible quality of care should be the overriding goal of our long-term system. We look forward to continuing to work with the Congress, as well as the Executive Branch, in pursuit of that goal, and we appreciate the opportunity you have provided us to participate in these hearings.

STATEMENT OF EUNICE COLE, R.N., PRESIDENT, AMERICAN NURSES' ASSOCIATION, INC., KANSAS CITY, MO.

Senator DURENBERGER. Ms. Cole.

Ms. COLE. Good morning. Mr. Chairman, and members of the committee, those left, I am Eunice Cole, president of the American Nurses' Association, representing 165,000 members nationwide. And with me today is Norma Small, who is the assistant director for genealogical nursing at Georgetown University, and Thomas Nichols, ANA's legislative counsel.

I'm appearing before the committee today to voice ANA's support for Senate bill 410, the Community Nursing Centers Act of 1983. This bill would offer millions of Americans access to low cost, quality health care services within their local community setting. ANA does commend this committee for holding hearings on alternative approaches to institutionalization.

For years we have voiced our growing concern that the health care system is structured around institutional care at the expense of more desirable modes of delivery. This focus on institutional care has made us illness oriented rather than wellness oriented in our society.

It is neither in the public interest nor in the interest of the patient to structure the health care delivery system in such a manner as to provide no alternative to institutional care. Institutions are often over utilized and are certainly expensive. It is no wonder that this country which more than any other industrial society relies on institutional care also experiences a higher per capita cost of health care.

Mr. Chairman, we believe the community is the core of any health care system. More of the needs of our elderly population can be and should be provided for in the community setting. And that is the thrust of Senate bill 410, to provide a mechanism for the delivery of cost effective quality health care services in the community, and to establish community nursing centers to provide for their health care needs. For the first 3 years of operation, CNC's would be open to those eligible under medicare who currently reside in an acute care institution or who have been institutionalized for at least 30 days within the last 2 years, and others that are deemed eligible by the Secretary.

In addition, medicaid services and well baby care could be initiated by CNC's at the individual State's option. We do hasten to note that CNC's would be substitutive in nature; not the establishment of a new group of providers to increase the burden on the Nation's medicare system.

The CNC's would be established within existing visiting nurse agencies, and within the local nursing components of public health departments. The primary focus of CNC's will be to keep people who would otherwise be institutionalized out of hospitals and nursing homes through the provision of nursing services.

Payment under medicare for CNC services will be provided on a per case basis. This fee to be substantially lower than the fee currently being paid to existing providers will be paid on a capitated monthly basis. This is similar to the prospective payment system recently initiated for part A hospital services.

ANA has supported the prospective payment concept, realizing that reasonable costs have long ago stopped being reasonable. In a CNC, a client's health care needs will be identified, classified in terms of nursing needs, and a health care plan would be formulated in collaboration with the medical plan.

The solutions to our ever-growing health care cost dilemma lies not in reducing the eligibility and benefits that millions of needy and older Americans rely upon, but by providing lower cost alternatives. We have HCFA data that has shown that VNA's and public health nursing departments as time-proven providers of lower cost medicaid services.

Moreover, the establishment of a CNC providing lower cost nursing services would result in fewer marginal visits to physicians or hospital outpatient departments.

We are aware that cost containment is an overriding concern. Senator Dole has requested a cost estimate from the Congressional Budget Office several months ago on Senate bill 410, but, as of yet we have not yet received a formal response.

To the best of our knowledge, enactment of Senate bill 410 would ultimately result in a net reduction for medicare outlays. Regrettably, we must deal with a catch-22 scenario that plagues all who try to develop reasonable alternatives to keeping people in hospitals and nursing homes. It is automatically assumed by cost estimaters that additional cost will be incurred by services provided to individuals who are eligible but are not currently using such services.

They contend that those presently eligible who do not have access to community nursing centers will take advantage of a new service resulting in increased costs. However, it is impossible to counter this argument without actual program data. That is why the star print of Senate bill 410 was introduced to restrict the eligible population to those already drawing upon medicare services and resources. This modification will adequately address the concerns of those who fear induced costs.

Nurses have long been recognized as providers of necessary health care services to the elderly and their families in an efficient cost effective manner.

We urge this committee to continue to weigh the benefits of our proposal. We, in the nursing profession, seek an opportunity to provide our services in a manner that will both benefit the community and alleviate the fiscal disaster facing health care today.

Thank you very much.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Ms. Cole follows:]

TESTIMONY

of the

AMERICAN NURSES' ASSOCIATION

on

S. 410

THE COMMUNITY NURSING CENTERS ACT OF 1983

before the

SUBCOMMITTEE ON HEALTH

of the

SENATE FINANCE COMMITTEE

by

EUNICE COLE, R.N.

PRESIDENT

on

NOVEMBER 14, 1983

Mr. Chairman, I am Eunice Cole, President of the American Nurses' Association, representing 165,000 members nationwide. I appear before this committee to voice ANA's support for S. 410, the "Community Nursing Centers Act of 1983." It is our belief that this bill, which was introduced by Senators Inouye (D-HI) and Packwood (R-OR) would offer millions of Americans access to low-cost quality health care services within their local community settings.

ANA commends this committee for holding these hearings on alternative approaches to institutionalization. For several years, we have voiced our growing concern that the health care delivery system was increasingly being structured around institutional care, at the expense of more desirable modes of delivery. We have expressed our belief that the focus on institutional care has made us "illness oriented" rather than seeking alternative approaches which would contribute to the "wellness" of our society. We do not believe that it is either in the public interest, or in the interest of the patient, to structure the health care delivery system in such a manner that there exists no alternatives to institutional care. Institutionalization is often overutilized, and it is always expensive. It is no wonder that this country, which more than any other industrial society relies on institutionalization for health care services, also experiences a higher per capita rate of health care costs.

Mr. Chairman, we view the community as the core of any health care system. The needs of our nation's elderly population can be, and should be provided for in the community setting. This approach would result in a higher standard of living for the elderly, while communities would benefit by retaining the entire spectrum of age groups within them. That is the thrust of S. 410, to provide a mechanism for the delivery of cost-effective, quality health care services in the community, and to establish community nursing centers to provide for their health care needs. These services would be provided by registered professional nurses and would be preventive as well as currative in nature. The principal beneficiary group would be the elderly. For the first three years of operation, CNC's would be open only to Medicare eligibles who: (1) currently reside in institutions; (2) those otherwise eligible and who have been institutionalized for at least 30 days prior to the enactment of this bill; and, (3) those persons deemed eligible by the Secretary who do not meet all of the criterion described in number 1 and 2 preceding. Medicaid services and "well-baby" care could be initiated at CNC's at the individual states' option should they determine CNC's to be appropriate, cost-effective providers of Medicaid services.

We hasten to note that CNC's would be substitutive in nature - not the establishment of a new group of providers to increase the burden on the nation's Medicare system. The CNC legislation does not seek "bricks and mortar" monies to create such entities. The first CNC's would be established within existing Visiting Nurses' Agencies (VNA's) and local nursing components of public health departments. The emphasis on building upon these entities currently operating will eliminate the costs and confusion of establishing overlapping and duplicate organizations while at the same time strengthening the financial soundness of these organizations.

Community Nursing Centers will be a lower cost alternative to the more costly settings of such institutions as hospitals, skilled nursing homes, and intermediate care facilities. The primary focus and effort of the CNC's will be to keep people who would otherwise be institutionalized out of hospitals and nursing homes through the provision of nursing services. And because CNC's will be a freestanding entity, controlled by professional nurses, there will be no opportunity for hospitals and nursing homes to use CNC's as a funneling mechanism to bring clients into their institutions. We wish to emphasize that CNC's will be a less costly alternative to institutionalization.

Payment under Medicare for CNC services would be provided on a per case basis. This fee, to be "substantially lower" than that fee currently being paid to existing providers, would be paid on a capitated monthly basis, one month in advance. This method of reimbursement is strikingly similar to the Prospective Payment System recently initiated for Part A hospital services. ANA has supported the prospective payment concept, realizing that "reasonable costs" have long ago stopped being reasonable.

By ensuring a fixed payment schedule on a per client basis, this known factor of a CNC's cash flow will enable the maximum utilization of the financial resources of the CNC and in turn, deliver services on a consistant basis. This will help consumers by providing for a more efficient, cost-effective health care delivery system, moreover, the client-specific fee would also reduce the administrative costs generally associated with itemizing bills and subsequently submitting them for reimbursement.

In addition to a prospectively paid reimbursement system, CNC's would operate a patient classification system very similar to the recently adopted DRG method. In a CNC, a client's needs would be diagnosed, classified in terms of these needs, and a health care plan would be formulated and subsequently submitted to the patient's primary physician for review. Although there are no specific groupings per se, the needs of the CNC eligible population would not be expected to vary radically.

The solutions to our ever-growing health care costs dilemma lies not in reducing the eligibility and benefits that millions of needy and elderly Americans rely upon, but by providing lower cost alternatives that offer a more economical approach to healthcare. HCFA data has shown VNA's and public health nursing departments as time proven providers of lower cost Medicare services. Contained in the language of S. 410 are several cost moderating provisions: the bill would not generate a whole new group of providers, but rather build upon existing VNA's and public health nursing departments; each CNC would have a limited and well defined service area in which to operate, thereby eliminating the creation of unnecessary CNC's; the establishment of a CNC providing lower cost nursing services could result in fewer marginal visits to physicians or hospital outpatient departments that would occur if there were no alternatives; and most notably, CNC's will provide the same services as any institution, but at "substantially lower" costs.

Mr. Chairman, we are aware that cost containment is an over-riding consideration for any responsible legislator these days. It is our understanding that Senator Dole had requested a cost estimate from the Congressional Budget Office several months ago on S. 410, and to date, no formal response has been brought forth. To the best of our knowledge, enactment of S. 410 would ultimately result in a net reduction for Medicare outlays, for reasons outlined in the preceding paragraph. Regrettably, we must deal with a Catch-22 scenario that plagues all who try to develop reasonable alternatives to keeping people in hospitals and nursing homes. It is automatically assumed by cost estimators that additional costs will be incurred by services provided to individuals who are eligible but are not currently using such services. They contend that the present eligible but not utilizing population will take advantage of CNC services resulting in increased costs. It is impossible to counter this argument without actual program data. That is why the Star Print of S. 410 was placed in the "Congressional Record" on August 1, 1983; to restrict the eligible population to those already drawing upon Medicare services and resources. We believe that this modification will adequately address the concerns of those who fear "induced costs."

Registered nurses have long been recognized as providers of necessary health care services to the elderly and their families in an efficient cost-effective manner. This is why we urge this committee to weigh the benefits of this proposal. The nursing profession seeks an opportunity to implement these services in a manner that will continue to benefit the community and its residents in the greatest possible way.

Mr. Chairman, I thank you and the other members of this committee for the opportunity to testify, and would be happy at this point to answer any questions that you may have.

Senator DURENBERGER. Senator Bradley.

Senator BRADLEY. Thank you, Mr. Chairman.

Mr. Hazelbaker first. The need for additional nursing home beds, do you think that need can be alleviated by the home health care option or do you think we are still going to have the problem?

Mr. HAZELBAKER. I think to some extent, Senator, it can be alleviated. How much, I think, is anyone's guess at this moment, until we have these demonstration projects to prove out the concept.

Senator BRADLEY. To Mr. Edwards. You alluded in your comments that you assumed the hospital prospective payments will lead to premature discharges. What is your evidence for that?

Mr. EDWARDS. Well, it's very possible that with the pressure on hospitals to free up beds under prospective payment system and get those patients into the less demanding and less costly environment of the nursing home that there will be subtle pressures to move people out. And in some cases it will be sooner than their condition warrants.

As far as evidence, in part it's based on anecdotal reports from our own administrators of homes who have been having conversations with hospital administrators.

Senator BRADLEY. Just for the record, in New Jersey, we have had the system for a while, and in the early stages there was no evidence of premature discharge. So I think the key is looking at the evidence over the next few years.

Let me ask Ms. Cole. The Community Nursing Centers Act of 1983, as I look at it, focuses primarily on caring for the elderly that are in institutions. What does it say for the community care needs of those outside of the institutions?

Ms. COLE. I would say that ultimately it could deal with those needs as well. What I think we were trying to focus on is that catch-22 that I spoke about, that would indicate that initially everyone could come in. But it would seem to me that over the long haul, that there would be reason to believe that this could focus on the needs of others in the community who need long-term kinds of supervision.

And, in fact, we have some demonstration-type projects that in nursing we have been able to demonstrate that they have been cared for effectively in the community. People have been.

Senator DURENBERGER. Ms. Cole, let me ask you a question on some of the advantages and disadvantages of splitting long-term care service delivery, part of it home based and part of it institutional. Are there some pluses and minuses to setting up the system that would divide it in that way?

Ms. COLE. It's our belief that home is really the best place for people. And if there were ways that those people who are presently in institutions could get back into their own home environment with some minimal types of supervision that that would be the best way for us to move. It just seems to us that there are a number of people who are being discharged from hospital settings directly into long-term care facilities perhaps who possibly could go to the home if they did have the kind of support services that are presently not available to them. So that it just seems to us that there is a place where both services could be used very effectively in extending the senior citizens' potential as far as their own life and the quality of the life that they want to live as older adults.

Senator DURENBERGER. A general question of all three of the witnesses: I'm curious to know—I mean there has been discussion here of prospective payments and skilled nursing facilities and other areas, but could any or all of you describe how a single provider might provide the continuum of long-term care that a person needs? What sort of payment mechanism might we use or might society use to purchase that continuum of care?

Mr. HAZELBAKER. We see on the part of a number of our proprietary providers are moving into some of these other areas of care. And we think that it is appropriate that the proprietary industry do this. Indeed, it's probably our obligation to do that kind of thing.

We have long been accustomed to prospective methods of payment in medicaid. Our industry is accustomed to it. We know how to operate efficiently thereby. And I think, by and large, we feel that we could help formulate a program of prospective reimbursement for a number of these kinds of programs.

Senator DURENBERGER. Mr. Edwards, do you want to add to that?

Mr. EDWARDS. Well, I'm not convinced that any single provider could provide the full continuum in every community in the country. I think it depends on the community. I think clearly in some communities that could be the case. Our AAHA members are involved in providing a wide variety of services. As far as payment, it's our feeling that the best way to assure quality services is to—well, there are two ways. First of all, it has to be based heavily on the cost of the services being provided. And also that if there is some way to link the amount of money that the provider would receive with the quality being delivered.

Senator DURENBERGER. Ms. Cole, do you want to add anything?

Ms. COLE. I would agree with the comments that have been made, but would add to that that I think that within the nursing component that we do have already established through visiting nurse agencies the kinds of quality care mechanisms that would assure that that continuum could exist. And we have some clear evidence of what that does already cost in terms of keeping people in their home care setting. And in addition to that, I think that through the continuum of care that can be provided in the community that we could prevent reinstitutionalization at the acute care, very costly costs that we are now experiencing.

Senator DURENBERGER. I have a number of other questions that I would like to provide to all of you. And I will just make a very brief statement which I was reminded of or at least a thought that occurred to me by the exchange that took place here earlier on the implications of prospective on skilled nursing facilities vis-a-vis hospitals.

I would suggest to all of you that whatever conversations, anecdotal and otherwise, that have taken place today probably are a different sort of a conversation than took place in the past when we had a cost reimbursement system. I would suggest that some of those conversations on the part of hospital administrators are how we can buy skilled nursing facilities for a portion of the time that a person might spend in a hospital, and, thus, make ourselves a little money.

I would suggest to all of you further that the prospect of expanding a prospective payment system along the lines of DRG to include skilled nursing facilities is very immediate; that you had better get your lobbyists all revved up because as soon as we get back here at the end of January this subcommittee is going to address itself to that issue. It may also be an opportune time for us to include home health and some areas. I get as desperate as some of my colleagues who are promoting this legislation with the need to wait until 1986 and so forth. So just sort of as a notice to all of you, I guess, who are interested in an appropriate continuum of care for the long-term elderly in this country and who are concerned like we are about the costs, that there are some of us who see the prospective payment system as a way to move in that direction. And by the kind of question that I just propounded say we will be looking to you to tell us where is the best place to send our check. Who are the most reliable purchasers of service for the elderly? That you will be given an opportunity, hopefully, within the next year or so to demonstrate your skills at allocating the most appropriate form of care to America's elderly.

[The questions from Senator Durenberger follow:]

QUESTIONS FROM SENATOR DURENBERGER

MS. EUNICE COLE

1. Apart from his approval for a plan of care, what is the role of the physician in CNC's?

2. To what extent are VNA's and public health departments now providing less intensive community-based long-term care services, such as homemakers, respite, adult day care, chore services? In view of the fact that these services seem to be among those most frequently mentioned as being needed by the elderly and disabled in the community, how can VNA's and public health departments expand their efforts in this regard?

3. Do you foresee any problems with community nursing centers being licensed in the future?

4. Other than VNA's and public health departments, what other entities could be charged with the functions outlined in S. 410?

5. What problems do you foresee in developing a prospective reimbursement payment system for home health services?

. We have heard testimony that the data about the cost effectiveness of home or community based long-term care are inconclusive. What is your evaluation of these findings?

ANSWERS TO QUESTIONS FROM SENATOR DURENBERGER

1. The focus of the Community Nursing Centers Act is to provide for the establishment of entities that will be staffed, operated, and managed by professional registered nurses. However, we do acknowledge the role of the physician as being responsible for the medical management of the patient. We have attempted to balance physician involvement in patient care with the need to hold down health care costs.

Section (bb)(3)(B) of S. 410 states that no payment shall be made if a physician disapproves of the nursing plan of care within 10 days after it is formally received. The purpose of this provision was to ensure physician involvement in the operation of CNCs. In addition, Section (bb)(3)(B) provides that any individual desiring to acquire community nursing center services who does not or cannot identify a primary source of medical care, shall be referred by the CNC to a qualified physician. Thus, the CNC will ensure that all patients will be under the care of a physician.

S. 410 attempts to balance the need for physician input into the activities of CNCs with the equally pressing need to minimize costs to the federal government. It is our belief that an increased level of physician involvement would negate the potential savings of S. 410. With the quality of care provided by CNCs subject to review by independent review committees, the legislation guarantees services at a savings to the federal government.

2. Currently, services provided through VNAs are financially limited to homemaker, respite, and adult day care services. Enactment of S.410

would allow for expanded nursing services as an incorporated part of the VNA structure.

VNAs have historically been utilized by that segment of our population that can afford to pay out of pocket for these services. This situation has created a financial incentive to institutionalize, since the federal government will pay for institutionalization. This policy has severely limited the potential use of VNAs. Such incentive could be eliminated if VNAs and public health departments were allowed to expand the scope of their reimbursable services. We believe that a consolidation and coordination of all health care modes could only enhance the overall effectiveness of the nation's health care delivery system, while restraining inflation. Only through a consistent dependable payment mechanism can VNAs and public health departments continue to supply community based services.

3. Section (bb)(2)(G) of S. 410 states that, in the case of a state which provides specifically for the licensing of community nursing centers, such licensure would be required in order for a CNC to secure reimbursement under the Act. We have added this provision in order to ensure the quality of care offered in CNCs, if the individual state so desires.

However, we hasten to note that all registered nurses are licensed in every state. Such licensure ensures that quality services are provided. Therefore, regardless of a state's decision to license CNCs, the quality of care provided in centers will be guaranteed.

Should a state decide that CNC licensure is desirable and necessary, we would suggest that the same criteria used by the National

League for Nursing for certifying home health agencies be adopted for CNCs utilizing existing accreditation mechanisms would eliminate burdensome and overlapping requirements, and assume uniform control standards.

4. The legislation, as drafted, would allow any group of professional registered nurses to undertake the establishment of a CNC as a freestanding entity. Existing entities, such as community health centers, provided they meet the criteria set forth in the legislation also could provide CNC services.

The establishment of CNCs could be undertaken by any institution that currently employs or trains nurses, such as a university's school of nursing. Preference will be given to existing entities, in order to reduce overhead costs.

In the alternative, however, a group of nurses could initiate the establishment of a CNC in areas where no current institutional entities exist. It will be up to those centers to maintain prices below that charged by similar entities providing comparable services.

5. We see no problem with a prospective payment system (PPS) for CNC services. ANA is on record supporting PPS for all health care services, regardless of location. S. 410 requires that CNC services be paid for on a pre-paid; pre-capitated basis. We have voluntarily accepted prospective reimbursement for CNC services, which further demonstrates our commitment to curbing health care costs. In our view, the only realistic way to control the costs of home health services would be to pay for them on a prospective basis.

Ideally, CNCs could be used as a prototype for establishing a prospective payment plan for similar home health agencies. Our members are eager to accept this mode of payment in order to prove their commitment to providing lower cost, quality care. Frankly, we fail to see any compelling reason for not utilizing prospective payment for home health services.

6. Regrettably, we must agree that there is currently insufficient data to demonstrate that home health or community leased long-term care is cost effective. Such data will never become available unless reimbursement for these types of health care delivery systems are implemented. CNCs could be an excellent vehicle to study the potential cost-effectiveness of home care.

Until there is a change in federal policy, we see a Catch-22 scenario: no data to support cost-effectiveness until services are actually reimbursed; but no reimbursement until cost-effectiveness is proven. Moreover, it will take several years before the system will begin to enjoy the savings that home care will eventually produce. We hope that the Congress will recognize this predicament, and be willing to reimburse CNC services as a way of proving the cost-effectiveness of community based, long-term care.

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Americare Corp.

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February 13, 1984

The Honorable David Durenberger
Chairman, Senate Finance Committee
Subcommittee on Health
Washington, DC

Dear Senator Durenberger:

Thank you for the opportunity to respond to your questions on long-term care. Your interest in issues that affect our nation's aged and disabled is most assuring to me personally and as a provider of long-term care services.

After you and your staff have had an opportunity to digest my responses, please feel free to contact me with any questions or comments. I think it highly important that our legislative policy makers and industry spokesmen maintain an ongoing dialog on these critical issues.

Yours truly,

Ralph R. Hazelbaker
President

REH:sae

Question 1:

<u>You mentioned that certain state cost containment efforts have attempted to introduce efficiencies and economies into nursing home operations. Could you elaborate on this and describe some of these efficiencies and economies?</u>

Many state Medicaid long-term care reimbursement systems have been resourceful in attempting to control program expenditures on institutional long-term care services. While each of the 49 state Medicaid programs (Arizona does not have a Medicaid program) has adopted a different reimbursement methodology, each reimbursement methodology is usually advocated by its proponents as having been designed to maximize cost effectiveness and produce provider operational efficiency and economy.

Few systems, however, live up to their advance billing. Most fail within a short period of time and are subsequently amended or replaced by the state. This is not surprising, given that most state Medicaid payment systems are designed solely to address short-range objectives which are dictated by then- current fiscal considerations or budgetary limitations.

There are, however, several existing systems that serve the cost containment goals of the state by promoting provider operational efficiency and economy, while at the same time recognizing the longer-range objectives of access to nursing home services and the maintenance of quality of care. With these objectives in mind, my home state of Ohio implemented a reimbursement system that is part prospective and part retrospective. Each individual facility rate is partially facility-specific (i.e., related to the particular facility's cost experience) and partially facility independent. In brief, Ohio's rate determination for SNFs and ICFs is divided into three categories:

1. a prospective rate for administrative and general costs,
2. a retrospective calculation for patient care costs subject to a statewide patient assessment limitation, and
3. an historical cost allowance for property costs subject to a per diem limitation.

The composite of the three rate allowances becomes the facility's payment rate. This is not to imply that Ohio's reimbursement system is the best nursing home payment model, but the system as developed has been meeting its primary objectives of efficiency, economy, and access to quality care. Its major present deficiency is its anachronistic and inadequate provisions for capital cost reimbursement.

There are other useful and innovative systems in effect. The system employed in West Virginia recognizes individual patient needs in establishing payment for nursing service, and breaks away from the use of accounting costs in its reimbursement for capital. It ignores book depreciation and quantifies payments for capital based on a current value appraisal of property. The West Virginia system has pioneered this concept.

Another innovative system, and one which was built on the experiences of both Ohio and West Virginia, is the system now in effect in Maryland. It uses a prospective ceiling for administrative and routine costs, with retrospective cost settlement establishing facility-specific incentive payments. A provider shares in the savings between the ceiling and the facility's actual costs, if lower. This approach encourages both efficient operation and Medicaid program cost containment.

Maryland nursing service costs are covered by prospective payments based on individual patient needs. Needs are verified periodically through patient assessments by the state Medicaid agency. This approach ensures that patients have access to quality care regardless of their need levels.

Finally, payment for capital costs is based upon the current appraised value of assets instead of historical cost. In essence, Maryland pays a rental allowance on the net value of the assets (gross appraised value minus mortgage debt) instead of the usual accounting-oriented depreciation allowance. Thus, instead of a cash flow on the capital account, which, after five to ten years, turns negative and induces the owner to sell, trade, lease, or refinance, the resulting cash flow turns positive in three to eight years and induces a larger initial equity investment and a quicker loan amortization.

Such exemplary system elements promote efficiencies and economies which result in cost containment, elimination of the backup of heavy care patients in hospitals, and pressure to develop and utilize lesser cost alternatives to nursing home care. They demonstrate that it is possible, through the implementation of rational and fair reimbursement principles, to serve simultaneously the interests of the patient beneficiary, the taxpayer, and the provider.

Contrarily, the more traditional response of states to fiscal concerns over their Medicaid long-term care program has been to disallow the legitimate costs of providing quality care. These policies may reduce costs in the short run, but in the long run are not effective in developing responsible health programs for our aging population. Such policies do not promote efficiency. They lead to a lowering of the quality of care provided, restrict access for all patients, virtually preclude access to care for heavy care patients, and cause total Medicaid program expenses to increase as these heavy care patients are maintained in higher cost hospitals rather than shifted to lower cost nursing homes.

In summary, almost all states have been experiencing fiscal and budgetary problems. Such economic problems have led to attempts to restrain Medicaid expenditure levels by placing restrictions on nursing home reimbursements. Such restrictions have raised industry concerns about whether quality care level can be maintained. There is a difference between the introduction of economies, and the failure to recognize legitimate costs. Both will constrain Medicaid budgets, but the former maintains or enhances the quality of care level, whereas the latter often results in a reduction of quality and access to appropriate care.

Question 2

You suggest that we might see capital investment flow from the nursing home industry. But aren't we seeing across the country nursing home providers acquiring more homes and beds?

While we are seeing some nursing home providers acquiring more homes and beds, this has been principally through acquisition of existing beds, and not a significant expansion of the aggregate number of beds. A recent GAO study concluded that the annual growth rate in bed supply has not kept pace with the annual growth rate in the number of the heaviest users of nursing home care (the 85 and older population) in recent years.

The primary reason for the lack of growth in the bed supply is two-fold:

1. artificial restraints on bed supply through CON restrictions and building moratoriums, and
2. inadequate reimbursement levels which make long-term capital investment in the industry unattractive for a large segment of providers.

The real question remains: Why is acquisition taking place without a concomitant expansion of the industry as a whole? Part of the answer is that U. S. corporate and business strategy is growth oriented. This strategy is characteristic of our American system. Implicitly it seeks to achieve economies of scale.

Another part of the answer lies in the deficiencies or disincentives in the Medicare and Medicaid reimbursement systems which make it more advantageous for a provider to sell than to continue operating. In addition to certain operating cost reimbursement inadequacies, ineffective

Medicare and Medicaid capital cost reimbursement policies discourage the investment of new capital, and, in the short run, stimulate the incidence of mergers and acquisitions by those firms which enjoy other economic advantages. These economic disincentives have not only encouraged providers to sell their facilities, but have also led to provider reluctance or refusal to participate in the Medicaid and Medicare programs and thus have exacerbated the shortage of program nursing home beds in many states.

Let me highlight three of the major disincentives of current capital cost reimbursement methods.

First, if a provider were to retain ownership of a facility over its entire estimated useful life, the total value of all annual depreciation allowances received by the provider over this period would be less in constant dollars than one-half the value of the facility's original acquisition cost. This assumes annual inflation rates of 5% per year. If annual inflation rates were 10%, as has been the experience over the past several years, the total value of the depreciation allowances received in constant dollars would be less than one-fourth of the facility's original acquisition cost!

Secondly, under conventional financing arrangements, Medicare/Medicaid depreciation allowances will, in the relatively short term, be insufficient to cover the principal payment portion of the debt service on the existing debt, thus creating a negative cash flow. This negative cash flow situation generally occurs in the seventh to tenth year of a conventionally financed mortgage, and confronts a nursing home owner with three options:

1. To continue under the present financial arrangement in spite of a continually increasing negative cash flow,

2. To refinance the facility under other, typically more costly, conventional financing arrangements, or
3. To sell or restructure the operating entity.

Thirdly, more than 70 percent of all of the nursing home beds existing in the United States today are twenty years old or older. The values recognized for Medicare and Medicaid depreciation purposes reflect only the historical cost basis of those nursing home beds. In some instances, these facilities may be almost fully depreciated. There is no recognition given to the actual capital asset value in current dollars, even though inflation in the U. S. economy has increased approximately 10 percent annually over the last ten years. Construction costs generally reflect inflation. As an example, between 1977 and 1982, the median construction costs for nursing homes increased approximately 80 percent. Providers owning existing facilities that were purchased or built during the 'sixties and early 'seventies have significant asset value appreciation reflected in their facilities. However, such appreciation is not recognized under Medicare and Medicaid reimbursement principles. The only way for a provider to recognize the increase in his facility's asset value -- the true worth of his investment -- is to sell the facility.

Of perhaps even greater future concern, as I pointed out in my earlier testimony, one of the most crucial issues for long-term care for the rest of the century will be the availability of capital financing for nursing homes. We are witnessing the ticking of a demographic time bomb. An increase in nursing home beds of 54 percent from 1977 to the year 2000, and an increase of 132 percent by the year 2030, will be needed simply to maintain the present age-specific level of service.

A 100-bed nursing home will need be opened each day from now to the year 2030 just to meet that projected demand. Thus capital needs of at least $10 billion for new construction alone during the next decade can be expected. Public policies will have to address these capital formation issues if these growing needs are to be met.

One issue of current urgency involves tax exempt bonds. These bonds are a major source of capital financing for the nursing home industry. Over the last few years they have been practically the only viable source of capital. Since health care providers are being squeezed between higher construction costs and tightened government reimbursement, conventional lenders are reluctant to finance new facilities. When conventional financing is offered, it is generally at interest rates higher than most providers can afford, reflecting the perceived risks by the financial community of the inadequacies and inconsistencies of Medicaid and Medicare capital reimbursement policies.

Another policy issue of great importance involves returns to equity. While, generally, most debt costs are recognized as reimbursable costs, both the Medicaid and Medicare programs place severe limits on returns to equity. As a logical consequence, the vast percentage of nursing home capital funding is achieved through debt financing. A more enlightened approach would be to encourage greater equity participation by lifting constraints and even increasing rates of returns to equity.

On behalf of the long-term care industry, I would urge you to oppose proposals which would restrict the use of tax exempt bonds for health care facilities. I further encourage you and your Congressional colleagues to support capital financing and capital funding policies which recognize realistic asset appreciation, and which encourage greater equity involvement by facility owners as a prudent option to control future health care expenditures under the Medicaid and Medicare programs.

Question 3

Your testimony calls for an expansion of Medicare's skilled nursing facility benefit. Given the problems we face with the Medicare trust fund, do you assume that a prospective payment system for nursing home care will contain the cost of an expanded benefit?

An appropriate Medicare prospective payment system for skilled nursing facility services will both encourage greater program participation by nursing homes and help constrain the growth in aggregate Medicare health program expenditures, in my estimation. Such a program will tend to substitute quality, but cost-efficient nursing home care for the present high cost patient care in acute care hospital settings.

There is considerable evidence to indicate that in our health care delivery system there exists a significant backlog of patients in hospitals awaiting placement in less intensive settings such as skilled nursing facilities. When one considers that the rate per day in a skilled nursing facility is only 20-25 percent of the basic daily rate in a hospital in the same area, the conclusion is inescapable that our public programs are paying four to five times more for health care services in an acute care setting than if skilled nursing facilities were utilized properly to provide such care.

In addition, as our population ages, and as hospitals are encouraged to reduce lengths of stay and seek patient placements in less costly care settings under Medicare's prospective payment system, the need for and utilization of quality health care in skilled nursing facilities will increase. While our health delivery system is complex and comprised of a wide range of providers, the Federal government needs to promote such efficient delivery of quality health care services in the most appropriate and least costly setting.

Encouraging the nursing home industry's greater involvement in providing Medicare skilled nursing facility services, where appropriate, in lieu of care in more expensive acute care settings, can be accomplished through the design of a proper prospective payment methodology. We, as an industry, feel that all of the above objectives can be attained if the nursing home industry is given the incentives to participate in the Medicare program, and if Medicare recognizes certified skilled nursing homes as the quality oriented, cost efficient health care providers which they are.

In sum, the objective of a Medicare prospective payment system for skilled nursing facility services should be to avail quality health care services to its program beneficiaries. Specifically, the system should:

- promote the efficient delivery of quality health care services in the most appropriate and least costly setting;
- facilitate (a) the reduction of the existing backup in hospitals of patients who could be cared for in long-term care facilities, and (b) increased access for the greater flow of the "sicker" patient population which is to be expected from the ongoing implementation of the Medicare hospital prospective payment system;
- insure future compatibility with Medicare hospital DRG payment concepts;
- be administratively simple to implement and monitor for both the Medicare program and providers;
- reduce the current cost reporting and paperwork burdens; and
- effectively address the issue of payment for capital costs.

The American Health Care Association and the National Council of Health Centers have been pursuing the development of such a Medicare SNF prospective reimbursement system for consideration by HCFA. While the mechanics have not been finalized, certain basic principles must be incorporated into this system. These basic principles include:

1. The Recognition of Patient Needs. A separate basic reimbursement rate must be provided for each of a limited number of classes of patients which require different levels of basic nursing services, i.e., assistance in activities of daily living. These classes should be determined based on the number and types of activity of daily living dependencies. A good proxy for these dependencies in the Medicare population may likely be the hospital DRG.
2. Bundling of Services Where Appropriate. Reimbursement for those services which are provided to most of the patients of a given class should be folded into the basic rate for that class. On the other hand, special services (i.e., tube feeding, decubitus ulcer care, turning and positioning, IV care) and ancillary services (i.e., physical therapy, occupational therapy, and speech therapy) which are needed by only a part of the patient class in question must be reimbursed on a per unit of service basis. Payment must rationally be equated to service required. Patients needing such services must not be financially unattractive to the admitting facilities, and as a consequence, encounter difficulties in obtaining nursing home care.
3. Monitoring of Unbundled Services. In order to prevent the excessive use of those services remaining unbundled, standards

should be developed for use by the fiscal intermediary, and/or prior approval should be made a necessary condition for utilization of the service.

4. Inclusion of Profit and Capital Costs. It may be undesirable, or at least a complex task, to make a special provision for profit, capital costs, return to equity, etc., or to utilize a pass-through mechanism for these items. These costs or allowances should be folded into the basic rate for each patient class. Since the use of charges automatically folds such costs into the base, the system would be simpler if it were charge-based rather than cost-based.

5. Regional Variation. Because wages vary significantly by region, separate rates for each patient class and unbundled service should be made available by major geographic region, and perhaps by urban/rural locations. No distinction should be made by ownership, size, or hospital affiliation, however. Only the valid differences due to regional factor prices and the patient needs of the facility should be recognized for reimbursement purposes.

Question 4

Do you have any specific thoughts on how long-term care services can be targeted so they are cost-efficient? Is it through a financing mechanism such as prepaid capitation or through a case management system, for example?

Preadmission screening is a fairly common method to target long-term care services. The following states have statewide assessment/screening programs.

Alabama
California
Colorado
Delaware
District of Columbia
Hawaii
Illinois
Indiana
Iowa
Kentucky
Maine
Maryland
Mississippi
New Hampshire
New Jersey
New Mexico
New York
North Dakota
Ohio
Rhode Island
South Carolina
Utah
Virginia
West Virginia

In the following states, portions of the state are under a preadmission screening program. These do not include those states with waivers. The states bearing an asterisk (*) were or are moving to statewide programs:

Idaho
Massachusetts
Minnesota
Missouri
Montana
Nebraska
Wisconsin
Georgia*
Oregon*
Kansas*

Although I am not aware of any cost-benefit studies which document the various programs' usefulness, the frequency of the incidence of preadmission screening among the states' Medicaid programs and the current plans of several states to expand these activities is ample testimony to the cost-effectiveness of such systems. In addition, to the extent that preadmission screening is cost effective in the Medicaid program, such a program would be even more effective -- in fact, I believe necessary -- under the Medicare program.

With the introduction of DRG hospital reimbursement, the hospitals will have a tremendous incentive to admit patients who could be cared for in an SNF environment. Such selected admissions will be encouraged because of the profit hospitals will realize under DRG prospective payment as a result of rapid patient discharges to SNFs. This behavior is currently conduced by the three day prior hospital stay requirement for Medicare SNF coverage. To avoid this type of behavior, three policies should be simultaneously implemented:

1. The HHS Secretary should waive the three day hospital stay requirement for SNF admissions, thereby permitting Medicare coverage for direct admissions to SNFS.
2. Preadmission screening should be instituted for Medicare eligible patients to ensure that the appropriate level of care is delivered.
3. Certain adjustments to the hospital and SNF deductibles and coinsurance provisions should be made to coordinate the benefits and remove perverse incentives, e.g.,
    a) introduce a SNF deductible for direct SNF admissions,
    b) reduce the amount of SNF coinsurance or, at least, remove its link to the inpatient hospital deductible amount,
    c) make hospital and SNF non-coinsurance periods the same length, and
    d) consider hospital days and SNF days additive for coinsurance-day computational purposes in cases of hospital discharges to SNF.

In order for targeting to work under any financing system (whether prepaid capitation, or vouchers, or through a case management system), the critical determinant for effectiveness will depend upon the level of Medicare's financial commitment, i.e., the price Medicare will pay for services. The greater the need for extensive patient care services, the greater the cost to the provider, and, thus, the greater his need for adequate payment.

The willingness of providers to take patients who require extensive care under almost all of these concepts will also depend on the provider's ability in risk pooling. The term "almost all" is used because if a patient-based system that recognizes patient need (as described in my response to Question 3, above) is employed, risk pooling is no longer a consideration, and essentially all SNF beds are opened to Medicare patients of all need levels. Without a patient-based system, however, prepayment and risk pooling are necessary to remove some of the financial obstacles in treating heavy care patients.

A Medicare payment which covers the cost of an average Medicare patient will cover the total cost of Medicare services only if the facility in question experiences average costs at, or below, the average for the group. Facilities which do not serve a large number of Medicare patients (say, less than fifteen on any given day), therefore, run a considerable risk of not having their costs of care covered by the Medicare reimbursements. With a small Medicare patient census, one or two heavy care patients are very likely to cause average facility costs to be above those supported by the Medicare payment. The only protection the facility has is to:

1. refuse to participate in the Medicare program,
2. participate but attempt to avoid heavy care patients, or

3. risk-pool by specializing in Medicare patients so that the patient census is large enough to provide a case-mix that approximates the case-mix (and average cost) implicit in the Medicare reimbursement rate.

Currently, all of these options are being employed by the industry. This explains why SNF participation in the Medicare program is so low, why half of all Medicare patients are served by less than 500 facilities, and why heavy care patients have difficulty in finding SNF placement (i.e., they back up in hospitals). As long as individual patient need is not reflected in the nursing service component of Medicare reimbursement, these industry participation, concentration, and access problems are likely to continue. One promising alternative, however, that may facilitate risk pooling is the use of social health maintenance organizations (SHMOs).

The social health maintenance organization concept, which was developed at Brandeis University, is a case managed system of health and long-term care services geared toward the elderly. Now in the demonstration stage, the concept has apparent merit and should be explored further. However, it must be assured that a representative mix of elderly will be enrolled (both well and significantly impaired individuals) in order for the system to be financially viable when addressing heavy care patients, and that the premiums under Medicare will acknowledge such a risk.

Summary

Several states are currently demonstrating that cost containment efforts can be successful by introducing efficiencies and economies into nursing home operations. These innovative systems selectively combine both prospective and retrospective reimbursement features, and typically employ alternatives to the use of depreciation for capital cost reimbursement, but this should present no barrier to the design of an effective Medicare SNF reimbursement system that is entirely prospective. In fact, five basic principles have been laid out in my response to Question 3, which, if followed, would produce a fully prospective Medicare SNF reimbursement system that contains costs by introducing efficiencies and economies into the Medicare part of the nursing home industry. These five principles would also measurably improve the participation rate of SNFs in the Medicare program and improve access to care for heavy care Medicare patients.

Should these steps not be taken, however, capital investment will continue to flow from the industry and the supply of adequately maintained beds will not keep pace with demand. Acquisitions of existing homes by large chains will be accelerated unless reimbursement system changes are implemented (both Medicare and Medicaid), with a resultant polarization of the industry into large, for-profit chains and well-funded non-profits. The historical foundations of the industry -- sole proprietor homes -- will have been seriously eroded.

Policy changes (such as the support of SHMOs, pre-admission screening, removal of the hospital three day stay requirement, coordination of hospital and SNF benefits, and the improvement of the climate for private long-term care health insurance) will certainly improve access, supply, and cost containment conditions in the industry. But the key, and the overriding concern of the industry, is to effect major design changes in the Medicaid reimbursement systems among the states and the national Medicare reimbursement system. Without such changes, access, cost, and quality problems will continue to grow.

In closing, I wish to express my gratitude for having the opportunity to respond to your inquiries. I hope that time and space limitations have not decreased the cognitive value of my responses. However, I will gladly elaborate on these responses as you require and I will be happy to answer further questions, as well. It is this type of forthright dialogue which shapes and forms the most useful social policies, and I am happy to be a part of that process.

Senator DURENBERGER. Senator Bradley.

Senator BRADLEY. Mr. Chairman, I would like to submit several questions from Senator Bentsen to Ms. Cole, if I could. But let me just ask one that Senator Bentsen requested to be asked.

And that is, Will the creation of CNC's establish another group of providers and add to the financial burden of medicare and medicaid? And if so, why? If not, why not?

Ms. COLE. We don't believe that it will add to the list of providers. That hopefully it will extend into the community those services already are being provided and would, in fact, prevent in many cases more costly care that is now being allocated as far as seniors are concerned.

Senator BRADLEY. So your answer is no, it wouldn't?

Ms. COLE. No, it would not.

Senator BRADLEY. OK. Thank you very much.

[The questions from Senator Bentsen follow:]

Senator DURENBERGER. Thank you all very much. We appreciate your testimony. And as I indicated, there may be other questions other than mine from members of the subcommittee who had to leave. There is some floor action on right now. We would appreciate your responses.

Thank you.

Ms. COLE. Thank you.

Senator DURENBERGER. Our next panel consists of Dr. David Rabin, professor and associate chairman, department of community and family medicine at Georgetown, representing the American Public Health Association; Jim Hacking, assistant legislative counsel, AARP; and Alice Quinlan, Government relations director, Older Women's League of Washington, D.C.

We welcome you all. I don't see Jim. There he is. Your full statements will be made part of the record, and you may now proceed to summarize them.

I'm going to alert you ahead of time I am going to get tough on the light. It was either give you 5 minutes or 1 minute and we chose 5 minutes. All of you who stop on amber are going to get brownie points. We will start with Dr. Rabin.

STATEMENT OF DR. DAVID L. RABIN, PROFESSOR AND ASSOCIATE CHAIRMAN, DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE, GEORGETOWN SCHOOL OF MEDICINE, WASHINGTON, D.C., ON BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. RABIN. Mr. Chairman, and Senator Bradley, I'm Dr. David Rabin. I'm here today representing the oldest and largest public health society in the world—the American Public Health Association—with a combined membership of over 50,000 public health professionals.

Senator Bradley reviewed dramatically the demographic characteristics of the elderly population. I would like just to emphasize a portion of that—the rapid growth of those 85 plus who are expected to double in number over the next 17 years.

Of these individuals, about 44 percent have at a point in time a need for help in performing their usual activities in the course of a day. About 23 percent of those 85 and over are currently residents in nursing homes. It's clear that over the next 17 years unless we are able to provide a series of alternatives to current kinds of care, any savings that you might expect from to the emptying of nursing home beds or the emptying of hospitals through prospective reimbursement, or certificate of need legislation or 2176 waivers, is going to be eaten up by this rapid, predictable, and substantial increase in the elderly, needy population.

The problem of massive Federal expenditures in health care derives from the institutional bias of medicare and medicaid. In 1981, over 40 percent of hospital expenditures were federally funded. And 50 percent of nursing home costs were reimbursed under public programs. By contrast, only 2 percent of medicaid and medicare expenditures were for home health care services.

Studies have shown that at any point in time about 10 percent of acute hospital beds are occupied by patients clinically ready for discharge, but retained because of the lack of alternatives. Increasing nursing home beds is a costly alternative. And, furthermore, it has been estimated that 20 to 40 percent of the nursing home population is inappropriately institutionalized and could be cared for in the community if appropriate services were available.

We support the need for new legislation. Savings from this legislation may be obscured by the aging of the population and the inevitable health care needs that this will bring. But these should be offset by the capital and revenue consequences of restraining the growth of the institutional sector.

Each of the legislative proposals addresses the long-term care problem in a distinct manner, and vary in their potential impact on the problem of long-term care. S. 410 is an innovative idea which should be particularly helpful for children, mothers and young adults. The applicability of this bill for long-term care is more conjectural and deserves further study. The great need in long-term care is for integration of services, particularly for the frail elderly. The integration of all these services is reflected in S. 1244, which provides for more comprehensive long-term care and would have the same advantages of defined payments for care.

The bill builds upon our current knowledge, and provides a fiscally sound and responsible mechanism for provision of long-term care services to the elderly. By requiring capitation payment for a range of services, the proposed bill supports development of mechanisms within which all health care providers can work to provide necessary, justifiable and fiscally appropriate services.

Our concern with this bill is its tentativeness, implying that the need for this care is as yet not demonstrated, and that there is insufficient experience to allow us to proceed in developing such services to elderly in all States.

The bill is also restrictive in permitting eligibility for services only through a lengthy, costly, and subjective patient assessment team mechanism. Financial eligibility becomes a State welfare process bank on income which will determine payment, a concept antithetical to the concept of medicare.

We would like the provision as a benefit available to all 50 States. The HHS should then evaluate national experience with this benefit, not only in regard to its cost and use of home health care, but most importantly in regard to its total impact on the health care system. We believe such an evaluation would be best beneficial.

We also support S. 1614. This proposal provides a coordinated program of acute and long-term care for the dual eligibles. This group, representing 18 percent of the elderly, has substantial medical and social need and is at great risk of using expensive medical services. They are impoverished and therefore have little influence in determining their use of services.

A substantial advantage of this bill is that it provides are and financing in a situation which is most favorable for allowing tradeoffs in care, and therefore allow for development of efficient, effective and appropriate systems of care.

Thank you for the opportunity to testify.

Senator DURENBERGER. Thank you.

[The prepared statement of Dr. Rabin follows:]

TESTIMONY BEFORE U.S. SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
PUBLIC HEARING ON LONG TERM CARE

NOVEMBER 14, 1983

STATEMENT OF

DAVID L. RABIN, M.D., M.P.H.
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DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE
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ON BEHALF OF

THE AMERICAN PUBLIC HEALTH ASSOCIATION
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Mr. Chairman and Distinguished Members of the U.S. Senate Committee on Finance Subcommittee on Health:

I am Dr. David L. Rabin. I am here today representing the oldest and largest public health society in the world - the American Public Health Association, with a combined national and affiliate membership of over 50,000 public health professionals and community health leaders. The organization was founded to protect and promote personal and environmental health by exercising leadership in the development and dissemination of health policy.

It is the responsibility of your committee to deliberate on proposed legislation relating to federal responsibility for health care expenditures. Mindful of the present vast commitment of federal funds and the spiralling increases that have far exceeded the overall inflation rate since the introduction of the Medicare and Medicaid programs, you will undoubtedly approach the prospect of legislation designed to create additional entitlement to service with reluctance and concern. While appreciating and sharing your anxiety we feel that the development of home health services should have priority in terms of reallocation and more appropriate utilization of federal funds, and the humane delivery of care to the increasing numbers of frail elderly in the U.S. population. We therefore support proposed legislation for the development of community based services and in particular Bills S1244 and S1614.

Currently 11% of the population is aged 65 and over and of these 9% or 2.2 million are aged 85 and over. This is the largest growing sector of the population and is projected to number 6.8 million by the year 2010. While mortality rates have showed a major decline for this age group over the last thirty years, advanced age is associated with increasing health care expenditures, with an increased rate of chronic disability and with need for help of another person in performing basic physical activities. Medicare reimbursement per enrollee rises from $1402 per person aged 65 through 69 to $2485 for those aged 80 and over. Although only 18% of persons receiving Medicaid are 65 plus, they account for 39 % of the total budget, the single largest component of which is nursing home reimbursement.

The problem of massive federal expenditures for health care, both in aggregate and per capita derives from the institutional bias of the Medicare and Medicaid programs. In 1981 over 40 % of hospital expenditures were federally funded and 50% of nursing home costs were reimbursed under public programs. By contrast only 1.7% of Medicaid payments and 2.5% of the total Medicare budget were for home health services. It is essential to eliminate this distortion in service provision and expenditure by legislating for a broader range of integrated care with an emphasis on the community and the home.

Studies have shown that at any one time 10% of acute hospital beds are occupied by patients clinically ready for discharge but retained because of lack of nursing home beds, selective admission by nursing homes, and lack of alternative services. It is estimated that up to 3% of total hospital days per year are attributable to patients awaiting discharge and that two-thirds of the cost is financed by Medicare amounting to well over 1 billion dollars per year.

In a desperate attempt to contain health care costs Congress has enacted legislation for propective reimbursement for Medicare hospital costs. In addition 19 States have implemented prospective reimbursement for Medicaid patients. While evidence from the 4 states which have instituted all payer prospective reimbursement indicate that average length of stay has decreased and costs have been constrained this earlier discharge will undoubtedly create a demand for more nursing home beds or for an increase in home health services, whether hospital or community based.

At the present time 70 to 80% of long term care is provided by families in this country. The development of home health and community services should help to ensure that this continues to be so. The situation now exists where many of those caring for an aged relative are themselves over 65 and in declining health. While preferring to avoid institutionalization of an aged parent they will increasingly find themselves in need of outside assistance in making this possible. Many other elderly people have outlived their families and yet wish to maintain their own homes and preserve their independence, but yet require assistance to achieve this.

Increasing nursing home beds is a costly alternative and furthermore it has been estimated that 20 to 40% of the nursing home population is inappropriately institutionalized and could be cared for the the community if appropriate health and personal care sevices were available. The appreciation of the potential benefits and the need for the development of home and community based services is demonstrated by the fact that 46 states have made submissions for 2176 waivers for the development of Medicaid programs.

We therefore support the need for new legislation. Coordinated system changes and reallocation of funds should lead to more appropriate and cost-effective care. Savings may be obscured by the aging of the population and the inevitable health care needs that this will bring, but these should be offset by the capital and revenue consequences of restraining the growth of the institutional sector. Each of the legislative proposal addresses the long-Term Care problem in a distinct manner, and vary in their potential impact on the problem of long term care.

S410 The Community Nursing Centers Act of 1983 is an innovative idea which should be particularly helpful for children, mothers and young adults. Much of the health needs of this age group could be provided by such nursing centers. S410 clearly provides for more extensive nursing services than currently permitted. The applicability of this concept to long term care is more conjectural and deserves further study and evaluation. The great need in long term care is for integration and coordination of all health and personal services, particularly for the frail elderly.

The integration of all these services as reflected in S1244 The Senior Citizens Independent Community Care Act provides far more comprehensive long term care and would have the same advantages of defined payments for care.

Senate Bill 1244 is a thoughtful and significant legislative proposal. It builds upon our current knowledge base and provides a fiscally sound and responsible mechanism for coordinated provision of long term care services to the elderly. The proposal provides a comprehensive benefit for those 65+ functionally in need of these services. By requiring capitation payment for a range of services the proposed bill importantly supports development of a mechanism within which all health providers can work to provide necessary, justifiable and fiscally appropriate services to elderly at high risk of institutionalization. Our concern with the bill is over its tentativeness implying that the need for this care is as yet not demonstrated and that there is insufficient experience to allow us to proceed in providing such services to elderly in all the states. The bill is also restrictive in permitting eligibility for services only through a lengthy and costly patient assessments team mechanism. The eligibility measures to be used are highly subjective. There is the likelihood of great variation in who receives care. If the restricted eligibility standards of Section S1893 are implemented, the opportunity for learning and benefiting from the 10 current channeling grants and 51 2176 waiver programs would be minimized. We could find ourselves saddled with a cumbersome and subjective mechanism for defining eligibility with its attendent legislative and administrative problems. We would like the provision as a benefit available to all 50 states. DHHS should then evaluate national experience with this benefit not only in regard to the cost and use of home care but most importantly in regard to its impact on total health system costs. This impact should be measured across many states where the full implications of capitated coordinated long term care can fully be appreciated. Passage of this desirable concept of legislation as a demonstration will have the unfortunate consequences of not allowing us to benefit from current knowledge of need and service delivery delaying until the end of this decade the provision of this needed service. It will perpetuate at great cost the continued inappropriate provision of institutional care. Since functional impairment is so highly correlated with age and we acknowledge your desire to be fiscally prudent, we can better understand restriction of this benefit to those of an older age group to alay concern about total costs by restricting the program to a 4 state demonstration.

We also support Senate Bill 1614 The Health Care Coordination Act of 1983. This proposal provides a coordinated program of acute and long term care for the dual eligibles. This group representing about 18% of the elderly have substantial medical and social needs and are a great risk of using medical services. They are impoverished and therefore have little influence in determining their use of health services. These people are in critical need of coordinated care. A substantial advantage of this bill is to permit the flexible co-mingling of all Medicare/Medicaid dollars to provide the most appropriate, and cost effective services. The substantial savings of home care will come from reductions in inappropriate use of acute and long term care institutions. Since Medicaid is comprehensive in coverage this bill would allow trade offs to be made between among all forms of care. This is the most favored situation for developing cost effective and coordinated health care services. Another advantage is the relative simplicity of eligibility which will allow both monitoring and assessment to be made more readily. Unfortunately, since standards of eligibility and breadth of long term care services for Medicaid vary so much by state, this proposal would still permit substantial variation in the care for similarly needy persons in different states. A lesser disadvantage of this bill is its restriction of participation to no more than 20 states and to small, unrepresentative populations, within these states. Furthermore, the 3 year period for these demonstrations to be re-evaluated is too short. Since the dual eligibles are particularly vulnerable, and generate a large part of total federal health care costs, and the states now have substantial experience in long term care, we favor enactement of S1614 for all states. We additionally would re-emphasize and suggest specific appropriations for the research provisions of this proposal. These provisions would permit assessment of the effectiveness of the program in meeting its objectives. Since the costs of the program are defined as being no greater than current Medicare costs, the risks are modest and the potential benefit great.

STATEMENT OF MARTIN CORRY, LEGISLATIVE REPRESENTATIVE, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, D.C.

Mr. CORRY. Mr. Chairman, my name is Martin Corry, a legislative representative for AARP. Jim Hacking sends his apologies for not being able to attend. Accompanying me is Meredith Cote, also a legislative representative at AARP. I ask that our statement be submitted for the record.

AARP appreciates the opportunity to state our views on long-term care and some of the legislation currently pending before this committee. At a time when this committee's attention is primarily focused on the staggering deficits which this country faces, we are particularly pleased to see the committee step back from that immediate problem to focus on a serious and growing problem for older Americans—the lack of adequate long-term care.

From the beneficiary perspective, long-term care today is more a hodge-podge than a system. Although there are many programs to help older persons, they tend to be fragmented and uncoordinated. Having been separately conceived at different times, they are separately administered with separate criteria for establishing income eligibility and need for service.

Moreover, the current array of services is biased toward acute rather than chronic care, as well as institutional long-term care rather than long-term care services in the home or community. It is estimated today that 30 percent of the present nursing home population could be cared for in less expensive settings. Yet we lack a comprehensive effort from the national level to promote the linkage and coordination of less costly forms of care such as in-home services, community based services, and special living arrangements.

Moreover, the longer we wait to address the problem of long-term care, the worse it becomes. Four demographic factors argue against deferring action.

First of all, we have a growing aged population. Today only 11 percent of the population is aged 65 or over. By the year 2015, over 18 percent of the population will be 65 or older.

Second, increasing life expectancy of the elderly. Within the elderly population the aged 75 and older subgroup is increasing most rapidly, a group which is predominated by single, elderly women.

Third, chronic illness is the dominant pattern of illness. Millions of lives have been saved through immunization and public health systems, much of this financed through Federal assistance in the past. We now face a situation where care of chronic illness is the primary problem. For those 65 and over, 83 percent of restricted activity days in 1980, and 87 percent of all deaths in 1978 were due to chronic conditions. This pattern increases dramatically for those over aged 75.

Fourth, changing family patterns. Today the family tends to be smaller than what was the case in the past. Smaller families mean fewer adult children to care for elderly parents in the home. Moreover, current trends will soon mean that many of the children of the elderly needing long-term care will themselves be aged.

Our goal should be the development of a continuum of care provided through a network of care-givers, including the family, community-based providers, as well as traditional institutional care.

Fortunately there are bills before the committee which would move toward the provision of a continuum of community based services with mechanisms to limit secondary demand.

AARP believes such limitations are necessary at this time, and that this bills will provide information essential to developing a strong continuum of long-term care services.

Beyond the problem of secondary demand are other tough questions for which answers are not readily apparent. For example, each of the bills identified above provide for some form of screening and case management. But who should determine this particular procedure?

Finally, we want to express again our strong support to the committee for looking into this area, and our willingness to work with you in trying to develop some solutions that would be good for the elderly as well as for the Federal budget.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Mr. Martin follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

UNITED STATES SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

on

LONG TERM CARE

November 14, 1983

Thank you, Mr. Chairman, for this opportunity to state AARP's policy perspective regarding long-term care and our views about three bills now pending in the Senate that address this difficult problem.

From the elderly's point of view, the lack of a long-term care system that encompasses medical, social and personal care services provided in a variety of community, home-based and institutional settings is the greatest deficiency in the present health care system. Four demographic factors dictate the reorientation of health benefits for the elderly: (1) a growing aged population; (2) increasing life expectancy for the elderly; (3) chronic disease as a dominant pattern of illness in the United States; and (4) changing family patterns. These demographic trends have been widely reported, and their implications must be taken into account by government health policy experts.

Today only 11% of the population is age 65 or older, yet the elderly account for nearly 30% of the nation's total personal health care expenditures. By the year 2015, over 18% of the population will be age 65 or older -- a significant increase with obvious implications for health expenditures.

Within the elderly population the age 75 and older subgroup is increasing most rapidly. By the year 2000, 45% of the elderly population will be in this category, compared to 39.5% at present. The proportion of the elderly who are aged 75 and older is important because the incidence of chronic disease and impairment and the utilization of medical services tends to increase with age, and increase dramatically after age 75.

Because of the aging of the population, demand for long-term care services is increasing. Yet, current demand is not even being met. Today, there are an estimated 3.5 million non-institutionalized persons age 65 and over who are "functionally dependent," and their numbers are increasing by about 100,000 a year. Fifty years from now, in 2030, there may be well over 7 million persons in this category. About one out of three of these functionally dependent older persons is homebound or bedridden. A still larger proportion are alone and isolated. Another 1.2 million older persons are in nursing homes, chronic care hospitals, or other institutions.

Americans are living longer (since 1960, over two years of life have been added to the life expectancy of the average 65 year old American). Millions of lives have been saved from acute heart attacks, strokes, early death from cancer, diabetes and other acute conditions. However, the more successful the nation's health care system has been in controlling acute disease and postponing death, the more chronic disease has tended to become the dominant pattern of illness. By definition, chronic disease is never cured. According to the National Center of Health Statistics, for those 65 and over, 83% of all "restricted-activity days" in 1980 and 87% of all deaths in 1978 were due to chronic conditions.

Today, the nuclear family tends to be a smaller family than was the case in the past. Smaller families mean fewer adult children caring for elderly parents in the home. Similarly, morei working women, later marriages, more divorce, and greater geographical mobility may portend less and less direct family care in the future.

These factors point to the need for the development and implementation of a long-term care program that provides, not just institutional care, but a complete continuum of services, including home-based and community-based services. Reasonable estimates indicate that 30% of the institutionalized elderly could be served as well or better at home or in sheltered living sites.

It is generally understood that the elderly are better served when they are helped in maintaining their independence in their homes and communities as long as possible. Yet, the federal government spends more to maintain older persons in nursing homes than it does on the combined cost of home care under Medicare/Medicaid, all social service programs, and all federally funded special housing programs for the elderly. Moreover, although there are many programs to help older persons, they tend to be fragmented and uncoordinated. Having been separately conceived, they are separately administered with separate criteria for establishing income eligibility and need for service. For example, social services provided under Title XX of the Social Security Act and Title III of the Older Americans Act serve many of the same sites; though services may be identical, eligibility criteria for recipients are entirely different. Thorough analysis of existing Federal programs for the delivery of health care and social services (i.e. Medicare, Medicaid, and social services under Title XX of the Social Security Act and Title III of the Older Americans Act) reveals an obvious bias in favor of acute care -- not chronic care -- and institutional long-term care -- not long-term services in the home or community. Furthermore, when it comes to in-home services, community services, special living arrrangements, nursing home care and other forms of long-term care at the state or local level, there has been no serious, comprehensive effort from the federal level to encourage the linkage and coordination of the management of these services within the community. All this must change. The nation simply cannot afford to continue to try to treat chronic conditions and impairments among the elderly with expensive forms of acute and institutional care.

With the overwhelming proportion of available long-term care resources being consumed by high-cost institutional care, it will obviously be very difficult to build and initiate an integrated, community-based service system. But if an adequate supply of sheltered living arrangements and congregate housing, homemaker/home health care and other community-based services were available, it is likely that 30% of the present nursing home population could be cared for in less expensive settings. The ultimate goal, therefore, must be a long-term care program which provides a complete continuum of care and creates in the process a network of community-based centers that would function as providers, payors, certifiers and evaluators of services.

In addition, the family unit is an important contributor of supporting services and must not be ignored in the design of a comprehensive long-term care program. Family members now provide about 80% of the elderly's long-term care services. With limited resources, the goal must necessarily be to supplement -- not supplant -- family care activities. Certainly, disincentives to family assistance (such as the one-third reduction in benefits under SSI when the beneficiary lives with his/her family) should be removed. Moving in a positive direction, federal income tax credits could be created that would provide taxpayers with incentives to care for their dependent elderly in the home and to utilize adult day care facilities. A relatively small public investment in adult day care services and respite care services, to ease the burden on family members who are the primary care-givers, could greatly help in avoiding a crisis situation where institutionalization of the older dependent family member becomes the only other option.

Despite the Medicare/Medicaid bias toward institutional-based services, some modest program has been made in reorienting the emphasis of these programs. In 1980, minor liberalizations in home health benefits under Medicare were achieved. More recently, Congress approved the Medicaid Community Care waiver as part of the 1981 Omnibus Reconciliation Act. States opting to utilize the waiver have been able to provide a wider range of community and home-based services in lieu of nursing home care including services such as case management, personal care services, adult day care, and respite care. The Association strongly supports the Medicaid waiver provisions and encourages states to take advantage of the opportunity to re-direct the focus of the long-term care components of their Medicaid programs.

Despite the economic and budgetary constraints that are impeding the development of a national long-term care program, additional modest steps can be taken that would build upon the progress made in the recent past. For example, with respect to home health services, Medicare's "homebound" and "skilled care" requirements should be eliminated and coverage of homemaker/chore services should be provided. In addition, a comprehensive pre-nursing home admission screening and assessment program for potential nursing home residents should be established. To facilitate a broader range of long-term care services (as well as preventive and primary care), Medicare beneficiaries can now enroll in HMO's and similar alternative delivery systems. AARP has high hopes for the social HMO (SHMO) concept too.

For the future, increased private sector involvement in meeting long-term care needs must also be explored. Private insurance companies should be encouraged to add long-term care benefits to existing policies and develop new policies which would specifically address the elderly's long-term care needs. Over the long term, health insurance accounts (similar to tax-deferred IRAs) could be created providing younger persons with an incentive to save for their future long-term care needs.

The big question confronting policy makers now is how to develop a more comprehensive long-term care system that we can afford? While it is generally recognized that a substantial portion of institutionalized patients could be cared for at lower cost in a comprehensive continuum of community based care, the problem is controlling the cost of secondary demand sometimes referred to as induced costs.

Secondary demand is the result of increased utilization attributable to the existence and availability of the benefit and without regard to the fact that no new eligibility is established in terms of individuals. The problem facing policy makers is the millions of individuals not now in institutions but with ailments, infirmities, and level of income that make them eligible for government benefits. Despite such eligibility, these people refuse to be institutionalized. If, however, they could receive services in their home, for example, then they would participate in the new benefit program at greater overall costs. Unfortunately, the state of the art is not such that policy makers can adequately distinguish those situations "truly" needing community based benefits. Secondary demand is perhaps the major obstacle to the development of a comprehensive continuum of long-term care services.

Policy makers need a great deal more information about, and experience with, chronically disabled patients in order to refine eligibility standards for services included in a community based continuum of care. Fortunately three bills pending in the Senate provide a means for developing the continuum of care and for gaining greater experience with chronically disabled patients in the community, at a reasonable cost.

The Health Care Coordination Act of 1983 (S. 1614), the Senior Citizens Independent Community Care Act (S. 1244) and the Community Nursing Centers Act of 1983 (S. 410), all provide a continuum of community based services and mechanisms to limit secondary demand, pending greater understanding of chronically disabled patients and utilization of community based services. AARP believes such limitations are necessary at this time and that these bills will provide information essential to developing, on a national scale, a strong, ccommunity based continuum of long-term care services.

Beyond the problem of secondary demand are other tough questions for which answers are not readily apparent. For example, each of the bills identified above provide for some form of screening and case management. But who should do such screening and management? Should the system be fully integrated in the sense that one provider provides all levels of care or should the system be fragmented so that home health providers provide home care, hospitals and nursing homes another level of care? At this point, AARP does not believe there has been sufficient experience with community based long-term care to make such policy decisions. The community based care legislation now before the Finance Committee, however, if enacted, will provide the information upon which these policy questions can be resolved.

AARP looks forward to working with this committee on developing a community based long term care system capable of addressing the needs of our people.

STATEMENT OF ALICE QUINLAN, GOVERNMENT RELATIONS DIRECTOR, OLDER WOMEN'S LEAGUE, WASHINGTON, D.C.

Senator DURENBERGER. Ms. Quinlan.

Ms. QUINLAN. Mr. Chairman, Senator Bradley, I am Alice Quinlan, government relations director of the Older Women's League which is the first national membership organization focusing exclusively on the needs and concerns of older women.

We appreciate very much the opportunity to share with you our perspective on long-term care. I attended the hearing that was held a week or so ago, and of course have been here this morning. We have been here almost 2 hours and my colleague just 1 minute ago used the word that I want to put before you with great force and its connection with long-term care. And that is the word "woman." I have not heard very much at all so far in these hearings on long-term care that would direct your direction to gender based distinctions. We think that it's very critical that you do so in order to develop both realistic and comprehensive long-term care policies. You must keep before you who are the primary providers and who are the primary consumers of long-term care. The primary providers both in institutional settings and inhome services for pay and of inhome services that are provided by family members, are women. And the primary consumers of long-term care are also women. Therefore, the demographics that relate to women in terms of their number, their longevity, their poverty and their marital status are critically important in highlighting who is most at risk of institutionalization.

Much of the beginning part of my testimony provides you with data, tables and charts and so forth on marital status and income to substantiate these statements. We believe that long-term care is a women's issue first of all because women make up the majority of the elderly and they certainly make up the vast majority of the frail elderly whether you are talking about institutional or community settings.

You know, of course, that women constitute some 60 percent of persons over the age of 65. But because of differences in longevity, they outnumber men 2 to 1 in the older age categories. And that ratio increases with age.

Since functional disability increases with age, women are, therefore, the vast majority of the frail elderly and they constitute more than 70 percent of the elderly who are in nursing homes.

Long-term care is a women's issue because older women are much more likely to be unmarried and living alone than are older men. And, of course, the long-term care both in the home and in the institution implications of that are very significant. Most older men are married and living with a spouse. Most older women are unmarried. That means if a man becomes incapacitated, becomes ill, becomes frail, he has a spouse to take care of him. When the woman becomes ill, on average, she does not have a spouse to take care of her. And, therefore, the needs of inhome support and the danger of her being institutionalized are substantially greater than is true for men.

Women make up 80 percent of those elderly persons who live alone. They make up 83 percent of the 6 million unmarried persons over age 75.

I would like to spend just a moment pointing out something with regard to marital status because it should be obvious that marital status and living arrangements and the potential need for long-term care are intimately related. The rate of nursing home use is nine times higher among the unmarried than it is among the married. I might also point out the connection between marital status and length of hospital stay. Older women on the average have longer length of hospital stay, and they have longer lengths of stay both in hospitals and in nursing homes than older men do.

In 1978, women who were married had an average length of stay of about 10½ days. If they were widowed, it was close to 12 days. And if they had never been married, it was 13.2 days. And I think you see the immediate connection because women who are married have a spouse at home; women who are widowed don't have a spouse at home, but the chances are they have children to take care of them; but those who were never married, have no one, in fact, to take care of them.

Long-term care is a women's issue because women are the primary caregivers. Here I would really urge you, beg you, to sharpen the focus and to force some more careful looking at terms that are used that are primarily euphemisms for who is it that is providing the care for disabled persons and for the elderly in the home. You will hear a wide range of them. The family does it. Informal supports do it. Community support. Sometimes they use the word "relative" or children. But it's women. It's primarily spouses and daughters who are providing informal supports and care to persons in the home.

And I think, again, the public policy implications of this are very great. If you don't focus precisely on who it is, then it is hard to see the desire and certainly the desirable public policy that we encourage families to care for their family members at home. It's not clear the inherent conflict there is between this and other retirement income policies that make it very important for women to vest pensions in their own right, to collect credits toward social security to aim for their own retirement income. There is a conflict between that and their need and desire to be at home caring for a dependent person.

Senator DURENBERGER. In the first 4 minutes of that presentation before you got to the distinction between single women and women with children, what were you telling us besides the point that we have got to get about the job of economic equity in this country for——

Ms. QUINLAN. One of the key issues, I think, Senator, is in the whole area of respite care. If you want women to be able to continue caring for their disabled spouses and elderly persons in the home, it is critically important to include provisions for respite care in inhome services. It is critically important because without some of that assistance, the women reach the breaking point; they simply can no longer continue caring for the disabled spouse or aged parents in the home and institutionalization occurs.

[The prepared statement of Ms. Quinlan follows:]

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STATEMENT OF THE OLDER WOMEN'S LEAGUE

on

LONG-TERM CARE

before the

HEALTH SUBCOMMITTEE

SENATE FINANCE COMMITTEE

November 14, 1983

Mr. Chairman, members of the subcommittee. I am Alice Quinlan, Government Relations Director of the Older Women's League, the first national membership organization focused exclusively on midlife and older women. The Older Women's League was formed following the White House Mini-Conference on Older Women in 1980, and now has nearly 8,000 members, and chartered chapters in 30 states. Through education, research and advocacy, our members work for changes in public policy to eliminate the inequities older women face.

Key items on OWL's national agenda are long-term care issues, including support for caregivers and alternatives to institutionalization, and access to health care. We are grateful to you, Mr. Chairman, for calling these hearings to explore long-term care issues, and for giving us the opportunity to share with members of this committee our perspective on long-term care.

LONG-TERM CARE AS A WOMEN'S ISSUE

Long-term care is pre-eminently a women's issue. Women in this country experience aging differently than men do, and those differences

—in longevity, marital status, and income—highlight why long-term care is so critical an issue for women. They are also central to the development of realistic and comprehensive long-term care policy. Compared with older men, women live longer, are much poorer, and tend to live alone.

- Long-term care is a women's issue because women make up the majority of the elderly, and the vast majority of the frail elderly, whether in institutional or community settings.

As of July 1982, there were 26.8 million Americans age 65 and over, about 10.8 million men and 16 million women. Women thus constitute about 60% of all persons age 65+. Because of differences in longevity, women outnumber men two to one in the older age categories, and this ratio increases with age. Women comprise 65% of persons over 75, 70% of those over 85, and 73% of those over 90. Since functional disability increases with age, women are the vast majority of the frail elderly. "Frail elderly" are often defined as those over age 75 who require assistance with daily living tasks. The following table gives an age-sex distribution of all persons over 75.

Table 1

Numbers of persons age 75+ in 1982, by sex and age (thousands)

Age	Men	Women	Total
75-79	1,968	3,138	5,106
80-84	1,084	2,054	3,138
85+	723	1,722	2,445
Total	3,775	6,914	10,689

(Source: Census Bureau, P-25, No. 929, Table 1)

Given this age distribution, it is not surprising that over 70% of persons residing in nursing homes are women.

- Long-term care is a women's issue because older women are much more likely to be unmarried and living alone than are older men.

When the marital status of older men and women is compared, there are no significant gender differences among those who are divorced, separated, or never married. But there are profound differences in the proportions of men and women who are widowed or married. As the following table illustrates, most older men are married and living with a spouse, while most older women are not. This is due both to women's greater longevity, to men marrying younger women, and to differences in remarriage rates. (Older men are seven times more likely to remarry than are older women).

Table 2

Marital status of persons age 65+ in 1981, by sex

Status	Men	Women
married	77%	38%
widowed	13%	51%
separated/divorced	6%	5%
never married	4%	6%

(Source: Census Bureau, P-20, No. 372, Tables 1 and E)

Because there are more older women than men, the result in absolute numbers is that many more older women are unmarried, and live alone. In 1981, about 7.5 million older persons lived alone, and 80% were women; 6.3 million persons over age 75 were unmarried, and 83% were women.

Table 3

Unmarried persons age 75+ in 1981, by sex
(thousands)

	Total Population	Percentage Unmarried	Number Unmarried
Men	3,669	30%	1,101
Women	6,692	78%	5,220

(Source: P-25, No. 929, Table 1 and P-20, No.372, Tables 1 and E)

The relationship between marital status/living arrangements and potential need for long-term care is obvious. The rate of nursing home use is nine times higher among the unmarried than among the married. We do not limit the use of the term "long-term care" to institutionalization, however, but mean the entire continuum of care, from in-home services, day care, resident facilities such as board and care homes, convalescent homes and skilled nursing, provided over a significant period of time in response to chronic disease or disability; ideally such services enable an older person to remain independent, or to live with family members as long as possible.

- Long-term care is a women's issue because women are the primary caregivers of the elderly.

The data noted above essentially mean that most older men have a spouse to provided needed care; most older women do not. It is interesting to examine policy statements and research studies for specific references to "caregivers." Sometimes "the family" is cited as the caregiver; other frequently-used references include "informal support systems," "community supports," and simply "relatives" or "children." But "caregivers," whether in institutional or non-institutional settings, is a euphemism for "women." Primary caregivers in family settings are overwhelmingly spouses and daughters, and then sisters, daughters-in-law, nieces, and other women. Concern for the caregiver, especially non-paid female relatives, but also the thousands of low-paid women providing care in institutions and in homes, is thus an issue of particular concern to women.

Most unpaid caregivers are midlife and older women. Housebound, physically exhausted, often depressed, experiencing social, familial and personal isolation, as well as financial depletion, these women are likely themselves to suffer a breakdown, or to abuse the person dependent on them for total care. Without support for the caregiver, the result may well be two dependent adults instead of one, and reluctant institutionalization, with both persons eventually dependent on public assistance for their survival. Thus while the primary focus of concern must be the care needed by the frail elder, public policy cannot afford to ignore the needs of the caregiver.

- Long-term care is a women's issue because women are likely to be caregivers and to need long-term care themselves, but they can least afford either to provide care to others or to pay for their own care.

In 1981 the median annual income of women age 65 and over was 58% that of older men, and within $400 of the official poverty level (men - $8173, women - $4757, poverty - $4359). The caregiving role most women fill throughout their lifetimes is one reason for these income disparities. Every year spent at home rearing children and caring for elderly family members means another "zero year" when Social Security benefits are calculated; jobs quit to care for incapacitated spouses mean the loss of pension benefits and potential retirement savings. Caregiving often leaves women exhausted, and if their spouses are ultimately institutionalized, frequently impoverishes them through Medicaid spend-downs. Finally, should older women no longer be able to care for themselves, they will become nursing home residents themselves, unless help is available in the community, and will quickly deplete their meager financial resources.

SPECIFIC LEGISLATIVE PROPOSALS

In the context of this perspective on long-term care, we would like to address some of the specific legislative proposals dealing with the issue. To the extent that older women need care for their prevalent chronic illnesses, or support in their role as caregivers for other family members, they are not well served by either Medicare or Medicaid. Medicare is based on an acute medical model, with cure rather than care as its central focus. And Medicaid, with its bias toward institutionalized care and its impoverishment of surviving spouses because of spend-down provisions, is equally problematic. Innovations that match services to needs better than the current piecemeal system, particularly the health and service needs of the chronically ill, must be developed.

Coordinated Care

We welcome the approach of S 1614, the Health Care Coordination Act, which would better coordinate programs of acute and long-term care. Pooling Medicare and Medicaid resources to allow a choice of coordinated services across the full continuum of long-term care, from acute care to community-based services, will allow the provision of service that is most appropriate to each situation. Although this legislation will affect only those persons who are dually entitled to both Medicare and Medicaid services, it is certainly a good first step toward appropriate coordination and a range of choice among needed services.

Medicare Home Health

The Older Women's League strongly supports S 1244, the Senior Citizens Independent Community Care Act, which would expand home health benefits available to qualified frail elderly under Medicare, although only on a limited test basis. We particularly favor its provision of respite care, which is so critically needed by caregivers, especially those caring for severely disabled spouses, parents, or other dependents. Relief and supportive services to unpaid caregivers is essential to any strategy that aims to prevent institutionalization.

Caregiver Incentives

A number of bills have been introduced that would provide families with tax credits for in-home care of frail elderly family members. While any financial assistance that helps offset the cost of providing in-home care is certainly welcome, careful thought must be given to the "incentive" nature of such proposals, if that is their motivation. Perhaps the point is best made by the visiting nurse who told one caregiving wife, "If you gave me $100 an hour, I wouldn't do (what you're doing)....You're crazy to keep it up." Policy makers who hope an annual tax break of $500 or $1000 or $2000 will tip the scales in favor of keeping a severely impaired family member at home might read the family guide from Johns Hopkins Press, The 36-Hour Day, or talk with caregivers, to learn what crushing burdens they carry.

Most families want to keep their relatives out of institutions; they want to and do care for them at home. What often finally precipitates institutionalization is the onset of incontinence, continuous loss of sleep, disruptive behavior associated with dementing illnesses, and the physical and emotional exhaustion of the caregiver. Often the family is depleted financially as well; sometimes women have no alternative but to institutionalize their spouse or parent, and return to the paid labor force. At some levels of impairment, adult day care may address this need. But in more severe cases, another alternative would be to reimburse the caregiver for services rendered, for example, by paying that person half the cost of nursing home care.

Restricted Targeting

In these times of limited federal and state funds, targeting that is too narrowly restricted to those most in danger of institutionalization can be counterproductive, again because of the impact on caregivers. When the availability of informal sources of care makes a frail older person ineligible for any community and in-home services, caregivers are penalized for their willingness to provide no-cost services. Minimal assistance--perhaps just some respite care--would encourage the caregiver to continue providing basic care indefinitely. Without that assistance, the caregiver may reach the breaking point. Currently some states that are quite liberal in the provision of services, prohibit in-home supportive services to an "able and available spouse"--in practice, the caregiver wife.

Home Care Quality

Attention must also be given to the poor quality of home health care that is all to often the norm, and that is frequently due to poorly trained and/or poorly treated staff who are expected to carry heavy work loads for low pay and long hours. The status of chore service and other in-home service workers (or those in institutional settings, for that matter) is particularly in need of reform. Inequities range from lack of mileage reimbursement for workers who must travel long distances from patient to patient, to a lack of training for many workers. Underlying many of these problems is the very low pay and poor or non-existent benefits available to these workers.

Other Issues

In concluding, we want to briefly mention three other concerns, two of which deal with private funding of long-term care. Tapping home equity through reverse mortgages may well become a common and risk-free way for millions of cash-poor older persons to get funds for many purposes, including long-term care. However, surviving spouses may end up no better off than with the property liens now allowed under Medicaid in order to reimburse the state for the cost of their husband's nursing home care; could this proposal be a privatization of Medicaid spend-down?

A second proposal is to pay for long-term care through private insurance. Much of the data cited in this testimony speaks to the likelihood that older women will need long-term care and yet will be less able to pay for it than men. Until the passage of legislation requiring non-discrimination in insurance, which would do away with the use of gender as the basis for risk-classification by the insurance industry, we are unconvinced that such insurance would be within the financial reach of any but a miniscule number of women.

Finally, we note the schizophrenic nature of many public policies affecting women, which become evident when the true identity of "caregivers" is made clear. On the one hand, health care costs and long-term care policy pushes families (read "women") to care for the dependent elderly at home. On the other hand, pressure on the Social Security Trust Funds has just resulted in the decision to raise the age of normal (full-benefit) retirement. Women's need to plan for more adequate retirement income through participation in the paid labor force is in direct conflict with the societal expectation that they continue in the traditional caregiving role. There was little consideration given last spring, when the Social Security amendments were under discussion, to the fact that women's employment—and hence retirement income--is much more impacted on by changes in family circumstances, including the health of other family members, than is men's. For women, life is substantially more complicated than merely "planning for your future."

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Senator DURENBERGER. Senator Bradley.

Senator BRADLEY. Thank you.

Dr. Rabin, you indicated that in S. 1244 the eligibility requirement was somewhat subjective. And you then went on to say that most of the people who are extremely frail are over 85. Are you suggesting that maybe an alternative to subjective eligibility criteria would be a simply age criteria?

Dr. RABIN. I think that an age criteria is appropriate. Age is the current criteria for medicare eligibility. Age is not only correlated with a decrease in the ability to remain independent on a physical basis, but it also is very much associated with a decrease in financial resources, and an increase in social isolation. This combination makes most very frail people above 80 or 85 who are unable to care for themselves physically to not have the financial resources to provide for their needs. This forces many very old into poverty and into medicaid which surely is not our society's intent.

If one has to restrict this kind of benefit, it is most important to focus on those who have least flexibility in adapting to a dependent state.

Senator BRADLEY. Ms. Quinlan, I found your testimony extremely helpful. Is the thrust of what you are saying that, most of home health care is currently delivered by women in home settings, in family settings; that the cost of having those individuals cared for in nursing homes or institutional settings is significant, and that the service being provided in the family by women has various other economic offsets, whether it is social security or pension rights or other support related to that age population?

Ms. QUINLAN. Yes; certainly. And as I said before, especially the issue of the need for respite care. There have been some States in which, because of the targeting, because of limited resources available, targeting was done in such a way that if the person in need of home care services had anybody on the scene who might be able to provide the services to them, then they were not eligible for any assistance whatsoever, including respite care.

Senator BRADLEY. Thank you.

Senator DURENBERGER. Again, I have got a long list of questions for all of you that I would like to submit to you. But I think you can tell from these hearings that there is some frustration here about our experiences in the past on picking and choosing. I think it was Ms. Matula from North Carolina who sort of said it all when she said that we haven't done much, but we have sure spent a lot of money trying to do good. And each time that we make some decision about targeting a particular form of delivery it seems that we increase the overall cost, thus, creating a larger problem.

So is there any kind of a sense of unanimity here on this panel about the need not to try to target a program for this and a program for that and a program for that, but to try to design a program of long-term care? And maybe some of the things you heard today about capitation payments or some other kind of payment where the individual, perhaps in many cases with the help of a professional, is able to make selections among a variety of forms of service. Is that not the general direction that we ought to be going in terms of what kind of a Federal financial involvement we have in the program?

Dr. RABIN. I am much impressed by your remark in terms of allowing people in need to have a breath of benefits, allowing professionals to be able to work with people, and their needs at the most appropriate place and with the most appropriate service. Combined with the concept of financial constraints on the cost of services promotes a situation in which one can work most effectively on the provision of long-term care for those who most need it.

Senator DURENBERGER. The difficulty now is who makes those choices, leaving aside whether or not there are enough alternatives in a community. You know, we have all seen enough of these situations where one of the kids takes mother by the hand, if there is a child, and takes her to the nursing home. It seems the end of the world in mother's eyes. And it seems to me that there is to a degree a need out there for some professional assistance in helping to make those choices, and particularly to make the choices that are most suitable for the particular person involved. It's very hard for the individual today it seems to me to make those choices on his or her own. And it usually is on her own.

Ms. QUINLAN. I think studies have shown, Senator Durenberger, that there are two common routes into nursing homes. One the most typical, being an older woman generally 81, 82 years old who was a widow who was living alone at home and finally reached the place where she was no longer able to care for herself. She had no one or no supports of any kind that would have made it possible for her to stay at home, and she became institutionalized.

The second most common route is that having reached that place, been alone, she then moved in with an adult child. And often what is the final breaking point is when there is a fall, a broken hip, a lack of mobility, or the problems that are associated with dementing illnesses which the family simply can no longer deal with. It isn't truly so much a sense of taking her by the hand, because at the point when she is finally institutionalized, it's in an ambulance.

Senator DURENBERGER. Mr. Corry, do you want to add anything?

Mr. CORRY. I think our concern is at the current time we have got an acute care system and we have got an institutionalized long-term care system. We don't have any sort of continuum so that people have choices whether by themselves or with their family members. And that is, I think, what we are urging the committee to address, is to fill in the gap that currently exists.

Senator DURENBERGER. Right. Well, we will sure try. We thank you all very much and especially for your patience in waiting until this hour of the day.

[The questions and answers follow:]

AMERICAN
ASSOCIATION
OF RETIRED
PERSONS

25 YEARS OF SERVICE

January 11, 1984

The Honorable David Durenberger
375 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

Attached are AARP's responses to your questions on long-term health care. We appreciate the opportunity you have provided us to express our views and would be happy to respond further.

Thank you for your continued interest in health care needs of the elderly.

Sincerely,

Peter W Hughes

Peter W. Hughes
Legislative Counsel

PWH:MC
Enclosures

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No. 1

Q. You indicate that AARP does not believe that there has been sufficient experience with community-based long-term care to make certain policy decisions at the national level. Do you, then, believe that more research and demonstration activities are necessary? If so, what direction should these activities take?

A. Previous research and demonstration activities have revealed the need and desirability of community-based long-term care. We are thus in possession of sufficient information on the kinds of services that are necessary for the chronically ill elderly and disabled. There are two areas in which we lack information: 1) Who should get access to these long-term care services and 2) How should these services be delivered?

The question of who should get access is tied to the issue of "secondary demand". Secondary demand refers to the potential for increased utilization attributable to expanded availability though no new eligibility is established in terms of individuals. The problem facing policy-makers is the millions of individuals not now in institutions but with ailments, infirmities, and level of income that make them potentially eligible for government benefits. Despite such eligibility, these people are not in current long-term care institutions. If, however, they could receive long-term care services in their home, for example, would they then participate in the new benefit program at greater system costs? Unfortunately, the state of the art is not such that policy-makers can easily distinguish unmet need for community-based care from secondary demand, posing one of the major cautions to the development of a comprehensive continuum of long-term care services.

The question of how long-term care services should be delivered is another area where more information would be helpful. For example, each of the bills discussed at the recent hearing provided for some form of screening and case management. But who should do such screening and management? Should the system be fully integrated, in the sense that one provider provides all levels of care, or should the system be divided so that home health providers provide home care, hospitals and nursing homes another level of care?

The need to find answers for the questions of who and how should not eclipse the fact that we have developed information as to the array of services, both medical and social, that should be part of any comprehensive long-term care system. Moreover, we have firmly established the need so it is no longer a question of <u>whether</u> community-based long-term care services are necessary.

Since we have crossed the policy threshold of need and we know the array of services which are desirable, the only responsible approach is to move forward in the development of a long-term care system. AARP envisions an approach that phases-in populations and delivery systems over time in order to better answer the who's and the how's that will enable a broad national system.

The bills before the Subcommittee fit very well into a phased implementation approach. Phase I could be S. 1612. This bill focuses on a highly appropriate population with which to begin a coordinated system of long-term care--the dually eligible. Individuals eligible for both Medicare and Medicaid are a defined population at significant risk of needing long-term care services. Phase II could build on the experience of Phase I, enlarging the eligible population but limiting services to defined geographic regions as in S. 1244.

Phase III, the final phase, would be national implementation of a comprehensive and coordinated system of long-term care. Phase III would come about as we have sufficient answers to many of the questions outlined above. Not only would Phase III build on the two previous phases but it would integrate the information from evaluating other demonstration projects such as the social/health maintenance organizations and from experience with hospices.

From the current vantage point the development of a comprehensive and coordinated long-term care system may appear to be an immense task. But if we proceed deliberately but "cautiously" we can arrive at a long-term care system that meets the needs of the chronically ill elderly and disabled.

No. 2

Q. Do you have any thoughts about how private insurance for long-term care should be developed, and what incentives should be built into an insurance package?

A. Before discussing the development of private insurance for long-term care, it should be noted that a recent AARP membership survey revealed that the vast majority of individuals when asked who will pay for their long-term care, indicated that Medicare would be the primary payor, with private savings and private insurance being secondary sources. This reflects a great deal of misinformation and misunderstanding as to what Medicare and private insurance currently pay for relative to long-term care.

Currently, private insurance covers a very small percentage of long-term care expenses. Only about 1 1/2 percent of nursing home expenses were paid by private insurance in 1982. In providing long-term care insurance coverage it should be remembered that only about 10 percent of those admitted to a nursing home are there for more than three years, and only about 4 percent of nursing homes stays extend for longer than five years. Also of importance is that only 45 percent of all nursing home stays exceed 90 days.

There would appear to be many problems and barriers to establishing meaningful long-term insurance coverage. For example, research is undoubtedly needed focusing on such areas as market demand, risk analysis, distribution (or marketing system issues), and mechanisms for limiting open-ended liability. Also, criteria need to be developed to distinguish between SNF, ICF, ICF/MR, and custodial care. There is today almost a total absence of reliable data relative to induced as well as planned utilization and claim cost experience.

In those limited instances where coverage less than Medicare-certified SNF care is provided by private insurers, administrative costs of determining the level of care and the controversy surrounding such decisions have led some insurers to cut back on the number of days of nursing home care they'll cover (for example, "up to 100 days"), yet not question the level of care received--as long as skilled care was initially required.

There are many questions that must be addressed when developing long-term care insurance: How should such a program limit, to the greatest extent possible, adverse selection on an open-enrollment basis? Should such insurance coverage be designed on an indemnity, as opposed to expense-incurred basis? How should it pay for certain levels of care? For example, for skilled care, the nursing facility could be reimbursed at a rate per day of confinement, and custodial or intermediate care could be reimbursed at half that rate. Another important question is whether such LTC insurance should be part of a general life insurers or annuity product, or whether it is preferable that it be stand-alone coverage. How should premium pricing be established? For example, it might be based upon the entry age of the individual and the year of policy issuance. This would mean that individuals would in essence pay level premiums throughout their lifetime based solely upon their age and the year in which they purchased the policy.

In addition to the type of benefits to be provided, there are certain underwriting issues that need to be considered to limit adverse selection such as: dollar denominated limits of liability or maximum payout on the plan; pre-existing conditions; waiting periods; medical recertification criteria; and coordination of benefits with other insurers (such a coordination provision would be particularly important relative to identical benefits available for skilled nursing care under Medicare and supplemental policies).

It is essential that private insurance for long-term care include a meaningful home care benefit. This would be more than a "get well benefit". It would provide an incentive for cost constraint. Broad acceptance of this coverage would probably be necessary to establish a sizable policyholder base so as to effectively spread the risk of underwriting this kind of benefit package.

In addition, there would probably be a need to take a very close look at the issue of taxation of interest on reserves. There will also probably need to be other state regulatory and legislative changes to facilitate the development of this private sector marketplace.

Finally, long-term care insurance policies would be fairly expensive. Although the dangers of adverse selection can be limited, they cannot be eliminated. Moreover, while claims on such coverage would be slow in emerging, they will likely have a "long tail", that is initially very low loss ratios, but a high payout over time.

No. 3

Q. What evidence do we have that the social/health maintenance organizations can meet the needs of the chronically ill elderly and disabled?

A. The needs of the chronically ill elderly and disabled are two-fold: The first need is that they receive the appropriate mix of services, allowing them to live in the least restrictive environment. The second need is that they be afforded a measure of financial protection since, depending on the severity of their illness, they will be frequent users of the health care system. A corollary of the second need is the additional need to implement a program that offers the public, as third-party payor, protection against open-ended liability.

Although the social/health maintenance organization (S/HMO) demonstration project is just beginning, the model's design as well as evidence from health care expenditure data suggest that S/HMO's may go a long way toward meeting the needs of the chronically ill elderly and disabled.

Under the S/HMO a wide range of services, both medical and social, would, for the first time, be centrally accessible to individuals having serious functional impairments. This is especially important for the chronically impaired, whose Medicare coverage is, at best, minimally supplemented by private "medigap" insurance policies. The S/HMO builds on previous long-term care demonstration projects that have shown that substituting in-home for institutional services has resulted in an improved quality of life and reduced costs for individual clients. In order to match services to needs the S/HMO will employ a case manager or case management team.

Previous long-term care demonstration projects have not, however, clearly indicated a reduction of costs to the system. Likewise, the effect of expanding benefits to many new beneficiaries has not been costed-out. The S/HMO concept builds upon the analysis of HCFA health care expenditure data by Brandeis University's Health Policy Center that indicates it may be possible to finance likely increases in ambulatory care and in community support services through savings in the acute hospital and long-term nursing home care sectors.

Currently, few elderly have ready access to comprehensive long-term care services beyond very limited home health benefits or placement in a nursing home. This situation prevails because: (1) only limited coverage is available under both Medicare and Medicare Supplementation insurance programs; (2) severe fragmentation is characteristic of the relationship between the primary medical, acute, and long-term care service sectors. As a result, many elderly persons have experienced lengths of stays in hospitals or nursing homes which were unnecessary or remained as custodial patients in lower level nursing homes because the support services required to achieve home placements were unavailable.

The S/HMO is intended to correct the problems of access and appropriate mix of services by creating a delivery system and financing plans that maximizes both provider flexibility and accountability. Thus, the potential savings in institutional costs may well allow for expanded benefits to enrollees while not increasing the overall cost to public third-party payors.

The private versus public financing of long-term care in the current system can be contrasted with the S/HMO. In the current system, the financing of long-term care is borne by the relatively small number of individuals who reside in nursing homes (or by public payors in their behalf) or who remain in the community but require household support on an ongoing basis. Under the S/HMO concept these costs are spread over a larger population and paid for by a combination of enrollee payments--that may include copayments as well as premiums--and contributions from public payors. The S/HMO, then, adopts the insurance principle of spreading risk over a larger population.

In summary, the evidence suggests that the S/HMO is on the right track for meeting the needs of the chronically ill elderly and disabled. Further, the public's concern that a program not provide an open-ended benefit and hence open-ended liability is addressed by the S/HMO's enrollment mechanism (which precludes disproportionate enrollment of high and low risk subscribers), and the S/HMO provider sharing the financial risk with public third-party payors for costs above the negotiated capitation budget. While some questions remain, they can best be addressed through actual experience.

No. 4

Q. In addition to tax incentives and expansion of daycare and respite services and other items mentioned, are there other ways in which the current service system should be changed to supplement--not supplant--family care of the chronically ill elderly?

A. Designing a long-term care program that addresses the needs of both the chronically ill elderly and family caregivers is long overdue. Many families, under the emotional and physical stress of caregiving, find themselves with no other alternative than to institutionalize their aged or disabled. It is for this reason that AARP supports the removal of disincentives to family assistance (such as the one-third reduction in benefits under SSI when the beneficiary lives with his/her family) and the expansion of incentives for family caregiving (such as tax incentives and expansion of daycare and respite services).

AARP's commitment to the role of the family as caregiver is tempered by a note of caution, however. Simply put, there are limits on how much families can do. Although the family's efforts should not be supplanted, we cannot assume that the family can do more. After all, family members now provide about 80% of the elderly's long-term care services.

Moreover, demographic trends reveal that the most rapid increase in the elderly population is the group age 75 and older; women make up the majority of the elderly; women are the vast majority of the frailest elderly who are most apt to need long-term care; and older women are much more likely to unmarried and living alone. Moreover, the children of the elderly needing long-term care may well be in or near retirement themselves, and unable to provide care. Can we legitimately demand that the retired and aging children of the older aging population support its long-term care needs? And how do we accommodate the growing number of older persons with long-term care needs who have no family?

A long-term care system truly responsive to the needs of the growing elderly population should encourage and support family participation but it should not be predicated on an assumption of increased family effort--indeed demographic trends may result in a decrease.

Senator DURENBERGER. Our final panel, the hungriest panel of all, will be Margaret J. Cushman, executive vice president, Visiting Nurse Home Care, Inc., Waterbury-Hartford, Conn., on behalf of the National Association for Home Care; Winifred Livengood, executive director, Home Health Agency Assembly of New Jersey; and John B. Smith, chairman of the board, Home Health Services and Staffing Association of Washington, D.C.

We welcome you all. Your statements will be made part of the record. And you may now proceed to abbreviate them. And we will start with—Bill, do you want to say something about Ms. Livengood?

Senator BRADLEY. I think the committee is fortunate to benefit from Ms. Livengood's experience in this field. I welcome her to these hearings, thank her for the work that she has done in New Jersey, and look forward to this testimony.

Senator DURENBERGER. Proceed.

STATEMENT OF MARGARET J. CUSHMAN, EXECUTIVE VICE PRESIDENT, VISITING NURSE HOME CARE, INC., WATERBURY-HARTFORD, CONN., ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. My name is Margaret J. Cushman. I'm the executive vice president of Visiting Nurse Home Care in the Waterbury-Hartford area of Connecticut. I'm here in my capacity as the chairman of Government Affairs Committee for the National Association for Home Care.

The National Association for Home Care is the Nation's largest organization representing home care providers. Our nearly 1,600 members include all sizes and types of home health agencies and hospices.

Here with me today is John Smith, chairman of the board of the Home Health Services Staffing Association.

I'm very pleased to have the opportunity to present our views on some long-term care legislative proposals, as well as legislative reforms needed to insure the provision of long-term care services for the elderly and disabled.

We commend the committee for holding this important hearing, and for recognizing the need for new approaches in long-term care. I would particularly like to thank Senators Inouye, Packwood, Bradley, Heinz, and Hatch for their leadership in introducing legislation, for their strong support of home care, and for their efforts in constructing these bills, all of which would expand community based and home care services.

Our Associations support both the concept and technical language of S. 1244 and S. 1614. Both are essentially experimental programs in design, and we believe it would be fiscally prudent for Congress to authorize these programs.

We support the underlying concept of S. 410, which would expand Government dollars going into home care as opposed to institutions. However, we have significant problems with the structure of the proposed new community nursing centers. I will not go into detail at this time, but representatives from our associations are available to discuss this with appropriate staff.

More important than the specific bills at this time is the basic concept they are addressing. That is, integrating the Federal and State Governments' long-term-care funding programs in such a way as to make community based and home care the first alternative in providing health care to the elderly, the infirm and the terminally ill. The need to take this action is particularly accentuated by several recent and pressing developments.

Those are: The current state of the medicare trust fund, the elderly population increasing, the recent Urban Institute study finding that about 3 million elderly living outside institutions need help in order to live independently, the phase-in of the DRG system in hospitals, which is increasing the number of persons being discharged earlier and in need of greater followup care, and a recent study by the National Governors Association and intergovernmental health policy project indicating that State medicaid programs have limited the growth of SNF beds.

Despite this evidence of a need for more home- and community-based care, medicare and medicaid still have an inordinate bias toward funding institutional care. We are particularly concerned that the existing medicare home health benefit is being unjustifiably limited, contrary to congressional intent, by the Health Care Financing Administration and its contract intermediaries. This is being done by restrictive and inconsistent interpretations of key definitions in the medicare statute which determine the nature and frequency of home care.

HCFA and its intermediaries have been circumventing the medicare statute and regulatory process by issuing memos, directives, and guidelines interpreting the terms "intermittent care," "homebound," and "skilled nursing" in a manner contrary to the medicare statute and the regulatory process required by the Administrative Procedure Act.

On creating the medicare home care benefit, Congress stated that covered care was to be intermittent, but it did not specifically define what that constituted. The Health Care Financing Administration issued guidelines on intermittent care to the fiscal intermediaries who process claims for home care providers. Under these guidelines, intermittent care would include daily care for a 2- to 3-week period, and thereafter under exceptional circumstances.

The major problem that has occurred with regard to these guidelines is the varying and inconsistent interpretations of fiscal intermediaries as to what constitutes intermittent care. Some intermediaries interpret daily to mean 7 days a week, others consider it to mean 5 days or less.

Some intermediaries will extend this 2- to 3-week period on a case-by-case basis; others consider the guideline to be a fixed ceiling. The implications of these inconsistent interpretations of intermittent are that there are thousands of cases where patients who have been authorized by physicians as medically needing home care have been denied home care outright.

With the implementation of hospital prospective payment plan, this problem will increase.

Again, while we applaud efforts at bringing about the long-overdue generic reform to the long-term-care system, we strongly urge that immediate attention be focused on a legislative remedy for the current interpretations of intermittent and related problems.

Thank you for giving me the opportunity to appear today. My colleague has brief additional comments, Mr. Chairman.

Senator DURENBERGER. Thank you.

[The prepared statement of Ms. Cushman follows:]

TESTIMONY OF MARGARET J. CUSHMAN, MSN, RN, EXECUTIVE VICE PRESIDENT, VISITING NURSE AND HOME CARE, WATERBURY-HARTFORD, CONN.

SUMMARY OF PRINCIPAL POINTS

Testimony of Margaret J. Cushman, MSN, RN
Executive Vice President, Visiting Nurse And Home Care (Waterbury-Hartford, Connecticut), and Chairman, Government Affairs Committee, for the National Association for Home Care (NAHC) testifying for NAHC and the Home Health Services and Staffing Association (HHSSA) before the Subcommittee on Health, Committee on Finance, U.S. Senate, November 14, 1983.

(1) We support both the concept and the technical language of S. 1244 and S. 1614, and believe it would be fiscally prudent for Congress to authorize these programs.

(2) We generally support the underlying concept of S. 410, which would expand government dollars going into home care as opposed to institutions. However, we have significant problems with the structure of the proposed new community nursing centers.

(3) We are concerned that the existing Medicare home care benefit is being unjustifiably limited by HCFA and its contract intermediaries in their restrictive interpretations of the "intermittent care" definition as it relates to home care.

(4) With the implementation of the hospital prospective payment plan, patients will leave hospitals more quickly and in a sicker condition. This will create new burdens on the home care industry, exacerbating the problem of resrictive definitions of "intermittent care."

(5) We support H.R. 3616 and urge the Senate to introduce parallel legislation.

My name is Margaret J. Cushman. I am Executive Vice President of Visiting Nurse And Home Care located in the Waterbury-Hartford region of Connecticut. I am here in my capacity as Chairman of the Government Affairs Committee of the National Association for Home Care (NAHC).

I am representing the National Association for Home Care, the nation's largest organization representing home care providers and individual home care professionals and paraprofessionals. NAHC's nearly 1600 members include large and small home health agencies, free-standing, hospital and nursing home-based agencies, Visiting Nurse Associations, major corporate chains, homemaker/home health aide agencies, and hospices.

Here with me today is John Smith, Chairman of the Board of the Home Health Services and Staffing Association (HHSSA). HHSSA represents 17 tax-paying investor-owned organizations that provide services through over 1000 offices in 44 states.

I am very pleased to have the opportunity to present our views on some of the long-term care legislative proposals introduced in this session as well as other needed legislative reforms necessary to insure the provision of long-term care services for the elderly and disabled.

On behalf of these organizations and myself, I'd like to commend the Committee for holding this important hearing and for recognizing the necessity of developing new approaches to long-term care. I would particularly like to thank Senators Inouye, Packwood, Bradley, Heinz, and Hatch for their leadership in introducing legislation, for their strong support of home care, and for their efforts in constructing these bills, all of which would expand community-based and home care.

Our Associations support both the concept and the technical language of S. 1244 and S. 1614. Since both are essentially experimental programs in design, we believe it would be fiscally prudent for Congress to authorize these programs. We generally support the underlying concept of S. 410 which would expand government dollars going into home care as opposed to institutions. However, we have significant problems with the structure of the proposed new community nursing centers. I will not go into detail at this time, but representatives from our Associations would be willing to sit down with appropriate staff to discuss our concerns.

More important than the specific bills at this time is the basic concept they are addressing. That is, the time is long overdue for us to integrate the Federal and State governments' long-term care funding programs and to do it in such a way as to make community-based and home care the first alternative in providing health care to the elderly, infirm, and the terminally ill. The need to take this action is particularly accentuated by several recent and pressing developments:

(1) The Congressional Budget Office and Department of Health and Human Services both have projected that without changes in the current law, the

Medicare trust fund will deplete its funds by 1989 or 1990.

(2) The elderly (over aged 65) population is increasing and will continue to increase. Recent projections by the Bureau of the Census predict that by the year 2030, 22 percent of our population will be age 65 or older compared to 11 percent in 1980. And during that same time period, the number of persons age 85 and older will jump from one to three percent of our total population.

(3) A recent Urban Institute study found that there are about three million elderly living outside institutions who need help in order to live independently and 5.8 million regardless of age. A September 1983 National Center for Health Statistics study made similar findings.

(4) The phase-in of inpatient hospital prospective reimbursement (DRGs) this October 1, 1983 will more than likely increase the number of persons being discharged earlier than presently and in greater need of follow-up care. The New Jersey all-payor prospective reimbursement experiment supports this forcast as do projections of such health care experts as David Ehrenfield of the Blue Cross and Blue Shield Association and Lynn Etheredge, former chief health economist at the Office of Management and Budget.

(5) A recent survey by the National Governor's Association and Intergovernmental Health Policy Project indicates that state Medicaid programs have limited the growth of SNF bed availability over the last five years. And a November 1983 GAO report (IPE 84-1) confirmed that there is limited SNF availability in certain states.

And, despite this evidence of a need for more home and community-based care, our Medicare and Medicaid systems still have an inordinate bias toward funding institutional care. Although home health outlays have increased significantly over the last three years, in fiscal year 1982 only 3.5 percent of the total Medicare outlays and 1.7 percent of the total Medicaid outlays went to home health.

As spokespersons for the home care industry, we are particularly concerned that the existing Medicare home health benefit is being unjustifiably limited, contrary to Congressional intent, by the Health Care Financing Administration (HCFA) and its contract intermediaries. This is beng done by restrictive and inconsistent interpretations of key definitions in the Medicare statute which determine the nature and frequency of home care. More specifically, HCFA and its intermediaries have been circumventing the Medicare statute and the regulatory process by issuing memos, directives, and guidelines interpreting the terms "intermittent care," "homebound," and "skilled nursing" in a manner contrary to the Medicare statute and the regulatory process required by the Administrative Procedure Act.

I'd like to briefly focus on the most glaring example of this process and its implications, which is the interpretation of the term "intermittent care."

On creating the Medicare home care benefit, Congress stated that covered care was to be "intermittent" but did not specifically define what constituted "intermittent care." The Health Care Financing Administration issued guidelines on intermittent care to the fiscal intermediaries who process claims for home care providers. Under these guidelines, intermittent care would include daily care for a 2-3 week period, and thereafter under "exceptional circumstances." The major problem that has occured with regard to these guidelines is the varying and inconsistent interpretations by fiscal intermediaries as to what constitutes intermittent care. Although Medicare is a national benefit, a Medicare beneficiary living in California can receive a substantially greater home care benefit than one living in Wisconsin. Some intermediaries consider "daily" to mean 7 days a week, but others consider it to mean 5 or even as little as 3 days a week. Some intermediaries view the 2-3 week initial period as a guideline and consider extensions of this period on a case-by-case basis; others see 2-3 weeks as a rigid cut-off point, regardless of medical reasonablesness and necessity as determined by a physician.

An example of the many types of problems this has created is illustrated in Michigan. In the same city, two home health agencies operate. Each is served by a different intermediary, because one of the agencies is a chain served by a central intermediary. One intermediary is liberal, the other restrictive. So, depending on which agency a patient uses, he/she will get more/less coverage.

The implications of these varying and inconsistent interpretations of "intermittent care" are that there are thousands of cases where patients who have been authorized by physicians as medically needing home care have been denied home care outright, or have had home care severly limited. For example, a 71-year old California woman with breast cancer with metastasis to the bone had a deep drainage wound requiring daily irrigation and packing. This care could be administered to her in her own home in approximately one hour by a visiting nurse. Despite her pain, the woman is an alert, determined woman who wishes to remain independent. The Visiting Nurse Service is available to help her, and has her physician's support to do so. However, she needs daily treatment of her wound, and the fiscal intermediary has denied reimbursement for her daily care. The number of tragic cases are too numerous to go into here. I would be pleased to provide the Committee with additional case examples.

With the implementation of the hospital prospective payment plan, the already acute "intermittent care" problem will be exacerbated. All the leading spokespersons on this issue have predicted that patients will be released from hospitals more quickly and in a sicker condition. In addition, a November 1983 GAO report (IPE 84-1) states it is likely that DRGs will exacerbate the number of Medicaid patients in hospitals awaiting nursing home or home care placement. Since the burden of caring for these sicker patients is likely to fall more and more on home care providers, standardization and liberalization of the definition of intermittent care is critical. If these new sicker patients can only receive 2-3 week of daily care uder the Medicare benefit, many patients will be falling between the cracks — too sick for home care, and not sick enough for nursing home eligibility.

Let us state clearly and unequivocably at this time that if Congress allows the current back door approach to restricting the "intermittent care" and other key definitions to continue, we will increasingly see thousands of elderly ad disabled citizens being discharged from hospitals with little or no home care available. We do not think that Congress intended this vacuum to be created when it passed the hospital prospective payment legislation, nor do we believe Congress intended the Medicare home health benefit to be restricted in such a way as to not be able to meet the needs of beneficiaries.

Again, while we applaud efforts at brining about long overdue generic reform to the long term care system, we strongly urge that immediate attention be focused on a legislative remedy to the intermittent care and related problems. Congressman Henry Waxman (D-CA) has already introduced H.R. 3616 which attempts to remedy part of this problem. We hope that the Senators who have shown their concern for home care in the bills being discussed today would join in a parallel effort in the Senate.

This concludes my testimony. Thank you for giving me the opportunity to appear today. My colleague has brief additional comments, Mr. Chairman. We will then be happy to respond to questions.

STATEMENT OF WINIFRED S. LIVENGOOD, EXECUTIVE DIRECTOR, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, PRINCETON, N.J.

Senator DURENBERGER. Ms. Livengood.

Ms. LIVENGOOD. Chairman Durenberger and Senator Bradley, I am pleased to be here today. I represent the 50 licensed and certified home health agencies which serve the citizens of all ages throughout New Jersey. I would like to testify today on S. 1244 and S. 1614.

We salute the sponsors of these bills for recognizing that our elder citizens need community- and home-based health care. Home health agencies serve the population that this legislation would affect; that is, elderly persons who have chronic health problems who need supportive services and who predictably will have episodes of acute illness.

What distinguishes S. 1244 is its provision of services to a large segment of the population which now has no home care benefits except for a few brief weeks under medicare when acutely ill. It recognizes that families from all economic sectors need health and supportive services at home. It is the basic philosophy of our great democracy that individuals be allowed to maintain their independence and to live with dignity in their own home with or near their families and friends. This legislation would help our elderly to do this and, for the first time, recognizes the true needs of our elder citizens.

Further, it would provide supportive help to those who are exhausted or anxious from prolonged caring for family members, and to those who have no family support at all.

Consider the following cases: Mr. and Mrs. X have no children and are trying to cope with his medical problems which are cirrhosis of the liver and organic brain syndrome, the latter causing him to be confused. Mrs. X is anxious about caring for her husband and experiences great stress and fear at his symptoms. She worries about congestive heart failure. Without professional help to support her, she cannot handle the situation and brings her husband to the hospital to the emergency room. After hospitalization, he goes on home care service. While this lasts, his wife, through visits and phone calls from the home health agency, receives the help she needs to care for her husband. But when medicare benefits stop, she is on her own again and the cycle repeats itself.

Another case: Mr. Y has cancer of the lung, with metastasis, and has difficulty breathing and swallowing. He is on complex medication. His food must be pureed and he is essentially bedbound. He lives with his 74-year-old sister, who is retarded, and his 40-year-old schizophrenic daughter who has never been treated for her disease. Recently, because the patient's status did not change, his medicare benefits stopped. His income was over the limits for medicaid and for title XX. He was left without supportive home care. Obviously, the family members were unable to care for Mr. Y without this help and within 10 days he was hospitalized.

Under S. 1244, home health care, plus respite services, supportive care, or adult day care would have offered these clients the help they need.

We support S. 1614, which would permit States to combine medicare and medicaid, and which recognizes the problems inherent in the present day dual reimbursement system. Our data shows that instability of health conditions is typical of the chronically ill, but the reimbursement patterns do not reflect this patient behavior. Rather, the current system fractures the delivery of care.

Consider the following data: Of 377 chronically ill medicaid patients in New Jersey, 130 were converted to medicare in the first 9 months of this year, and this is just in one of our 50 home health agencies.

There has been great concern that expanded home care benefits would increase the number of beneficiaries to such a degree that costs would be prohibited. I believe HCFA calls this the woodworking benefit. Two provisions in S. 1244 would permit cost control and would target user population. The first is prospective reimbursement demonstrations which will permit the provider to give only the services required by the status of the client. This differs from the current situation where the most expensive services may be given because that is the only means by which the patient will receive any care at all.

The second provision is the assessment for eligibility into the program. This legislation, for the first time, would use functional status, as opposed to medical diagnosis as a measurement of eligibility. It targets those individuals who really cannot cope.

[The prepared statement of Ms. Livengood follows:]

TESTIMONY BY WINIFRED S. LIVENGOOD
HOME HEALTH AGENCY ASSEMBLY OF NJ, INC.
before
SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON FINANCE
WASHINGTON, DC
November 14, 1983

Chairman Durenberger, Senator Bradley, and members of the Subcommittee on Health I am Winifred S. Livengood, Executive Director of the Home Health Agency Assembly of NJ, Inc. We represent fifty licensed and certified home health agencies which serve citizens of all ages throughout New Jersey.

I am pleased to be invited to testify today on S-1244, the Senior Citizens Independent Community Care Act, and S-1614, the Health Care Coordination Act of 1983. We salute the sponsors of these bills for recognizing that our elder citizens need community and home-based health care.

Home health agencies serve the population that this legislation would affect. These are elderly persons who have chronic health problems, who need supportive services and who predictably will have episodes of acute illness.

What distinguishes S-1244 is its provision of services to a large segment of the population which now has no home care benefits except for a few brief weeks under Medicare when acutely ill. It recognizes that families from all economic sectors need health and supportive services at home. It is the basic philosophy of our great democracy that individuals be allowed to maintain their independence, to live with dignity in their own homes, with or near their families and friends. This legislation would help our elderly to do this and for the first time recognizes the true needs of our elder citizens. Further, it would provide supportive help to those who are exhausted or anxious from prolonged caring for a family member and to those who have no family support at all.

Consider the following cases:

Mr. and Mrs. X have no children and are trying to cope with his medical problems which are cirrhosis of the liver and organic brain syndrome, the latter causing him to be confused. Mrs. X is anxious about caring for her husband and experiences great stress and fear at his symptoms. She worries about congestive heart failure. Without professional help to support her, she cannot handle the situation and brings her husband to the hospital through the emergency room. After hospitalization, he goes on home care service. While this lasts, his wife, through visits and phone calls, receives the help she needs to care for her husband. But when Medicare benefits stop, she is on her own again and the cycle repeats itself.

Mr. Y has cancer of the lung, with metastasis, and has difficulty breathing and swallowing. He is on complex medication. His food must be pureed and he is essentially bedbound. He lives with his 74-year-old sister, who is retarded, and his 40-year-old schizophrenic daughter who has never been treated for her disease. Recently, because the patient's status did not change, his Medicare benefits stopped. His income was over the limits for Medicaid and Title XX. He was left without supportive home care. The family members were unable to care for Mr. Y without this help and within ten days he was hospitalized.

Under S-1244, home health care, plus respite services, supportive care, or adult day care would have offered these clients the help they need.

S-1614, which would permit states to combine Medicare and Medicaid, recognizes the problems inherent in the present day dual reimbursement system. Consider the following data: Of 377 chronically ill Medicaid patients, 130 were converted to Medicare from January to September of this year in just one of our agencies in Elizabeth, NJ. Again, we see that instability of health conditions is typical of the chronically ill.

There has been great concern that expanded home care benefits would increase the number of beneficiaries to such a degree that costs would be prohibitive. Two provisions in S-1244 would permit cost control and target user population. The first is prospective reimbursement demonstrations which will permit the provider to give only the services required by the status of the client. This differs from the current situation where the most expensive services may be given because that is the only means for the patient to receive any care at all.

The second provision is the assessment for eligibility into the program. This legislation, for the first time, uses functional status, as opposed to medical diagnosis, as a measurement of eligibility. It targets those individuals who really cannot cope and would prevent entry into the program of those who do not need home health care. Home health nurses have given consistent testimony that nursing care at home is different from medical intervention. It is the amount of disability and the home environment that determines what care should be given. We recommend Mary Mundinger's book, <u>Home Care Controversy</u>, which details this situation.

You can see from case histories that the current system is not designed to meet the needs of the elderly at home. Medicare is too restrictive and Medicaid is limited to the very poor. Further, the current interpretations of regulations by HCFA, both in Baltimore and in the regional offices, curtail the use of these limited Medicare home health benefits.

The proposed legislation overcomes many of the limitations of Medicare and Medicaid. It will be essential for Congress to monitor closely the administration of these laws so that regulations and guidelines are not interpreted so narrowly that eligible clients are denied service.

We do need some clarification of certain sections of the legislation and we look forward to working with Senator Bradley and the Committee.

Overall, we emphatically support the concepts and thrust of this legislation and we thank you for the opportunity to speak today.

Senator DURENBERGER. I think we are going to have to put you all on hold right now. We have a vote and I have about 5 minutes left to get over there. So I hope you are willing to wait until we get back. I know Bill has another commitment at 2, so I will be back in 5 minutes.

Thank you.

[Whereupon, at 1:58 p.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. Thank you all very much. Have we lost New Jersey?

Ms. CUSHMAN. I don't think we have lost permanently.

Senator DURENBERGER. All right. Mr. John B. Smith.

STATEMENT OF JOHN B. SMITH, CHAIRMAN OF THE BOARD, HOME HEALTH SERVICES AND STAFFING ASSOCIATION

Mr. SMITH. Thank you, Senator; particularly for coming back to hear the remaining statements.

Senator DURENBERGER. Thank you. Pull your mike up as close as you can so we can hear you.

Mr. SMITH. My name is John B. Smith. And I'm chairman of the board of the Home Health Services and Staffing Association and senior vice president of Medical Personnel Pool.

Our association's members are investor-owned, taxpaying organizations which provide home health care services in 44 states. On behalf of our organization and myself, I would like to commend and thank the subcommittee and you, Mr. Chairman, for conducting this series of hearings on long-term care.

We are, of course, in agreement with the concepts embraced in these legislative initiatives and we concur with the earlier remarks of Ms. Cushman on behalf of the National Association for Home Care.

My statement includes a number of statistics which illustrate the rising costs and inappropriateness of the present health care delivery system. Home care is cost-effective, and will help to restrain rising health care costs if services are targeted on persons in institutions and on those who are ready to be admitted, and if proper assessment and case management takes place.

Mr. Chairman, I firmly believe that there is a clear and convincing evidence to support the cost-effectiveness of home care. Our association recently published a report entitled "Expansion of Cost-Effective Home Health Care," that was written by Health Policy Alternatives, a widely respected Washington, D.C. consulting firm.

This report summarizes all of the published information about home care cost-effectiveness and delineates those aspects of home care that contribute to its cost savings as well as, identifying sources of potential savings. The executive summary of this report is attached to my statement, and with your permission I would like to offer the full report at today's hearing for the record.

Senator DURENBERGER. Without objection, it will be made a part of the record.

[The report from Mr. Smith follows:]

Expansion of Cost-Effective Home Health Care

May 1983

Prepared by
Health Policy Alternatives, Inc.

Health Policy Alternatives, Inc.

HPA provides reports, analysis and advice on health policy issues and strategies to numerous governmental, professional, and private sector organizations. HPA's address is 545 Eighth Street, S.E., Washington, D.C. 20003.

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EXPANSION OF COST-EFFECTIVE HOME HEALTH CARE

Executive Summary

Introduction

This paper reviews the cost experience with home health care services reported in published studies. These reports conclude that cost savings can be clearly documented in some, but not all cases. Cost-effective home care programs require targeting to patients who would otherwise incur institutional costs and designing effective assessment and case management mechanisms to assure that proper care and cost savings are achieved. Programs which incorporate these objectives would be the most promising first step in expanding third party coverage of home care benefits.

This review of the published home care cost-effectiveness literature was commissioned by the Home Health Services and Staffing Association for the benefit of policy makers and others interested in the development of home care.

Following is a summary of the six major sections of this paper.

Characteristics of Reviewed Studies

Over 70 reported studies were studied as part of one of the most extensive reviews of the cost-benefit literature that has been reported. About 40 report data indicating the possibility of cost savings; most of the others do not report on costs. In some cases, total costs were reduced. In others, costs were reduced for certain subgroups. In some, costs were lowered to public payors as families and other private sources assumed more responsibilities.

The reported studies cover a wide variety of locations and situations. Many are based on functioning service programs that present the "clinical" experiences of first-line practitioners. Many local programs appeared to have targeted their efforts in a pragmatic fashion to achieve cost-effective benefits.

On the other hand, a number of indepth reviews that concentrate on statistical tests of significance, have concluded that past research results are, on the whole, inconclusive when such tests alone are taken into account. However, generally the studies did not test the results that could be achieved by targeting services to circumstances where they can be expected to be most cost-effective.

Benefits of Home Health Care

Home health care provides tangible and intangible benefits to patients and their families. The most dramatic findings are those indicating that persons receiving organized services have a reduced mortality rate. Other studies have reported gains in contentment, mental functioning and social activity. In some cases improvements in functioning and independence have been reported although these outcomes are complicated by the inevitable losses in the sample studied due to deaths among this very aged and ill population. Home health services have also been beneficial in identifying undiagnosed medical problems and facilitating arrangements for needed care.

Organized home health services can also help reduce stress on family members and others giving care to persons at home. As a result, effective home care arrangements relying primarily on family members may be extended if supplemented by organized services.

Sources of Potential Cost Savings

Net cost savings are the result of total savings reduced by any cost increases. The possibilities of cost savings are greatest when the forgone services are very costly, such as hospital care. However, if the forgone services are minimal, even a modest amount of home health services may result in added costs.

Potential cost saving factors include shorter hospital and nursing home stays, fewer admissions, reduced use of other services and increased use of family and other non-compensated services. Potential cost increasing factors include caring for additional patients and providing added services, substituting less efficient for more efficient services with higher costs per unit of services and inadequately managing and coordinating services.

Cost Experiences: Three Objectives

The first objective of home care is to speed discharges from hospitals and nursing homes. Blue Cross plans have been

especially interested in this goal. Savings have been reported from plan activities in more than 10 states.
Medicaid and Medicare programs have also given more attention to these approaches as the number of patients in hospitals awaiting nursing home placement has increased.

Studies have also identified a large number of nursing home patients who might be effectively and economically cared for at home. There are, however, difficulties in arranging discharges from nursing homes, especially after six months, often because of changes in the home environment. These difficulties have focused the attention of the studies on pre-admission reviews.

The second home care objective focuses on preventing admissions to institutions, especially nursing homes. Such programs and studies have been expanding; reports from about 15 states are reviewed. In most cases, the extension of home health services has resulted in lower institutional use and costs either on an overall basis or for certain groups of patients. Often, overall cost results have been substantially affected by the large percentage of patients in control or comparison groups who did not choose to enter nursing homes even though eligible for such services. More attention is being focused on patients most likely to enter nursing homes in the near future. Broad interest in this is indicated by the fact that, during the last year or so, about 40 states have been granted waivers for the extension of community-based services as part of their Medicaid programs.

The third objective involves serving chronically disabled persons who have a medical condition requiring service, who therefore can benefit from home health services, but who are not likely to enter an institution in the near future. A decision on the amount of organized services to be financed for this group is a critical, and difficult, decision. A paradox is presented to policy makers: the strong desire of disabled persons to remain in their own homes who would do so even if their care is inadequate makes it more "costly" to provide services that can enhance the quality of their lives while at home even though such services can sometimes delay institutionalization in the long term.

Conditions for Cost-Effective Delivery

The cost-effective delivery of home health services must take into account the many different types of individuals and the wide variety of activities involved. The degree of impairment and the functional status of patients are key factors determining the need for services.

Organized services vary greatly in their scope and intensity. Current uncertainties focus largely, though not exclusively, on the amount of personal and maintenance services that should be provided as part of "formal" services and financed by third parties.

Family and friends provide most support in the home on an "informal" basis. Their efforts are essential to effective home care arrangements. Organized services are often useful in assisting the primary family care-giver who, in turn, supports the patient. Programs should be designed so that "volunteer" services are maintained and maximized.

Availability of appropriate services and their effective management and coordination are other important ingredients. Despite increases in services, there are still serious deficiencies in many areas. Services should be staffed and deployed to maximize productivity and impact.

Strategy for Cost-Effective Expansion

A strategic approach which takes advantage of current knowledge and capacities and provides flexibility to make use of future opportunities is indicated. An incremental approach can realize the potential benefits of home health services to public programs and to patients and their families without undue delay and/or risk of increasing costs. A model is the authority in Section 123 of P.L. 97-248, The Tax Equity and Financial Responsibility Act of 1983 (TEFRA) authorizing waiver of the three-day hospitalization requirement for Medicare coverage of skilled nursing care.

Authority could be given to the states for Medicaid and to the Department of Health and Human Services (DHSS) Secretary for Medicare to provide for the expansion of home care of such a nature, to such patients and under such circumstances as they conclude will not increase costs to the states or the federal government. Furthermore, extension of benefits could be authorized for limited geographic areas or to sample of patients where there is substantial uncertainty about the consequences of broader coverage. Extensions could be reduced or eliminated should the initial estimates prove to be in error.

Under such authority, actions could be taken to expand home health coverage in a way likely to achieve net savings. The capacities of state and federal programs to assess patients in order to identify those for whom health services will be cost saving and to determine the nature and levels of service required to supplement the unpaid services provided by families and others can be enhanced. As confidence about cost-saving opportunities is extended, broader eligibility can be offered progressively and prudently.

EXPANSION OF COST-EFFECTIVE HOME HEALTH CARE

Introduction

Home health services have been steadily expanding in recent years. There is wide agreement that such care has proved attractive and valuable. Under certain conditions, it can prevent admissions to hospitals and nursing homes and speed discharges from these institutions. Many persons with chronic health problems and their families strongly prefer arrangements for care at home in the familiar, supportive environment of the home, rather than in the structured world of institutional care. In fact, many prefer to forgo nursing home care which would be paid for by a public program in order to remain at home even without help from government benefits.

Private and public payors of health care have both extended coverage for home health care in recent years. Blue Cross plans and commercial insurance companies as well as Medicare and Medicaid have joined in these actions. These decisions reflect pragmatic judgments that such services provide benefits whose value at least equals their cost.

This paper reviews recent studies of the cost experiences as well as the benefits of home health services. It seeks to clarify current issues and suggests a strategy to facilitate future expansion in a cost-effective manner.

In considering further expansion of home health services, it is necessary to consider carefully their demonstrated effects. A carefully designed expansion, building on learning from past and ongoing experiences, can achieve maximum benefits while con-straining public outlays. As discussed in the last section of this paper, a program providing for incremental benefits can take advantage of proven gains and facilitate progressive advances.

This analysis has identified the importance of identifying the particular circumstances and conditions in which home health services are cost effective. A recent report of the U.S. General Accounting Office confirmed the benefits of home health care while pointing out that they, like most other health services, do not always result in cost savings. They concluded that "the elderly should benefit from expanded home care but increasing these services will not insure cost reductions" (emphasis added). Because home care is neither medically appropriate nor financially beneficial for all patients, the challenge is to identify and utilize the specific situations in which home health services can be targeted to achieve cost-effective results.

Home health services are generally provided on an organized basis to achieve one or more of the following objectives:

1. to make it possible to discharge patients earlier from institutions;
2. to make it possible to prevent admission of persons to institutions; and
3. to serve individuals who are likely to remain at home for the immediate future whether or not such services are paid for by a third party, but who have a medical condition that requires one or more services.

Past studies demonstrate that achieving the first two objectives can produce cost savings, even in the short term. Achieving the third can improve the quality of life and delay institutionalization but will often involve additional costs, at least short-term costs. These costs may be significant due to the "latent" demand for home health services.

The potential demand is enlarged because of the large number of persons with serious chronic disabilities, many of whom are eligible for nursing home care but who resist being institutionalized, preferring to remain in their own homes as long as feasible. The availability of paid-for home health services may encourage many of these persons to seek more extensive support. In some cases, it may substitute in part for services provided on a voluntary basis by family or friends. The degree to which these effects occur depends in part on the design of the benefit program.

Before considering cost issues, we shall review briefly the characteristics of the reviewed studies and the reported benefits of home health programs to patients and their families. Cost experiences in the three types of circumstances outlined above are reviewed and conditions for cost-effective expansion are discussed. The paper's last section outlines potential actions that may be taken to assure that public financing of home health care is expanded in cost-effective ways.

Characteristics of Reviewed Studies

This report is based on one of the most extensive reviews of the literature that has been undertaken. It covered over 70 reported studies, including 13 review articles. A summary of the papers is presented in Appendix A. They are listed in the attached bibliography.

About 40 of the studies report data indicating the possibility of cost savings arising from the availability of home health services. Most of the others do not report on costs. Where cost data are reported, in some cases, total costs were reduced; in others, costs were reduced for certain sub-groups of patients. In some, costs to public payors were lowered as families and other private sources assumed more responsibilities and met the living expenses for patients at home. All of these situations appear to present important opportunities for prudent managers of public programs.

Clinical Experiences

The reported studies cover a wide diversity of locations and situations. Many of them are based on functioning service programs. While the number of cases considered by any one study is usually small and the research designs frequently are inadequate to reach conclusions which are statistically significant, they offer the "clinical" experiences of first-line practitioners attempting to assist their patients within available resources. There are no statistical tools for combining the weight of the totality of these examinations.

Nevertheless, the conclusions of these practitioners have often been the basis for local decisions to broaden home care benefits; such operating experiences and program judgments provide pertinent insights and should not be dismissed. Many local programs seem to have "targeted" their efforts in a pragmatic fashion to achieve cost-effective benefits.

Controlled Tests

On the other hand, a number of indepth reviews, largely concentrating on statistical tests of significance and failing to test the results of specific targeting approaches, have concluded that past research results are, on the whole, inconclusive (Grimaldi, Kane, Stassen, O'Shaughnessy, GAO 1982[1/]). Ongoing DHHS-supported research and demonstration projects involve larger populations at multiple sites; nevertheless, their findings concerning the specific circumstances and conditions in which particular home health services are most likely to be cost-effective are likely to be more important than the aggregate cost-savings occurring during the course of the demonstrations.

[1/] References are to principal authors of items listed in the Bibliography to this paper.

Benefits of Home Health Care

Home health care provides both tangible and intangible benefits to patients and their families. While some benefits are difficult to measure, they are no less important. A number of recent reports document many gains even in the hard-to-measure category.

Mortality Effects

The most dramatic findings are those indicating that persons receiving home health care services experience a reduced rate of mortality. A DHHS-supported study in 6 cities of the effects of day care and homemaker services for the chronically ill found a lower proportion of those receiving organized home services died during the study period than did a comparison group (Weissert). Similar results have been reported from studies in Georgia (Skellie) and Wisconsin (Seidl) and among stroke patients (GAO, 1981).

Effect on Well-Being

The DHHS study also reported that higher proportions of those receiving services improved or maintained levels of contentment, mental functioning and social activity (Weissert). Similarly, higher contentment levels have been documented among groups in Chicago (Hughes), Georgia (Favor) San Francisco (Zawadski) and Utah (Haglund).

Some studies have also demonstrated improvements in the functioning and independence of those receiving organized services. Identifying these outcomes is complicated by the fact that all groups suffered inevitable losses due to the aging process and disease progression. Nevertheless, such gains have been identified among groups in Chicago (Hughes), Cleveland (Katz), Connecticut (Hicks), Florida, New York City (Brickner), San Francisco (Zawadski), South Carolina (Learner) and Utah (Haglund). Similar results have been found among those receiving day care services (Weissert) and in the Veterans Administration program (Mitchell).

Early Diagnosis

Home health services have also been beneficial in identifying undiagnosed medical problems earlier and facilitating arrangements for needed care. Such experiences were reported from programs in Connecticut (Hicks) and the six cities study (Weissert). These experiences have implications for the period of time over which cost effects should be measured since early diagnosis may produce higher costs early in the period of care due to treatment of newly discovered problems and lesser costs over time. The advantage of earlier diagnosis may contribute importantly, moreover, to the reduction in mortality rates.

Family Stress

Organized services of this type are also beneficial in helping reduce stress on family members and other care-givers who are providing support to chronically disabled persons. Assistance to these persons can enhance their skills and morale and provide needed relief, such as respite care (Callahan). As a result, providing such services may make it possible to maintain effective home care arrangements for more extended periods.

Sources of Potential Cost Savings

Net cost savings are the result of total cost savings reduced by the amount of any cost increases. Table 1 summarizes sources of potential cost savings and cost increases. The balance determines results in individual cases and in the aggregate.

Table 1. Summary of Sources of Potential Cost Savings and Cost Increases

Potential Cost Saving Factors	Potential Cost Increasing Factors
Shorter hospital stays	Additional patients
Shorter nursing home stays	Additional services
Fewer hospital admissions	Substitution of less efficient services
Fewer nursing home admissions	Earlier identification of medical problems (increase in early costs)
Reduced use of other health care services	Higher cost per unit of service, including travel costs
Reduced use of other support services	Reduced use of family and other non-compensated services
Increased use of family and other non-compensated services	Inadequate management and coordination of services
Earlier treatment costs may be less than later treatment costs	Incentive for unnecessary services

Cost savings result when new services replace more costly services. When the forgone services are very costly, such as hospital care, a good deal of home health services can be provided and savings still realized. However, if the forgone services are minimal, even a modest amount of additional home health services may result in additions to total health expenditures, although the benefits to patients and families may outweigh the increased payments.

Other circumstances may also result in an unfavorable cost balance. As noted above, organized services may replace services that were provided without payment. Or there may be a more efficient arrangement for services in a nursing home than in the patient's home, e.g., if 24-hour attendance is required by the patient. Or home services that are sometimes less expensive than the alternatives may become more costly if management of the home services is poor or coordination is inadequate.

Availability of new services may stimulate a substantial amount of the "latent demand." As noted above, there are a large number of persons with chronic health problems who are not receiving organized services at present but who would benefit from them. Thus, depending in part on how the program is designed, aggregate costs may increase as additional persons receive paid-for home services, even though there are savings in the care of many patients.

Program vs. Total Costs

Individual third-party payors tend to view cost issues from their particular perspective. Even when home health services are cost-saving, they may result in added costs to certain payors--that is, the forgone services may not be covered or only covered to a limited extent under the existing benefits of the program. For example, while Medicaid covers long-term care, Medicare and most private health insurance programs do not. Thus, some home care in the latter programs may reduce total health costs but not the costs of these programs themselves. Still, persons who purchase private insurance may often find home health coverage that increases premiums to be valuable both because of the availability of a preferred service and the financial advantage in helping avoid nursing home care that may lead to an exhaustion of financial resources and dependence on Medicaid, a result many find objectionable. Similarly, the Federal government may find it desirable to increase home health care expenditures in Medicare if a larger reduction in Medicaid costs results, even though states would share in such savings in Medicaid.

Third-party payors may also benefit as family and other private parties assume costs when individuals are cared for at home. Such arrangements relieve public programs of the costs of room and board and medical services in a hospital or nursing home not only by providing paid-for home care but also by inducing the provision of many support services by caregivers who are not compensated. On the other hand, in some cases, there may be added costs to non-health public programs for persons at home, such as food stamps and housing subsidies, that substitute in part for costs of health facilities.

Marginal Cost

It is useful to consider marginal as well as total costs on both sides of the equation. Marginal costs are those incurred by providing services to additional patients; the costs of servicing the first patient are often called fixed costs. In the short-term, some "fixed" costs will be experienced regardless of reduction in patient loads. In cases of institutional care, in the short-term, most of the costs of operation and of capital assets will continue even if occupancy rates decline; in the long-term, it may be possible to avoid all costs, including avoidance of the capital costs of additional construction for institutional capacity. Reducing needs for capital costs is especially important at times when there are high costs and major difficulties in obtaining capital. In many cases of home care, the costs of maintaining the household of a family occurs whether or not the patient is at home so that the marginal (i.e. additional) costs of maintaining that patient at home are often far less than the proportion of total family budget cost attributable to him.

Review of Cost Experiences

In reviewing cost experiences, it is desirable to consider separately the three circumstances in which home health services are provided, as described above:

1. when home health services make it possible to discharge patients earlier from institutions;
2. when home health services make it possible to prevent admissions of persons to institutions; and

3. when home health services are offered to individuals who are likely to remain at home for the immediate future whether or not such services are paid for by a third party, but who have a medical condition that requires one or more services.

Case One--Early Discharges

Home health care can facilitate earlier discharges from hospitals for certain patients. As hospital costs increase, the potential savings from such actions become larger and more important.

Blue Cross plans have been especially interested in studies on the provision of home health services for post-hospital patients. Studies reporting cost savings are reported from Connecticut, Michigan, Philadelphia, New York City (Hammond), Maryland, St. Louis (Berry) and Virginia (Virginia Blue Cross). Some hospitals and visiting nurse associations have also carried out analyses with similar results in Boston (Talkoff), Cincinnati, Denver and Rochester (Hammond). Most of these studies were made in the 1960s and early 1970s. Recently the Washington Business Group on Health issued a paper encouraging their corporate members to consider home health benefits in their health insurance plans, especially for post-hospital patients (Schwartz).

Medicaid and Medicare programs have also given more attention to these activities as the number of patients backed-up in hospitals awaiting nursing home placement increased. In some states, especially in the northeast, the substantial number of these "administratively necessary"[2] days stimulated action. For example, the ACCESS program in Monroe County (Rochester, New York), devoted considerable effort to hospital patients and reduced the share of Medicaid beneficiaries among those awaiting placement (Eggert).

Potentialities for discharges from nursing homes to home health care have also been identified. It has been estimated that a large number of nursing home patients, especially those moderately dependent, might be effectively and more economically cared for at home if adequate community-based services and housing were available. For example, the Congressional Budget Office concluded in 1977 that 10 to 20 percent of elderly persons in skilled nursing homes and 20 to 40 percent of those in intermediate care facilities could be cared for in this way. Similarly, a Minnesota study found that about 9 percent of skilled nursing home residents could be cared for at lower costs in the community (Pollack).

However, efforts to arrange discharges from nursing homes have encountered serious difficulties (Knowlton). Such actions are very complex, especially after the first six months of a patient's stay since the patient's home may have to be reestablished (Kane). These experiences have tended to focus attention on pre-admission reviews and screening, as discussed below.

2/ Days required while awaiting nursing home placement.

Case Two--Prevention of Admissions

Increasing attention has been concentrated on activities to review and screen candidates for admission to nursing homes to determine those who might be cared for at home. Medicaid programs in about 30 states have initiated efforts along this line, two-thirds on a statewide basis (Knowlton); this fact suggests a broad consensus on its cost effectiveness, especially in view of the fact that some states that did not make this move do not have broad nursing home benefits in their Medicaid programs. Some programs were initiated or expanded as part of HCFA-supported research and demonstration projects. These activities are likely to be extended under the waiver provisions for long-term care community-based services under Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L.97-35). At present, over 40 states have been granted waivers under this authority.

Pre-admission screening and assessment activities may be on a voluntary or mandatory basis. There is a trend among state Medicaid programs to require such reviews as a condition of payment for nursing home care.

In Monroe County (Rochester), New York, the ACCESS program included pre-admission assessments for adults at risk of long-term care. The comprehensive evaluation considers medical, nursing and psychosocial needs. During 1977, Medicaid costs for all direct non-institutional services provided after assessment to skilled level patients were estimated at 52 percent of the comparable Medicaid institutional rate. Average monthly costs for aged and disabled Medicaid beneficiaries increased by 12% in Monroe County when in six comparison counties they increased 17%. (Eggert).

In Georgia, a system for screening, placement and case management was developed in the Atlanta and Athens areas for Medicaid beneficiaries over 50 years of age who were certified as eligible for nursing home care and for whom alternative community-based home care services were appropriate. Three types of alternative services were offered. While total costs for the 24-month study period during 1977-79 were higher, for the experimental group which was provided personal care services and daily activity supervision in supportive living arrangements (e.g., boarding homes and other congregate living facilities) costs were lower than for the comparison group during the second year. Nursing home use and costs overall were reduced slightly and hospital costs were less for two of the three groups. Average project service costs per service period were only about a third of average costs of nursing home care, but overall cost-savings were not achieved due to the new services and the small portion of the control group which actually received nursing home care. It was concluded that savings were more likely if more efforts were focused on those most likely to enter a nursing home and if pre-admission screening were made mandatory (Favor, Skellie).

In South Carolina, a mandatory pre-admission screening program for Medicaid elderly patients in three counties providing community-based services has reduced the use of nursing home resources. Reductions were most evident among persons with lower levels of functional impairment, those most likely to be eligible for care in intermediate care facilities (Nock). Medicaid costs for those persons in the experimental group who were eligible for nursing home care were lower than for similar persons in the control group (GAO, 1982).

In Florida, cost savings were identified in a program that provides community care for persons 60 years of age or older who are functionally impaired and eligible for nursing home services. Cost per client in 1979, including food stamps and SSI payments, were between $232-261 per month in the experimental group; nursing home care for Medicaid patients ranged between $455-641 and costs in congregate living facilities and foster homes were $288 and $334, respectively (Florida).

In Utah, a statewide program of alternative services focused on persons applying for nursing home admissions for non-medical reasons achieved a 25 percent reduction in state expenditures for nursing home care. Cost per client day in 1978-79 was about $8 compared to costs of $24-33 for daily nursing home care (Haglund).

In the Cape Ann-North Shore area of Massachusetts, a screening activity denied or diverted from institutionalization about 14 percent of requests for approval of nursing home placements. The number of applicants served in the community might have been increased more than fourfold if adequate services were available. Community placements at $10.00 a day in 1979 cost all public payors $4.32-9.07 less per day of care than nursing home placements (Saphire).

In Virginia, a statewide pre-admission screening program for Medicaid nursing home applicants reduced placements 20 percent during 1977-80. Potential average savings of $560 per patient per month was estimated by maintaining individuals in the community. It was estimated that the rate of disapprovals of nursing home placements could have been increased to 35-40 percent if adequate community services were available (Knowlton).

In Wisconsin, a demonstration project involving screening and expanded community services at three sites reduced the use of hospitals and nursing homes, but reductions were not consistent across sites. Overall Medicaid costs for hospitals were reduced significantly. The study concluded that pre-screening of all nursing home admissions would be likely to reduce total costs for long-term care and recommended that expanded services be focused more directly on individuals in nursing homes or on waiting lists for admission (Seidl).

In Washington, a research project in two communities (and a comparison site) conducted indepth screening and assessment of designated high risk clients. A significant reduction in the rate of nursing home use was achieved. Only about 10 percent of all high risk patients were estimated to cost more to serve in the community than in nursing homes. The study report indicated that total costs could have been reduced if more stringent requirements--i.e., likelihood of admission was greater--had been applied to patients considered at high risk of nursing home placements and if services had been focused on that group (Solem).

In Connecticut, the second phase of the Triage project focused on persons at high risk of institutionalization. A 1982 report indicated that fewer Triage clients entered skilled nursing facilities than did members of the comparison group and they had fewer days of care during this period (Nocks).

In Arkansas, a program of in-home services for frail, vulnerable elderly in imminent danger of institutionalization produced substantial savings in public outlays. While the total costs of services, regardless of who bore those costs, for the extremely impaired clients at home were about the same as comparable patients in nursing homes, only 30 percent of the costs were paid from public funds whereas almost all facility costs were paid from public funds. Families and friends provided the largest portion of care to patients at home at all levels of impairment. As a result, the cost of care for an extremely impaired person was estimated at $330 per month with in-home services and more than $860 a month in a facility. (Arkansas).

In San Francisco, the On Lok Senior Health Services program achieved savings by providing a variety of day care services to elderly patients who had been certified for institutionalization. Service costs per patient day were about 80 percent of the Medicaid payment rate for nursing home care (Zawadski).

Two projects in New York City reported savings from programs of home health care. In the Bronx, the median cost of such a program was about a fourth the cost of care in skilled nursing facilities and less than half the costs in health-related facilities (Widmer). In Chelsea and Greenwich Village, annualized costs of the program were 47-80 percent of nursing home care depending on the patients' problems (Brickner).

A study in six cities of the effects and costs of day care and homemaker services for the chronically ill found that, while the addition of the new services covered in this study increased overall outlays for Medicare and Medicaid, for certain sub-groups institutional services were reduced. Skilled nursing days were lower for (1) patients receiving day care; (2) patients receiving homemaker services who had minimal dependency needs and those with a diagnosis of circulatory diseases; and (3) patients receiving combined day care and homemaker services. Hospital days were also lower for day care participants and those receiving combined services (Weissert).

The December 1982 report of the General Accounting Office focused on 11 studies of home health services in which the study design included a control or comparison group. As indicated in Table 2, the use of nursing homes was found to be lower in six studies, higher in one case, with no difference in four cases. Hospital use was found, in the eight cases where this was reported, to be lower in one case, higher in three cases, with no difference in four cases. It is not clear to what degree early diagnosis may have been responsible for the increases in hospital use or the failure to reduce hospital use; it also does not appear that early discharges were emphasized in all of these programs. None of the studies followed a case more than 2 years and only 3 studies reviewed cases as long as two years. The GAO report concluded that "costs may be constrained if ... a specific population is targeted to receive services." To that end, they urged additional research to help better identify persons at high risk of entering nursing homes.

Table 2. GAO Reported Effects of Expanded Home Health Care on Nursing Home and Hospital Use and Total Costs*

	Nursing Home Use	Hospital Use	Total Costs
Studies using control groups			
Cleveland	lower	higher	
Georgia	lower	no difference	higher**
Michigan	no difference	no difference	no difference
South Carolina	lower		
Wisconsin	no difference	lower	no difference
6 cities	no difference	no difference	higher
Studies using comparison groups			
Chicago	lower**	no difference	
Connecticut	higher	higher	higher
Rochester	no difference	higher	lower
San Francisco	lower		no difference
Washington	lower**		higher

* Based on Tables 3, 4 and 6 in "The Elderly Should Benefit From Expanded Home Health Care But Increasing These Services Will Not Insure Cost Reductions," U.S. General Accounting Office.

** Statistically significant

In summary, many local and state efforts have attempted to arrange home health services for patients who were eligible for admissions to nursing homes. In numerous cases, this approach has been successful in arranging such care at lower costs. However, these approaches have not always achieved overall cost--savings. Findings were often influenced by the very large number of "false positives," that is, persons eligible for nursing home care who prefer to remain at home whether or not organized home care benefits are provided; as a result, cost reductions were not large enough to affect cost increases for new services at home. Consequently, more attention is being focused on identifying persons most likely to enter nursing homes in the near future and concentrating home health services on these individuals.

Case Three--Benefits to Other Chronically Disabled Persons

Many other persons with chronic disabilities can benefit from organized home health services. Such services can help improve their level of satisfaction and quality of life and may delay (or avoid) institutionalization in the long term. However, these services will result inevitably in additional costs at least in the short term when there are no offsetting costs due to reduced institutionalization.

Studies have shown that in many circumstances, 25 percent or less of the patients eligible, on the basis of their physical conditions, for nursing home care will seek to enter such facilities (Weissert). In 1977, only 24 percent of those with dependency needs and 50 percent of those severely dependent lived in nursing homes (GAO, 1982). This situation reflects the strong reluctance of most persons--and their families--to enter such facilities and the widespread preference to remain at home as long as possible. Thus, a paradox is presented to policy-makers and society: the strong desire of disabled persons to remain in their own homes makes it more "costly" and, thereby, more difficult to provide services that can enhance the quality of their lives while at home, and delay institutionalization.

For those persons living at home and not anticipating nursing home care in the near future, a modest amount of home health services might be aimed at maintaining (and, if possible, enhancing) their level of functioning. Such activities might serve to prevent or delay more complicated and costly services in the long term. Additional knowledge and tools may make it possible to identify cases of greatest potential with more sophistication and dependability.

The cost impact of increased utilization due to "latent" demand is shown in the 1982 GAO report noted above. As indicated in Column 3 of Table 2, despite the reported reduction in the use of nursing homes or hospitals in most studies, total costs were higher in four of the eleven studies. No difference was found in three studies and there were lower total costs in two studies. The limited duration of the studies and the short-term effects of early diagnosis on costs may have affected findings. The GAO report indicates the "belief (of the Department of Health and Human Services) that targeting services to people who can be served the most cost effectively in the community is the most critical issue in the expansion of home health care services." Such targeting efforts, of course, should consider long-term impact as well as short-term results.

Conditions for the Cost-Effective Delivery of Home Health Care

The reported studies identify conditions that are important in the development and delivery of cost-effective home health services. These conditions are reviewed briefly in this section.

Home health care is provided to many different types of individuals and involves a wide variety of activities. Confusion often results from failure to take fully into account the great diversity of both patients and services. Viewing home health care as a single unit is the same as viewing the service to all hospitalized patients as similar. Recognition and determination of differences are essential in considering the best ways for targeting home health services in a cost-effective manner.

Patient Assessment

Persons benefiting from home health care suffer from many different diseases and problems. In determining needs for home health services, functional health status has been found to be more important than diagnostic category (Greenberg). A patient assessment process will be a necessary element in cost-effective home care programs. Methods for measuring the degree of impairment and functional capacities of patients, including both physical and mental aspects, have been developed but further refinements are needed (Kane). A minimum, although often too simplistic, approach is to divide populations into those who are moderately dependent and those who are severely dependent.

Most persons receiving care at home are moderately dependent. They may be living alone, with families and friends, or in congregate housing. As patients become more dependent, they usually require more support. In some cases, these services are provided at lowest cost in an institution. In many cases, though, individuals who are severely dependent can be maintained at home if adequate services are available. It has been estimated that 60 percent of the elderly who are extremely impaired live outside of institutions; persons living alone are most likely to be institutionalized sooner. (Callahan)

Program Classification

Home health services also vary greatly in their scope and intensity. Organized services have been classified as intensive, intermediate and basic (LaVor); they also have been categorized as health care services, homemaker services and chore services (CBO). Within each of these categories, there may be substantial variations in the level and scope of services. Current uncertainties focus largely, although not exclusively, on the amount of personal and maintenance services (e.g., homemaker and chore services) that may be cost-effective as part of organized services when delivered independently of health care services (Pollack). Services that are provided should be designed to match as precisely as possible patients' needs based on their functional health status.

Family Participation

Families and friends provide most support services in the home, offering substantial amounts of personal and maintenance care as well as emotional support. The National Center for Health Statistics (NCHS) surveys of persons 55 years of age and over receiving care at home found that 80 percent received some care (usually a large portion) from a relative, generally on a part-time basis. CBO estimated in 1977 that 3 to 6.7 million persons received such support. GAO found in Cleveland that families and friends provided 50 percent of the home health services received by older persons at all impairment levels and 80 percent received by extremely impaired persons (GAO, 1977). In Arkansas, family and friends provided over 60 percent of the home care (Arkansas).

Families and friends commonly make it possible for moderately dependent persons to remain home and often make it feasible for severely dependent persons to do so. It has been estimated that about a third of those receiving care at home are very disabled requiring continuous care. In some cases, organized "formal" home health services are most valuable in supporting--helping and relieving--the primary family care-giver who, in turn, supports the patient.

In view of the extent and importance of "informal" support from families and friends, there is concern that the expansion of "formal" or organized home health services may serve in substantial part to replace support that has been provided without payment in the past. To maximize cost saving, programs should be designed so that "volunteer" support is maintained.

A number of demographic and sociological trends create pressures to reduce donated services over time (Callahan). Especially important is the tendency of more middle-aged women, who have traditionally provided much of the care, to seek paid employment. Analysis of the impact of these factors must take into account the preferences and satisfaction of newly employed women as well as the additional federal and state taxes paid by them. (It should also be noted that, in many cases, donated services are also critical to the provision of adequately needed services in nursing homes) (Callahan).

A related point to consider in the design of home care benefit programs is that patients, their families and physicians must be interested and committed in order to develop effective home care arrangements in most cases. As noted, elderly persons and others have tended to show strong desires for these approaches. However, there may be "natural limitations" on the demand for organized services, reflecting styles of contemporary life, shortages of suitable housing, and resistance to public services (Dunlop). For example, a number of research and demonstration home care projects have had difficulties in enrolling their full quota of patients (Weissert).

Availability of Services

Furthermore, appropriate organized services must be available in adequate supply to make home care effective. Despite the increase in home health services in recent years, there are still many areas of the country with serious deficiencies (GAO, 1982). For example, a study in Massachusetts in 1979 found that 28 percent of those approved for nursing home care could have been maintained at home if adequate community services had been available (Saphire). A recent HCFA study noted that many states have reported that the lack of appropriate community services, or their unavailability at night or on weekends, has significantly reduced their effectiveness in preventing nursing home placements (Knowlton).

Finally, the quality of management of organized home health services is an important aspect of their effectiveness and these factors should be considered in program design. Services must be staffed and deployed to maximize productivity and impact. Services provided by various agencies must be well coordinated (GAO, 1977). Inefficient administration, duplication and overstaffing, either in skills or numbers, can reduce or even destroy a potentially favorable cost-benefit balance. Many of the reported studies address management issues (Amado, GAO Sept. 1981, Nestor, Rozell, Schlenker, Solem).

Conclusion

Findings of Studies

Home health care has been found to be effective and popular, according to the findings of the reviewed studies. These services can contribute importantly to the capacities of chronically impaired persons to continue to remain at home and to carry out their daily activities in a satisfactory and personally satisfying manner. In some cases, they have been found to reduce mortality and improve the quality of life. Under certain conditions, they can be and have been cost saving for third-party payors and others.

The cost-saving contribution of home health care depends on the amount of institutional costs that is avoided and the extent of services that are provided and financed on an organized basis. It appears that substantial savings in public costs can be realized by targeting efforts on those already in hospitals and nursing homes and those about to enter such facilities.

The costs of home health care tend to vary with the degree of impairment. Family and friends generally willingly assume the majority of these costs. Only a small minority of those eligible for nursing home placement choose to accept institutionalization even if they must depend on home care arrangements for which public support is inadequate.

Costs of organized service activities depend on the scope and level of the services which are provided. Refinements in assessment tools can help match support more closely to patients' needs. Effective management of such services is also important in reducing their costs.

While the U.S. General Accounting Office was very cautious in its 1982 report about cost-savings, it recognized that costs may be constrained if specific high risk populations are targeted to receive services. They reported that the DHHS agreed with their conclusions and indicated that:

1. "Targeting services to people who can be served the most cost-effectively is the most critical issue in the expansion of home health care services," and
2. "some of the current research efforts will produce better information about the characteristics of cost-effective targeting."

State Medicaid agencies are not only participating in these research and demonstration efforts but many are acting to take advantage of new knowledge and capabilities as soon as possible. These agencies have had ~~extensive~~ experience in long-term care and are on the front-line of programming along these lines. About 30 states have established programs of pre-admission screening of nursing home applicants. Over 40 states been granted waivers to expand community-based services under the waiver provisions of the 1981 Omnibus Budget Reconciliation Act (PL 97-35). To obtain a waiver, states must assure the Secretary of HHS that the availability of the new services offered under the waiver will not increase the overall costs of their Medicaid programs beyond the costs that would have been incurred to pay for institutional care. Furthermore, the states are themselves very concerned about Medicaid costs.

The expansion of these activities under Medicaid programs may have important implications for the Medicare program. The experiences of the ACCESS program in Monroe County, New York, were that the Medicare proportion of hospital patients awaiting post-hospital placement, often to nursing homes, rose at the same time as more Medicaid patients were discharged earlier to home care. Thus, it would seem desirable for Medicare to take advantage of the same opportunities for effective home care that are identified for Medicaid patients.

Past research studies have been of limited utility in defining all the specific circumstances and conditions in which cost savings are most likely to result from home health care. On the one hand, many of the studies have only involved small populations and short periods of time and have often had inadequate research protocols. On the other hand, others have tried to deal with multiple groups in complex and shifting environments and have tended to concentrate on aggregate results not on potential groups that may be targeted. Still, the experiences of those seeking to extend services with limited resources are noteworthy; many local and state agencies have developed and applied pragmatic approaches to targeting services in their particular circumstances. Findings from current efforts should soon provide further information and insights along these lines.

It is not possible currently to set forth all the circumstances and conditions in which Medicare, Medicaid and private insurance programs might realize savings by targeted expansion of home health care services. Thus, a strategic approach providing for the use of current knowledge and capacities while ensuring flexibility to take maximum and prompt advantage of future opportunities is indicated.

Strategy for Cost-Effective Expansion

This section outlines an approach to the cost-effective expansion of home health care in public programs that takes advantage of current knowledge and provides for progressive changes in light of this knowledge. Such an incremental approach can realize the potential benefits of home health services to public programs and to patients and their families without undue delay or risk of increased costs.

An approach similar to the authority provided in Section 123 of the Tax Equity and Fiscal Responsibility Act of 1983 (P.L.97248) regarding a waiver of the three-day prior hospitalization condition for Medicare coverage of skilled nursing facilities appears appropriate for the expansion of home care services. Section 123 authorizes the Secretary of Health and Human Services to provide for post-acute SNF coverage "... for as long as the Secretary determines and under such terms and conditions as the Secretary finds appropriate (so) that the inclusion of such services will not result in any increase in the total of payments or alter the acute care nature of the benefit." The Secretary may provide "for such limitations on the scope and extent of services ... and on the categories of individuals who may be eligible to receive such services ... for restrictions and alternatives on the amounts and methods of payment for services...."

Authority could be given to all states for Medicaid and to the Secretary of Health and Human Services in the case of Medicare to provide for expansion of coverage of home care of such a nature, to such patients, and under such circumstances as they conclude will not increase costs to the State or the Federal Government. Furthermore, it should be provided that extensions may be provided in limited geographic areas or to samples of patients where there is a substantial element of uncertainty about the consequences of broader coverage and that extensions shall be reduced or eliminated should the initial estimate that costs would not be increased prove to be in error.

Consideration might also be given to a limit on the average costs of authorized services. For example, in New York, payments for community-based services are limited to 75 percent of the average monthly skilled nursing facility rate. The South Carolina program has a similar limit. This approach would be similar in concept, although different in detail, to the limit included in the recently authorized Medicare hospice benefit.

The studies that were reviewed for this paper suggest some measures that seem likely to produce cost saving home care expansions. The program provisions that seem to be suggested include the following:

1. Development of program capacity for:
    a. assessment of patients to identify those for whom home services are likely to be cost saving;

   b. determination of nature and levels of service required by patients to supplement unpaid services provided by families and others;

   c. estimation of cost of additional home care payments versus institutional care payments; and

   d. availability and coordination of services. (All forms of home care should be considered as potential services rather than limiting coverage to specified types. Such limitations may result in failure to realize the full cost-saving potential of such care.)

2. Patient categories which, in appropriate combinations with other factors, are associated with cost reduction when further home care is covered:

   a. patients in hospitals whose stay can be shortened by care at home;

   b. patients in nursing homes requiring levels of care that may be provided efficiently outside an institution; and

   c. patients applying for admission to nursing homes in the near future (60 to 90 days).

3. Identification of levels of impairments that may be treated at home at lower cost than in institutions.

   a. evaluation of patients' functional state (ability to carry out activities of daily living);

   b. psychosocial evaluation, including emotional condition, mental functioning and social adjustment; and

   c. impairment sufficiently severe that the individual cannot provide necessary care, including personal care and housekeeping services, without aid.

4. Assessment of patients' resources, including residence, family, other unpaid care resources, community services, financial capacities, and other factors.

   a. adaptability of residence to the provision of efficient home care, e.g., congregate living permits service to a number of patients in the same location, permitting economies of scale and may provide congregate meal services and common housekeeping help that permits the frail elderly to reside with little or no additional help. Providing admission to such a residence, when available, may facilitate home care and even reduce the amount of needed home care. Coordination between benefit program, home care, and congregate living facility administration would appear advantageous;

b. availability of an individual or individuals (family members or friends) who can provide much but not all supporting services required by the patient. Respite service may make home care more feasible for an extended period; and

c. availability of efficient and effective services in the community, e.g., day care, meals on wheels, dining room in congregate living facility, heavy cleaning for many tenants of facility, shopping service, etc. (establishment and coordination of such services may be promoted by a program aggressively pursuing cost-reducing measures).

5. Limitations on cost of covered services to protect against the possibilities of aggregate cost increases.

   a. The level of limitation on services covered might take account of the cost of the alternate, forgone service (i.e., hospital, nursing home, or ICF). Those who require, for discharge from a hospital, services equivalent to 24-hour assistance at home for a limited duration (perhaps 7 days) while patient mobility remains very impaired should not necessarily be denied the service if it is less costly than hospital service. Where the home care is proposed as a substitute for SNF services, a lower limit might be set and an even lower level when ICF care were the alternative.

Consideration might also be given to refinements along the following lines in the longer term:

1. establishment of disability related groups so that ceilings or rates for home health services were directly related to the needs of different types of patients; and

2. introduction of an age factor--to recognize that the very high level of disability among the very elderly and the high costs of institutional care for these patients may make it desirable to provide additional incentives for maintaining these persons at home (i.e., there might be easier-to-meet requirements for authorizing home health care services for persons 75 or 80 years of age and over).

It would seem virtually certain that programs which proceed to extend home health services by taking into account the factors discussed above will yield cost savings. For example, if a program started with an assessment for possible discharge to home care of nursing home and ICF patients who are mildly or moderately dependent not needing intensive care and have a family or other person available as a care-giver or live in a congregate living facility, it is almost certain to achieve a net saving. Similarly, working with hospital discharge planners, hospital patients who would be retained for added days because of inadequate help at home can be identified. As experience is gained with additional categories of patients for which savings are most likely and confidence about cost-savings is extended, broader eligibility can be expanded progressively and prudently.

Table 1. Summary of Studies Included in Review

Author	Date (1)	Policy Focus	Need/ Demand	Cost (2)	Health Outcome	Management	Family Support	Case Studies Place	Size(3)	HCFA
Amado	76-7					X		Rochester	25	
Amado	78			XS-H				Rochester	55	
Appelbaum	77			X				Wisconsin	417C	
Arkansas	80			XS				Arkansas	406	
Berry	78-9		X							
Berry	79			XS				St. Louis	194	
Bloom	80*			XS-H				Phil.	38C	
Brickner	73-7			XS				New York	66	
Buckingham	78	X-H								
Callahan	80*	X					X			
Chowdhury	77-9		X-OT					Phoenix		
Colt	74-5			XS				Providence	98	
C.B.O.	77*	XR		XP						
Creese	70			XS				England	14	
Davies	80*			XS				England	70C	
Dunlop	80*	X	X				X			
Eggert	77-9			XS				Rochester	4433C	X
Emerg. Med.	71-8			XS-AT				Oregon	33C	
Favor	78-0			XP	X			Georgia	1332C	X
Florida	80-1			XS	X			Florida	227	
G.A.O.	77*	X		X				Cleveland	1609	
G.A.O.	78*	X						V.A.		
G.A.O.	79*					X				
G.A.O.	81*					X	X			
G.A.O.	81*	X	X	X	X		X			
G.A.O.	82	XR	X	XP			X			
Gibbins	79-0			XS				England	48	
Greenberg	76		X				X	St. Paul	226	
Grimaldi	81*	XR	X	XP			X			
Haglund	78-9			XS				Utah	162	
Hammond	79*	XR		XP						
Hansen	80			XS-H				Seattle	73C	
Hellinger	68	X		X						
Hicks	76-8			X	X			Conn.	502C	X
Higgins	75-8			XS-DT	X			Canada	65	
Hollander	79*	X-H								
Hughes	81*				X			Chicago	245C	
Hunt	59-75			XS			X	Canada	2171	
Kane	80*	XR								
Knowlton	81	XR		XS			X			
Kraus	75-8	XR		XS				Canada	2171	
LaVor	76*	XR		XS						

(1) - date of field work if relevant and reported; otherwise date of publication which are indicated by asterisk
(2) - report of cost saving in total is indicated by S
report of cost saving in part is indicated by P (3) - use of a control or comparison group is indicated by C

AT - antibiotic therapy
DT - dialysis treatment
H - hospice program
N - nutrition program
OT - oxygen therapy
R - review article
X - factor investigated in study

Author	Date (1)	Policy Focus	Need/ Demand	Cost (2)	Health Outcome	Management	Family Support	Case Studies Place	Size(3)	HCFA
Learner	80-1				X			S.C.	619C	X
Medeiros	80		X					Kansas		
Mitchell	78*				X			V.A.	318	
Nestor	76					X		N.J.		
Nocks	80-1				X			S.C.	619C	X
O'Shaughnessy	82*	XR		XP						
Pegels	80*	X		XS				Minneapolis		
Pollack	79*	XR		XP			X			
Ricker-Smith	66-73	X	X					California		
Rozell	76-7					X		Dayton		
Saphire	79-80			XS				Mass.	498	
Schlenker	77					X				
Schwartz	81*	XR		XP						
Seidl	76-9			X	~~X~~			Wisconsin	999C	X
Sharma	74-6		X					Pittsburgh		
Skellie	77				X			Georgia	287C	X
Skellie	76-80			XP	X			Georgia	727C	X
Smyer	76-7				X			N.C.	66	
Solem	76-8			XP		X		Wash.	1751C	
Stassen	81*	XR								
Tolkoff	74-6			XS				Boston	324	
Trager	74-6	XR	X							
VanBuren	80			XS-H					120	
VandeCreek	79			XS-H				Columbia	45	
Virginia B.C.	79-80			XS				Virginia	116	
Walecka	76-8			XS-N				Cleveland	8	
Weissert	80*			X				6 Cities	1566C	X
Weissert	80*			X				4 Cities	778C	X
Weissert	81	X								
Widmer	76-8			XS	X			Bronx	420	
Young	76	X		X						
Zawadski	80			XS	X			San Fran.	263	

(1) - date of field work if relevant and reported; otherwise date of publication which are indicated by asterisk
(2) - report of cost saving in total is indicated by S
report of cost saving in part is indicated by P (3) - use of a control or comparison group is indicated by C

AT - antibiotic therapy
DT - dialysis treatment
H - hospice program
N - nutrition program
OT - oxygen therapy
R - review article
X - factor investigated in study

Mr. SMITH. To achieve cost savings, my association suggests that the following six steps be incorporated into any program or legislative initiative aimed at providing home health care and community-based services:

One, the target population must be clearly defined to include those individuals who are in hospitals or who are at home awaiting nursing home placement.

Two, home care providers must comply with initial and periodic assessment and centralized case management requirements.

Three, home care benefits should be restructured so that any reasonable health status related service is provided.

Four, a reimbursement mechanism should be established that sets levels of payment to assure savings when compared to foregone institutional costs.

Five, family and other voluntary caregiver support must be encouraged to continue, even increase. Paid services should not substitute for contributed services. And, finally,

Six, adminstrative trappings should be kept to a minimum.

Again, Mr. Chairman, I want to commend you for conducting these hearings and to thank you for this opportunity to present our views. I want also to say that Mr. Irvin Wolkstein, a principal in health policy alternatives and the principal author of the report I mentioned in my statement, would be available to talk with committee members and staff about the report.

Senator DURENBERGER. Thank you.

[The prepared statement of Mr. Smith follows:]

HOME HEALTH SERVICES
and STAFFING ASSOCIATION

STATEMENT

OF

HOME HEALTH SERVICES AND STAFFING ASSOCIATION

to the

Subcommittee on Health
The Honorable David F. Durenberger, Chairman

Committee on Finance
United States Senate

Hearings on Long-Term Care

Submitted by

John B. Smith
Chairman of the Board

November 14, 1983

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Statement of
Home Health Services and Staffing Association

SUMMARY

- HHSSA supports legislative initiatives which would strengthen the national long-term care policy through the expansion of community-based and home care services for the elderly and disabled populations.

- Demographic trends indicate that the elderly population will grow at a rapid pace, increasing 37 percent by the year 2000 and 130 percent by 2025 and thereby increase the number of persons that will need long-term care services.

- The Congressional Budget Office has concluded that 10 to 20 percent of elderly persons in skilled nursing facilities and 20 to 40 percent of those in intermediate care facilities could be cared for at home.

- Data from Medicaid expenditures and Medicare costs show that the average costs of caring for individuals in the home are less than for those in institutional settings.

- Home care is cost-effective when the services are targeted on persons in institutions and on those who are ready to be admitted, and when proper assessment and case management takes place.

- Many programs throughout the United States have demonstrated cost-savings through the provision of home health services to individuals who would otherwise be institutionalized.

- Cost savings can be achieved by replacing higher institutional costs with lower home care costs through the following six steps:
  - define the target population clearly to include those individuals who are in institutions or who are at home awaiting nursing home placement.
  - require home care providers to perform initial and periodic assessment and centralized case management functions.
  - restructure the home health care benefit to ensure that all reasonable health status-related services are provided.
  - establish a reimbursement mechanism that sets levels of payment to assure savings when compared to foregone institutional costs.
  - encourage the continuation of contributed services.
  - keep adminstrative trappings to a minimum.

Statement of
Home Health Services and Staffing Association

Mr. Chairman and Members of the Subcommittee:

A. Introduction

My name is John B. Smith and I am Chairman of the Board of the Home Health Services and Staffing Association and Senior Vice President and Legal Counsel of Medical Personnel Pool.

On behalf of the Association, I want to thank you for the opportunity to appear before you today and talk about issues surrounding long-term care.

Our Association's members are investor-owned, taxpaying organizations, which provide both home health care services and supplemental nursing services through over 1000 offices in 44 states. Our members are:

Alpha Nurses, Inc.; Beverly Home Health Services; Kelly Health Care; Kimberly Services, Inc.,; Manpower, Inc.; Medical Personnel Pool; Norrell Corporation; Nursefinders; Olsten Corporation; OMNA Health Care Services, Inc.; Professional Nurses Bureau, Inc.; Quality Care, Inc.; SRT Med-Staff International; Staff Builders, Inc.; TAC/Medical Services, Inc.; Temporaries, Inc.; and Upjohn HealthCare Services, Inc.

By our most recent count, our members serve more than 200,000 people and employ more than 160,000 persons in either a full-time or part-time capacity. We estimate that approximately 60% of our total employees are home health aides while approximately 15% to 20% are registered nurses and licensed practical nurses. The largest percentage of our home care patients are private pay; that is, the costs of their care are borne by private insurance coverage or out-of-pocket payments. However, an increasing number of our patients are funded by Medicare (Title XVIII of the Social Security Act), Medicaid (Title XIX), Social Services (Title XX), and the Older-Americans' Act (Title III).

The home care services our members provide include professional nursing care; physical, occupational, or speech therapy; medical social services; home health aide services; medical supplies and equipment; and homemaker services.

B. Opening Comments

On behalf of HHSSA and myself, I would like to commend the Subcommittee and you, Mr. Chairman, for conducting this series of hearings on long-term care. In particular, I would like to congratulate Senators Heinz, Packwood, Bradley, Inouye and Hatch for their leadership in sponsoring the legislation now pending before the Subcommittee.

Our Association is in agreement with the concepts embraced in these legislative initiatives which propose to broaden the national long-term care policy through the expansion of community-based and home care services for the elderly and disabled populations. We concur with the earlier remarks of Peg Cushman from the National Association for Home Care on these proposals. And, like our colleagues, HHSSA would be happy to discuss the specific details of these proposals with staff and would be willing to assist the Subcommittee in the development of any additional legislative proposals.

At this time, Mr. Chairman, I would like to offer a few statistics that will help to focus my remarks:

1. Our elderly population is increasing at a rapid pace. In 1980, the over age 65 cohort numbered 26 million and comprised 11 percent of the population. U.S. Census Bureau projections indicate that the over 65 population will increase 37 percent by the year 2000 and 130 percent by 2025.

2. The Congressional Budget Office projects a Medicare deficit of $400 billion by 1995 under present conditions.

3. The Congressional Budget Office has concluded that 10 to 20 percent of elderly persons in skilled nursing homes and 20 to 40 percent of those in intermediate care facilities could be cared for at home.

4. The National Association for Home Care has analyzed 1982 Medicaid expenditure data and has calculated the national average cost per patient services in each of the following settings:

a) Skilled nursing facility	$7,854
b) Intermediate care facility	6,395
c) In-patient hospitals	2,179
d) Home health agencies	1,251

5. The average Medicare cost of a day of hospital care in 1980 was $208.00.

6. The average Medicare cost of a nursing visit at home in 1980 was $29.55.

7. The cost of caring for a ventilator - dependent child in a hospital is around $1,325 per day. Equivalent care at home would cost $300 per day.

The facts clearly illuminate the task that you, as policy makers,are facing: the costs of health care must be restrained, and home-based care can help to do it.

Home care <u>is</u> cost-effective and will help to restrain rising health care costs <u>if</u>:

1) services are targeted on persons in institutions and on those who are ready to be admitted, and

2) proper assessment case management takes place.

Mr. Chairman, I firmly believe that there is clear and convincing evidence to support this conclusion. Our Association recently published a report entitled "Expansion of Cost-Effective Home Health Care" that was written by Health Policy Alternatives, Inc., a widely respected Washington, D.C. - based consulting firm. This report summarizes all of the published information about home care cost-effectiveness and delineates those aspects of home care that contribute to its cost-savings, as well as identifying sources of potential cost savings.

The findings of the report indicate that home care provides both tangible and intangible benefits--we were not surprised to learn that patients who receive home care live longer and feel better. However, I am not here today to attest to the virtues of home care; its growing popularity testifies to that. Rather, I want to explain how money can be saved through the provision of services to individuals in their homes, instead of subjecting them to inappropriate institutional care.

Examples of reported cost-savings include:

In Minnesota, a study found that about 9 percent of the skilled nursing home residents might be cared for more effectively and more economically at home--if adequate community-based services were available.[1] The findings of this study parallel those of the Congressional Budget Office that I previously mentioned.

Similarly, in the Cape Ann-North Shore area of Massachusetts, a screening activity diverted from institutionalization about 14 percent of requests for approval of nursing home placements. The number of applicants served in the community (rather than in institutions) might have been increased more than fourfold if adequate services were available. Community placements at $10.00 a day in 1979 cost all public payors $4.32-9.07 less per day of care than nursing home placements.[2]

In Florida, cost-savings were indentified in a program that provides community care for persons 60 years of age or older who are functionally impaired and eligible for nursing home services. Costs per client in 1979, including food stamps and SSI payments, were between $232-261 per month in the experimental group; nursing home care for Medicaid patients ranged between $455-641; and costs in congregate living facilities and foster homes were $288 and $334, respectively.[3]

In San Francisco, the On Lok Senior Health Services program achieved savings by providing a variety of day care services to elderly patients who had been certified for institutionalization. Service costs per patient day were about 80 percent of the Medicaid payment rate for nursing home care.[4]

In Utah, a statewide program of alternative services focused on persons applying for nursing home admission for non-medical reasons. The program achieved a 25 percent reduction in state nursing home expenditures because alternative care was used. Cost per client day in 1978-79 was about $8 compared to costs of $24-33 for daily nursing home care.[5]

In Arkansas, a program of in-home services for frail, vulnerable elderly in imminent danger of institutionalization produced substantial savings in public outlays. While the total costs of services, regardless of who bore those costs, for the extremely impaired clients at home were about the same as comparable patients in nursing homes, only 30 percent of the costs were paid from public funds. Families and friends provided the largest portion of care to patients at home at all levels of impairment. As a result, the cost of care for an extremely impaired person was estimated at $330 per month with in-home services and more than $860 a month in a facility.[6]

Blue Cross plans have been especially interested in studies on the provision of home health services for post-hospital patients. Studies reporting cost savings are reported from Connecticut, Michigan, Philadelphia, New York City[7], Maryland, St. Louis[8] and Virginia[9]. Some hospitals and visitting nurse associations have also carried out analyses with similar results in Boston[10], Cincinnati, Denver and Rochester[11].

Recently the Washington Business Group on Health issued a paper encouraging their corporate members to consider home health benefits in their health insurance plans, especially for post-hospital patients[12].

I must be perfectly clear. The achievement of program savings will not occur by merely expanding home care benefits and hoping --

-- hoping that hospital and nursing home costs will automatically be restrained;

-- hoping that utilization will be appropriate;

-- hoping, in short, that all will be well.

On the contrary, published studies reveal that program savings may be non-existent unless targeting and adminstrative controls are incorporated. In fact, overall costs have been shown to increase if expanded home care benefits draw patients into their programs who would otherwise remain in their homes. Indeed, program savings must be first priority, as we cannot affort to indiscriminately expand home care benefits, regardless of the merits of home care.

To achieve cost-savings, specific steps should be taken:

1. The target population must be defined as Medicare aged and disabled beneficiaries and Medicaid recipients who are in hospitals awaiting placement in skilled nursing facilities or intermediate

care facilities or in SNFs waiting ICF placement or, at home but clearly awaiting nursing home admission.

2. Home care providers must comply with initial and periodic assessment and centralized case management requirements.
3. Home care benefits must be re-structured so that any reasonable health-status related service is provided, so long as the provision of that service will keep the targetted beneficiaries out of institutions.
4. A reimbursement mechanism should be established for the payments to a provider for serving these targetted patients, to set levels of payment that would assure savings when compared to institutional costs that otherwise would have been incurred.
5. Family and other voluntary care-giver support must be encouraged to continue, even increase. Paid services should not substitute for contributed services; this is why respite and adult day care are essential covered services--they help to assure that continued family supportive services are feasible.
6. Administrative trappings must be kept to an absolute minimum. Paper work inspired by good intentions is the worst enemy of program savings.

Legislative initiatives with these features will take partial, useful, economic steps toward the goal of saving money by replacing higher institutional costs with lower home care costs.

C. Closing

Again, Mr. Chairman, I want to commend you for conducting these hearings and to thank you for this opportunity to present our Association's views. I want also to say that Mr. Irwin Wolkstein, a principal in Health Policy Alternatives, Inc. and the principal author of the review I mentioned in my statement, would be available to talk to you and the Committee staff about it.

I will be happy to respond to any questions that you might have.

FOOT NOTES

[1] Pollack, William. Expanding Health Benefits for the Elderly: Long-Term Care. Urban Institute, Health Policy and Elderly Series, Vol. I.

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[4] Zawadski, R. T., and Ansak, M. L. On Lok's CCODA, The First Two Years. San Francisco, Calif.: On Lok Senior Health Services, 1981.

[5] Haglund, Richard F. Final Evaluation Report of the Program for the Elderly. Salt Lake City, Utah: Management Resource Associates, 1979.

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[7] Hammond, John. "Home Health Care Cost Effectiveness: An Overview of the Literature": Public Health Report 94(4) (July-August 1979):305-311.

[8] Berry, N. J. "Measuring and Projecting Demand for Home Health Care." Home Health Review 3(2) (June 1980): 24-27.

[9] Virginia Blue Cross. "Blue Cross of Virginia Reports $42,000 Saving by Home Health Plan." Employee Benefit Review (August 1980).

[10] Tolkoff, Rubin N.F.; Fisher, S.L.; O'Brien J.T.; and Rubin, R.H. "Coordinated Home Care: The Massachusetts General Hosptial Experience.: Medical Care 16(6) (June 1978): 453-464.

[11] Hammond, loc. cit.

[12] Schwartz, Gail. "Home Care: A Review of Current Policy and Future Possiblities." Washington Business Group on Health, Fall, 1981. (Unpublished)

Senator DURENBERGER. I have a couple of questions that we will submit for the record from Senator Bradley. And I believe they are each directed to Ms. Livengood.

Senator DURENBERGER. Perhaps I could ask you because of your experience, Ms. Livengood, and any of the others of you who would like to respond to tell us at what point home health care becomes more expensive than other forms of care.

Ms. LIVENGOOD. Twenty-four hour would obviously be more expensive. I think when you start talking about anywhere up to 8 hours you are probably talking about a less expensive mode. You have to remember what you are comparing, however, because not all patients receive the same amount of care. A patient may have potentially the same amount of expenses on home care, yet end up in a nursing home. So you have to really target the kind of population you are talking about to come out with true cost benefits, true cost savings.

But I would say roughly that anything 8 hours or less would be less expensive.

Senator DURENBERGER. Margaret, before you answer, I will just add a dimension to the question. Ms. Livengood talks about targeting. I'm very apprehensive about our being able to do a very good job of targeting. The way we do it is to say that the following folks are eligible for home health of this kind, and the following folks are eligible for another kind, and the following folks, et cetera. And you can probably tell by some of the questions that I have asked today that I prefer that someone else makes those choices, some combination of the individual and someone with some skill, professional skill.

With that extra notion in mind, Ms. Cushman, why don't you respond to my question, and maybe you can add a dimension to it in terms of home health.

Ms. CUSHMAN. Certainly. I would like to respond and carry the answer a little bit further. We are talking about a continuum of care when we are talking about long-term care, which frequently starts from an acute care setting. And focusing on the intermittent problem that I mentioned a moment ago, we are seeing more and more patients being discharged to home care for their intensity of illness need; not just for their long-term care need.

So that between the continuum of acute care and skilled nursing facility care, indeed it may be. And I would support that comment that much past 8 hours, depending upon the services delivered, home care may not be cost effective as an alternative to selected forms of long-term care. But may often still be more cost effective as an alternative to hospitalization. And it is attempting to fill both of those needs for the patient who ends up in long-term care from acute care.

Senator DURENBERGER. Do you have a problem or could you describe for us the problem you have with the structure of the community nursing centers as incorporated into S. 410?

Ms. CUSHMAN. I did indicate in the testimony that we will submit in detail further comments and staff of the Association would be available to discuss that with the committee. The issues are mostly of the technical nature.

Senator DURENBERGER. Have the three of you individually given some thought to prospective payment for a long-term care for the continuum of service, whether based on the present DRG system or some other? And could you either encourage or discourage my tendencies in that direction?

Ms. LIVENGOOD. We have thought a lot about it, living in a DRG prospective reimbursement State. And we have discussed it a lot with the health economists in the State health department.

Early on, we became quite convinced, along with Dr. Bruce Vladeck who was running the program in New Jersey at that time and was helping to design it, that medical diagnosis wasn't necessarily the way to go for a prospective reimbursement for home care. And when I stopped giving my testimony, I was praising S. 1244 because it took functional status as a measurement of eligibility. And, therefore, prospective reimbursement could be tied in to a set of standards that would have a price tag to them that were related to functional status rather than to medical diagnosis. Most of the medical diagnosis information relates to intervention in acute care, and does not relate to the kind of nursing diagnosis and nursing care at home.

Senator DURENBERGER. But suppose we pulled the acute care side out and consider, as I suggested in my question, an expansion of the DRG system to encompass a variety of providers, including home health for acute care, and SNF and a variety of other things? And then look at some other form of a capitation payment for using your functional approach. Would you encourage us to move in that direction? We won't try to use the medical model to cover all forms of long-term care, but at least we can cover some of the providers that are in those long-term care systems with a prospective payment system. Think of that same kind of an approach as used in a capitation system for the other needs that bring people into the long-term care system. Would you encourage that approach?

Ms. LIVENGOOD. I would encourage it. We did some analysis and developed some cost for the medicaid 2176 waiver in New Jersey where we described a caseload of 100 patients over the age of 65; it listed how many would be age 65, 75, 84 and, how many would be 85 and over. We described the intensity of services that they would receive based on functional status, what numbers would go to nursing homes what numbers would need intensive nursing care and how many others would need minimal help. And through that targeting of sample population of 100, we did come up with some costs that could be used for a capitation or prospective rate for home health. I will be glad to share that information.

Senator DURENBERGER. That would be helpful to us.

[The information from Ms. Livengood and Cushman follows:]

HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.
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Center for Health Affairs
(609) 452-9280

Senate Finance Health Subcommittee Hearings
on Long Term Care - November 14, 1983
Question from Senator Durenberger

Do you think states can effectively manage a capitation payment program for acute and long-term services?

The State Health Department in New Jersey has had the responsibility of developing and implementing the DRG Reimbursement System for hospitals. Although it is not a capitation payment program, it could serve as an example of state management of a reimbursement system.

As a close observe of the four years of this effort, I would like to make the following comments:

1. The state set up a division of Health Economics which was composed of staff with a wide range of expertise and abilities. This group had to negotiate the development with HCFA, the fiscal intermediaries, the hospitals, <u>all</u> third party payors (both public and private) and the legislature.
2. As the plan was implemented incrementally, each phase and each year brought new problems to be resolved. Many of these ended in litigation and resolution by the courts as no one group had the power to make an unchallenged decision. If this scenario were repeated in each state, there would be, of course, 50 different programs.
3. If the states were to implement a federal program, local political and judicial power would be reduced and a standard capitation system would be more possible.
4. These comments would suggest a program managed by a combination of federal and state authorities might work best. The administration of the Medicaid program could serve as a model, both for its strengths and weaknesses.
5. I would conclude, therefore, that a federal capitation system could not be administered equitably by a state alone.

Winifred S. Livengood
Winifred S. Livengood
Executive Director

12/14/83

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January 16, 1984

Senator David Durenberger
Room 372
Russell Senate Offi~~ce Building~~
Washington, D.C. 20510

Dear Senator Durenberger:

I want to thank you for the opportunity to testify at your November 14, 1983 hearing.

The following are my responses to the three follow-up questions contained in your December 7, 1983 letter:

Question 1:

Your testimony quite correctly points out that we face some major problems with the Medicare trust fund and also that home health care outlays under Medicare have increased significantly over the past three years. What approaches do you recommend we consider to try to control increasing home health care outlays which at the same time will assure our elderly the benefits they deserve? Is prospective payment for home health care the answer?

Answer 1:

Home care outlays have risen under Medicare, but they still comprise a very small part of the overall Medicare budget -- approximately 2.4 per cent ($1.2 billion) of the overall fiscal year 1982 Medicare budget of nearly $50 billion. Three reasons account for most of this growth. One is the growth in the availability of home care. Between the end of 1980 and end of 1983 the bumber of Medicare-certified home health agencies grew from 2,967 to 4,202. This was caused, in large part, by a change in the Omnibus Budget Reconciliation Act of 1980 which made it easier for free-standing proprietary agencies to receive Medicare certification and the

REPRESENTING THE NATION'S HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS AND HOSPICES

move by hospitals, and to a lesser extent nursing homes, to vertically integrate home care and other non-inpatient health care services into their organizational scheme.

Second is the growth of our elderly population and the increasing percentage of the over 65 population that is over 85. A recent U.S. Bureau of the Census report shows that from 1960-1982 the elderly (over 65 years old) population grew twice as fast as the rest of the population and the over 85 years of age group grew at an even greater rate. The report also finds elderly population has more health problems, and more chronic health problems, than the rest of the population.

Third is the growth of technology which now enables more procedures to be performed at home that previously were exclusively done in an institutional setting. This is particularly true of dialysis treatment, respiratory care, insulin therapy, chemotherapy, and parenteral and enteral nutrition.

All of these trends are expected to continue. And it is in response to these trends that home care costs, in terms of aggregate Medicare outlays, have increased. Unlike the growth in institutional health care outlays home health outlays have not increased due to overutilization. In fact, HCFA has advised the National Association for Home Care (NAHC) that its most recent post-payment reviews show only a 2.5 percent rate of overutilization.

The current home health benefit is a very limited benefit so it would not be sensible to control costs by further limiting the already limited benefit. The law requires that the beneficiary must be homebound and must receive advance and ongoing certification by the beneficiary's own physician of the medical necessity and reasonable home care (i.e., the need for intermittent skilled nursing care, physical or speech therapy) pursuant to the physician's plan of care. If the beneficiary qualifies, he is entitled only to coverage of limited services: intermittent skilled nursing care; physical, speech or occupational therapy; medical social services (under a physician's direction); intermittent home health aide services; and certain medical supplies and appliances.

It is because of this limited benefit that approximately only 3.4 percent of all Medicare enrollees receive Medicare home health benefits and the average Medicare home health beneficiary receives only 26 home health visits a year.

In short, Senator, I suggest that the Medicare home health benefit is a small, controlled part of the overall Medicare budget. Efforts to deal with the Medicare trust fund problem should not be directed at limiting home care, but at dealing with the acknowledged reason for rising Medicare costs -- institutional costs. The new DRG system aims at rectifying this problem, but it will be some time before we know the results of this experiment.

One thing is clear -- people are getting older and sicker. This trend will, de facto, create a growth of Medicare expenditures unless there is a cut in benefit levels and/or an increase in the revenue base. This view has been repeated by the Congressional Budget Office, the most recent report of the Social Security Trust Fund, and the President's Advisory Council on Social Security. We would suggest that if Medicare expenditures are to be made it is more fiscally prudent that, medical conditions permitting, they be made in the home care and non-institutional care sector rather than the generally more costly institutional sector.

As to whether prospective payment (or any other alternative reimbursement system) is "the answer" for home care depends on the question. I have noted above that home care costs, while they have increased in the aggregate, are not out of control. I do not believe a new payment system will deal with the causes of rising aggregate home care expenditures (i.e., increased numbers of elderly, increased availability of home care, and increased technologies for use at home). A new payment system might yield a more consistent and predictable basis for rendering care and, if properly designed, that would help home care beneficiaries, providers, and the government.

But let me caution that any precipitous move to impose a prospective-type payment system on home care would be unwise. In fact, the NAHC Government Affairs Committee adopted the following position on this issue last February:

1. Demonstration projects involving several different kinds and sizes of home health agencies in different parts of the country should be conducted and evaluated before any prospective reimbursement system is put into place for home health agencies.

2. Any prospective reimbursement system which is selected should be scientifically valid.

3. Any proposed prospective reimbursement model should be independently evaluated by experts in the academic or professional community.

Our rationale is that at the present time insufficient data exists to determine the predictors of the cost of home health care. We also feel that until the impact of the Medicare hospital DRG system can be properly assessed, we cannot reasonably project the impact on the need for and cost of home care or any other type of health care. Since the DRG system is being phased in over four years, it will be at least several years before we have any statistically valid and reliable preliminary data. We also have the Medicare hospice benefit experiment in progress, the results of which will not be known until 1986. These variables must be determined before any alternative reimbursement system can be fairly considered for home care, nursing home care, or any other form of health care.

HCFA itself has recognized the inadequacy of data. In January 1984 HHS planned to send to Congress a report entitled "Alternative Reimbursement Methodologies for Home Health Under Federal Programs." The report was prepared pursuant to the Hatch amendments to the Orphan Drug Act (P.L. 97-414) mandate to "compile and analyze the results of significant studies carried out by any public or private entity, group, or individual, relating to current and alternative reimbursement methodologies for home health services" and any "recommendations with respect to such reimbursement methodologies" as HHS might have.

The final draft of the report concluded that the current state of the art on home health is about where HHS was ten years ago with hospitals - namely, the first stage of developing a meaningful data base to evaluate the possible use of alternative reimbursement methodologies.

In addition, also pursuant to P.L. 97-414, HHS awarded a grant in December 1983 to Abt Associates for a five year demonstration project to test alternative reimbursement methodologies for home health agencies which may include, but need not be limited to, fee schedules, prospective reimbursement and capitation payments. While P.L. 97-414 requires HHS report to Congress by January 1, 1985, the full term of the demonstration project is five years. The schedule calls for sixteen months to develop the projects, three years of operation and eight months of wind down. This means, under the best of circumstances, the projects won't be operational until May 1985. An evaluation grant for review of the Abt work will be solicited sometime in 1985 or 1986.

At the November 14, 1983 hearing you were supportive of HCFA's position that proposed legislation to expand home care should not be passed until the necessary statistically valid and reliable results of pending research is completed. HCFA estimated usable research results on the chanelling research and 2176 waiver programs would not be available for at least two years. Surely the same logic could and should be applied to the consideration of a possible generic revision of the methodology for reimbursing home care.

Question 2:

Do you see Medicare home health care outlays increasing at an even higher rate as a result of DRG's?

Answer 2:

We do not know. Again, we must watch and track the situation and see the results of the various reports on the DRG system's impact which Congress mandated of HHS.

We expect that DRGs will increase the number of persons being discharged earlier than present and the number in need of post-hospital skilled care. We expect this will increase the potential number of persons needing and seeking home care, including Medicare-covered home care. However, as I've noted, the current Medicare home health benefit is a very limited one and its utilization is also affected by claims processing decisions of fiscal intermediaries.

Question 3:

Could you briefly describe some of the problems you have with the structure of community nursing centers under S. 410?

Answer 3:

While we support the basic S. 410 concept of a prospective payment system for nursing services (including health prevention, promotion and maintenance services), we feel the bill cannot effectively achieve this goal.

Among our specific concerns are:

(1) It is unclear how this system will mesh with Medicare, Medicaid and Title XX programs.

(2) Since reimbursement has not been available for health prevention, promotion, and maintenance, this proposal may increase costs.

(3) The composition of the independent review panel is too general and may be too restrictive to get necessary participation.

(4) Review of nursing care plans by an independent review committee can be cumbersome and service could be delayed if there is a large number of patients. The way the proposal is worded it appears that the review committee is the Fiscal Intermediary even though this fact is denied. We are concerned that decisions on care would not be made by the care giver but the review committee and would compound problems as has been shown by PSROs.

(5) The payment mechanism is very confusing and could lead to a major disruption in the community health care system. Why can't the current system be reformed rather than imposing another health care entity? The proposal is amending the Medicare Act and says nothing of removing the "reasonable and necessary" exclusion which would disallow preventive type medical and nursing procedures.

I hope these responses are helpful to your efforts. Please feel free to contact me or the National Association for Home Care if we may be of further assistance.

Sincerely,

Margaret J. Cushman, Chairman
NAHC Government Affairs Committee

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COST PROJECTIONS
FOR THE
COMMUNITY CARE (2176) MEDICAID WAIVER (1983)

The estimate of service costs per person on long term home care is based on a projection of nursing and home health aide service use across a hypothetical population of 100 persons. In this model, patients are defined by the services we estimate they would use, rather than being assigned by other discriminating variables. This estimate has been made by community health nurses based on their experience in home health agencies. Research to substantiate the characteristics of chronically ill patients and the variables that would predict service use is not in the literature. The Home Health Agency Assembly has begun planning to perform this research and would welcome discussions with the Senate Finance Committee regarding this project.

The following tables describe the projected service use and attached costs. Based on our experienced estimates, patients fall into the following service categories:

- Respite
- Daily
- Forty hours per week
- Half-day service two or three days per week
- Daily half-day service
- Once a week half-day service

The number of service hours for each of the six categories is calculated and then divided by an eight hour shift to reveal the number of home health aide shifts necessary. No attempt is made to discriminate between homemaker and home health aide time because of our impression that all individuals will require some physical assistance with acitivites of daily living and will therefore require a home health aide. In addition, the hourly cost for homemaker and home health aide are very close.

The final computation of per-person cost is then derived as follows:

Multidimensional health assessment: Prior to the initiation of service, the individual will receive a thorough home visit assessment by the community health nurse.

Home health aide: The number of total shifts per person per month is multiplied by the average going rate in the state to reveal a cost of $65.31 per shift.

Nursing supervision: It is estimated that the chronically ill individual will require an average of nine nursing supervision visits per year, a visit every six weeks. Some people will not need as many visits and some may require them on a monthly basis.

Social worker: We anticipate two visits per year per patient. For some individuals this will include a social work assessment visit.

Medical supplies: Supplies include bed pads, syringes, Foley catheters, Fleets enemas, etc.

Twenty percent co-payment by patient and family: The Community Care Waiver requires a cost-sharing factor by the patient. Our estimation is based on a 20% cost-sharing by patients toward their nurisng home costs as reported in the GAO Report "Costly Implications of Entering a Nursing Home (1977)."

PROPOSED WAIVER PROGRAM COSTS PER INDIVIDUAL RECIPIENT

SERVICE	VISITS/MONTH	CHARGE/VISIT	AVERAGE MONTHLY PER PERSON CHARGE
Home Health Aide	14.17 (shifts)	$65.31	$925.00
Nursing Supervision	.75 (9/year)	$35.00	26.00
Social Worker	.17 (2/year)	$58.00	10.00
*Eligibility Assessment	--	$35.00	3.00
Medical Supplies	--	--	8.00
			$972.00
Less 20% Co-Payment of $194.00			-194.00
			$778.00

Annual budget for home care case load of 100 --	$933,600	(778 x 100 x 12)
Annual budget for nursing home case load of 100 --	$1407,600	(1173 x 100 x 12)
Net savings	$474,000	

*Eligibility assessment costs assumes an average six months length of stay in the community care program.

PROJECTED SERVICE USAGE

ESTIMATES BASED ON 100 CASES

No. of Cases	Type of Service	Shifts Per Day	Shifts	Per Week	Shifts Per Month
2	Respite	3	21	42	182
2	Daily Sun-Sun.	1	7	14	61
25	Daily Mon-Fri.	1	5	125	542
40	Half day service 20 Patients B.I.W. 8 hrs. 20 Patients T.I.W. 12 hrs.	½	-	100	433
15	Half day service Five days per week	½	-	38	165
16	Half day Once Weekly	½	-	8	35
					1418 Total Shifts Per Month

Formula for computation of shifts per week -- shifts per day X number of days X numbers of cases

1418 shifts per month ÷ 5 days per week ÷ 4 weeks per month = 71 aides

Senator **Durenberger**. Would any of the others of you care to make any additional comments?

Mr. **Smith**. Well, I don't think we are yet at the point of having the data base for a home health prospective pricing system that existed for hospitals. But, I think a lot can be done to reach that point swiftly if interested parties so desire.

One of the risks—I guess you can view this as a comment from the proprietary sector—of using a capitation payment is that providers may be inclined to provide less than the necessary amount of services. That's something to be aware of and to try and deal with.

One of the risks, on the other hand, of a payment system that is based on time or duration of services is, of course, overutilization where people try to provide too many services.

It seems that with case management and assessment you can help control that overutilization because these imply almost a form of utilization review.

Ms. **Cushman**. The National Association for Home Care has gone on record as supporting the prospective reimbursement system for home health care. However, on Ms. Livengood's comments, based upon a valid, reliable data base, which as Mr. Smith said we do not believe is really available, any prospective reimbursement system which is based specifically on DRG's as previously commented is not sufficient to provide the kinds of data needed for home health care reimbursement.

Senator **Durenberger**. Well, thank you all very much. I have some other questions myself, and maybe other members of the committee who are authors or cosponsors of this legislation might have some, and we will submit those to you in writing.

[The questions and answers follow:]

HOMECARE™

NATIONAL ASSOCIATION FOR HOME CARE
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January 16, 1984

Senator David Durenberger
Room 372
Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

I want to thank you for the opportunity to testify at your November 14, 1983 hearing.

The following are my responses to the three follow-up questions contained in your December 7, 1983 letter:

Question 1:

Your testimony quite correctly points out that we face some major problems with the Medicare trust fund and also that home health care outlays under Medicare have increased significantly over the past three years. What approaches do you recommend we consider to try to control increasing home health care outlays which at the same time will assure our elderly the benefits they deserve? Is prospective payment for home health care the answer?

Answer 1:

Home care outlays have risen under Medicare, but they still comprise a very small part of the overall Medicare budget -- approximately 2.4 per cent ($1.2 billion) of the overall fiscal year 1982 Medicare budget of nearly $50 billion. Three reasons account for most of this growth. One is the growth in the availability of home care. Between the end of 1980 and end of 1983 the bumber of Medicare-certified home health agencies grew from 2,967 to 4,202. This was caused, in large part, by a change in the ~~Omnibus Budget Reconciliation Act of 1980 which made it easier for free~~ standing proprietary agencies to receive Medicare certification and the move by hospitals, and to a lesser extent nursing homes, to vertically integrate home care and other non-inpatient health care services into their organizational scheme.

Second is the growth of our elderly population and the increasing percentage of the over 65 population that is over 85. A recent U.S. Bureau of the Census report shows that from 1960-1982 the elderly (over 65 years old) population grew twice as fast as the rest of the population and the over 85 years of age group grew at an even greater rate. The report also finds elderly population has more health problems, and more chronic health problems, than the rest of the population.

Third is the growth of technology which now enables more procedures to be performed at home that previously were exclusively done in an institutional setting. This is particularly true of dialysis treatment, respiratory care, insulin therapy, chemotherapy, and parenteral and enteral nutrition.

All of these trends are expected to continue. And it is in response to these trends that home care costs, in terms of aggregate Medicare outlays, have increased. Unlike the growth in institutional health care outlays home health outlays have not increased due to overutilization. In fact, HCFA has advised the National Association for Home Care (NAHC) that its most recent post-payment reviews show only a 2.5 percent rate of overutilization.

The current home health benefit is a very limited benefit so it would not be sensible to control costs by further limiting the already limited benefit. The law requires that the beneficiary must be homebound and must receive advance and ongoing certification by the beneficiary's own physician of the medical necessity and reasonable home care (i.e., the need for intermittent skilled nursing care, physical or speech therapy) pursuant to the physician's plan of care. If the beneficiary qualifies, he is entitled only to coverage of limited services: intermittent skilled nursing care; physical, speech or occupational therapy; medical social services (under a physician's direction); intermittent home health aide services; and certain medical supplies and appliances.

It is because of this limited benefit that approximately only 3.4 percent of all Medicare enrollees receive Medicare home health benefits and the average Medicare home health beneficiary receives only 26 home health visits a year.

In short, Senator, I suggest that the Medicare home health benefit is a small, controlled part of the overall Medicare budget. Efforts to deal with the Medicare trust fund problem ~~should not~~ be directed at limiting home care, but at dealing with the acknowledged reason for rising Medicare costs -- institutional costs. The new DRG system aims at rectifying this problem, ~~but it will be some ti~~me before we know the results of this experiment.

One thing is clear -- people are getting older and sicker. This trend will, de facto, create a growth of Medicare expenditures unless there is a cut in benefit levels and/or an increase in the revenue base. This view has been repeated by the Congressional Budget Office, the most recent report of the Social Security Trust Fund, and the President's Advisory Council on Social Security. We would suggest that if Medicare expenditures are to be made it is more fiscally prudent that, medical conditions permitting, they be made in the home care and non-institutional care sector rather than the generally more costly institutional sector.

As to whether prospective payment (or any other alternative reimbursement system) is "the answer" for home care depends on the question. I have noted above that home care costs, while they have increased in the aggregate, are not out of control. I do not believe a new payment system will deal with the causes of rising aggregate home care expenditures (i.e., increased numbers of elderly, increased availability of home care, and increased technologies for use at home). A new payment system might yield a more consistent and predictable basis for rendering care and, if properly designed, that would help home care beneficiaries, providers, and the government.

But let me caution that any precipitous move to impose a prospective-type payment system on home care would be unwise. In fact, the NAHC Government Affairs Committee adopted the following position on this issue last February:

1. Demonstration projects involving several different kinds and sizes of home health agencies in different parts of the country should be conducted and evaluated before any prospective reimbursement system is put into place for home health agencies.

2. Any prospective reimbursement system which is selected should be scientifically valid.

3. Any proposed prospective reimbursement model should be independently evaluated by experts in the academic or professional community.

Our rationale is that at the present time insufficient data exists to determine the predictors of the cost of home health care. We also feel that until the impact of the Medicare hospital DRG system can be properly assessed, we cannot reasonably project the impact on the need for and cost of home care or any other type of health care. Since the DRG system is being phased in over four years, it will be at least several years before we have any statistically valid and reliable preliminary data. We also have the Medicare hospice benefit experiment in progress, the results of which will not be known until 1986. These variables must be determined before any alternative reimbursement system can be fairly considered for home care, nursing home care, or any other form of health care.

HCFA itself has recognized the inadequacy of data. In January 1984 HHS planned to send to Congress a report entitled "Alternative Reimbursement Methodologies for Home Health Under Federal Programs." The report was prepared pursuant to the Hatch amendments to the Orphan Drug Act (P.L. 97-414) mandate to "compile and analyze the results of significant studies carried out by any public or private entity, group, or individual, relating to current and alternative reimbursement methodologies for home health services" and any "recommendations with respect to such reimbursement methodologies" as HHS might have.

The final draft of the report concluded that the current state of the art on home health is about where HHS was ten years ago with hospitals - namely, the first stage of developing a meaningful data base to evaluate the possible use of alternative reimbursement methodologies.

In addition, also pursuant to P.L. 97-414, HHS awarded a grant in December 1983 to Abt Associates for a five year demonstration project to test alternative reimbursement methodologies for home health agencies which may include, but need not be limited to, fee schedules, prospective reimbursement and capitation payments. While P.L. 97-414 requires HHS report to Congress by January 1, 1985, the full term of the demonstration project is five years. The schedule calls for sixteen months to develop the projects, three years of operation and eight months of wind down. This means, under the best of circumstances, the projects won't be operational until May 1985. An evaluation grant for review of the Abt work will be solicited sometime in 1985 or 1986.

At the November 14, 1983 hearing you were supportive of HCFA's position that proposed legislation to expand home care should not be passed until the necessary statistically valid and reliable results of pending research is completed. HCFA estimated usable research results on the chanelling research and 2176 waiver programs would not be available for at least two years. Surely the same logic could and should be applied to the consideration of a possible generic revision of the methodology for reimbursing home care.

Question 2:

Do you see Medicare home health care outlays increasing at an even higher rate as a result of DRG's?

Answer 2:

We do not know. Again, we must watch and track the situation and see the results of the various reports on the DRG system's impact which Congress mandated of HHS.

We expect that DRGs will increase the number of persons being discharged earlier than present and the number in need of post-hospital skilled care. We expect this will increase the potential number of persons needing and seeking home care, including Medicare-covered home care. However, as I've noted, the current Medicare home health benefit is a very limited one and its utilization is also affected by claims processing decisions of fiscal intermediaries.

Question 3:

Could you briefly describe some of the problems you have with the structure of community nursing centers under S. 410?

Answer 3:

While we support the basic S. 410 concept of a prospective payment system for nursing services (including health prevention, promotion and maintenance services), we feel the bill cannot effectively achieve this goal.

Among our specific concerns are:

(1) It is unclear how this system will mesh with Medicare, Medicaid and Title XX programs.

(2) Since reimbursement has not been available for health prevention, promotion, and maintenance, this proposal may increase costs.

(3) The composition of the independent review panel is too general and may be too restrictive to get necessary participation.

(4) Review of nursing care plans by an independent review committee can be cumbersome and service could be delayed if there is a large number of patients. The way the proposal is worded it appears that the review committee is the Fiscal Intermediary even though this fact is denied. We are concerned that decisions on care would not be made by the care giver but the review committee and would compound problems as has been shown by PSROs.

(5) The payment mechanism is very confusing and could lead to a major disruption in the community health care system. Why can't the current system be reformed rather than imposing another health care entity? The proposal is amending the Medicare Act and says nothing of removing the "reasonable and necessary" exclusion which would disallow preventive type medical and nursing procedures.

I hope these responses are helpful to your efforts. Please feel free to contact me or the National Association for Home Care if we may be of further assistance.

Sincerely,

Margaret J. Cushman, Chairman
NAHC Government Affairs Committee

HOME HEALTH SERVICES
and STAFFING ASSOCIATION

Responses to Questions
Raised Subsequent to
Hearing on Long-Term Care

November 14, 1983
Health Subcommittee
Senate Finance Committee
Chairman, Dave Durenberger

Prepared by:
John B. Smith, Chairman of the Board
Home Health Services and Staffing Association

January 4, 1984

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Question 1: In your testimony, you state that savings from use of homecare services can be achieved through better targeting on those who would otherwise be institutionalized. The big question is how can this targeting be accomplished? How do we really know who would be institutionalized?

Response 1:

General agreement appears to exist that targeting can achieve cost-savings. In addressing this issue, a 1982 GAO report stated that it is the "belief (of HHS) that targeting services to people who can be served the most cost-effectively in the community is the most cirtical issue in the expansion of home health care services." This same report concluded that "cost may be constrained if...a specific population is targeted to receive services."

Four specific populations already exist that could be used as target groups. Three of these consist of individuals in institutional settings, while the fourth group is composed of certain persons still living in their homes.

In order to maximize cost-savings, it is important to focus on easily definable groups that have been objectively selected as requiring the medical-social services found in institutions. Once these target groups are defined, then assessment techniques can determine which individuals within these groups should, for medical and economic reasons, receive home care, rather than institutional care.

Three such groups can be identified:

1. individuals in hospitals awaiting discharge to their homes.
2. individuals in hospitals awaiting discharge to nursing homes.
3. individuals in nursing homes who can be cared for at home.

These groups are target groups because they are receiving institutional services. There is no question as to their actual need or to their willingness to use the institutional setting. The task then becomes that of assessment to determine which individual patients can be treated at home appropriately and cost-effectively.

For individuals in nursing homes, assessment may be as practicable as it is for hospital patients, but dealing with the results may not. The longer a patient is in a nursing home, the less likely that a supportive home environment remains to receive him/her. For this population, a post-admission assessment should be performed shortly after admission, to assure that home placement is not possible. We suspect that, as preadmission review becomes more widespread, the utility of post-admission review will recede.

The fourth target group is made up of individuals in the community that would otherwise be institutionalized. A fairly stringent definition of this target group is required if cost-savings are to be achieved. Expanding the target group to all of those individuals who might someday be institutionalized would not insure cost-savings. However, by looking only at those who have been certified for nursing home placement, cost-savings become achievable.

There is no one system that is accepted for defining this target population; however, several programs do exist that appear to have been successful in targeting on persons for whom institutional placement is certain, rather than possible.

One example is the San Francisco On Lok program that is funded through a Medicare waiver and HCFA Research and Demonstration Grant. Preliminary analyses of the cost data show that On Lok has been successful in the provision of cost-effective services--integrating all necessary medical and social care--by targeting only those individuals in the community who have actually been certified as eligible for institutional, skilled or intermediate care.

Another example is the ACCESS program in Monroe County, New York, which utilizes a comprehensive evaluation that considers medical, nursing and psychosocial needs to successfully divert Medicaid beneficiaries from the nursing home waiting lists to home settings. Similarly, the widespread use of pre-admission screening and assessment by state Medicaid programs and the concentration of efforts to those seeking admission to nursing homes attest to the benefits of targeting individuals that would otherwise utilize the institutional health care system.

For those patients who are part of the target populations within the hospital setting, offering home health services for post-hospital care has demonstrated cost-savings by Blue Cross plans in various programs throughout 10 states. Even the Medicare and Medicaid programs have reacted to increased numbers of patients backed-up in hospitals awaiting nursing home placement through assessments review and screen these individuals to determine those more suited for home care services.

With respect to hospital patients, HCFA will monitor admissions for purposes of the new DRG prospective payment system. It seems plausible to suggest that a screening mechanism could be built into this system to be used to determine which indivduals applying for hospital admission actually need hospital care and which ones could be managed at home.

Another aspect of a successful targeting program would involve more careful supervision by HCFA of peer review organizations (PRO's) and fiscal intermediaries to see that they press for the lower-cost alternative where a choice of treatment location is possible. Furthermore, PROs and intermediaries should be required to do "cost of care" calculations. HCFA should help to provide the expertise and funds to carry out these cost calculations.

In short, when defining target groups, don't go looking for patients. Simply refer to the institutional systems to which patients have already come. Assess those patients for home care using medical and economic factors. That is how to achieve cost-savings.

Question 2: You say that family and voluntary support must be encouraged. How can we expand the financing of home care services and at the same time not undercut the voluntary involvement of family and friends?

Response 2:

Avoiding the substitution of paid services for voluntary services is a significant challenge. Targeting, along the lines suggested above, is one way to achieve this.

Another way is to emphasize respite care and adult day care. These are services that aid the voluntary care-giver as much as or more than the patient. The coverage of both of these services should be encouraged in the benefit design of any successful, cost-effective home health care program. These services are especially beneficial if they permit the continuation of employment of the primary care-giver or provide the necessary reprieve to reduce stress and allow for continued care at home.

For example, if two weeks or 336 hours of respite care or adult day care were incorporated into the benefit design--with the ability to spread the hours out over time at the discretion of the care-giver--this could permit the care-giver enough flexibility to carry out their own obligations as well as plan for and integrate necessary relief periods. Full-time day care in congregate arrangements should be available if full-time employment of the volunteer care-giver is thereby assured.

An example of who might benefit from this is the all too frequent scenario that follows: An over 65 year-old woman is living with and caring for her 85 year-old mother.

The daughter functions as a full-time voluntary care-giver, but finds herself requiring assistance from time to time. She might determine that it is necessary to have respite care only once a week for a 4-hour period. Or perhaps, two half-days a week of adult day care would be adequate to enable her to remain in the essential role as the primary care-giver.

One way to control costs might be to have respite and adult day care be viewed as a partial alternative to other home care services. In other words, if a family qualifies for respite or day care services perhaps they should be disqualified from receiving the full extent of the other services included in the home health benefit.

Initially, and in order to receive the greatest cost-savings, we would suggest that the recipients of respite or adult day care be limited to individuals in the four target groups - as defined in the answer to the first question. However, over time, it may become feasible to broaden this group as cost-data is collected and analyzed and the other home health services remain targeted on these persons.

Senator **Durenberger**. Thank you very much for being here today.

The hearing is adjourned.

[Whereupon, at 2:24 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY THERAPY

As President of the American Association for Respiratory Therapy, I am pleased to have this opportunity to share the Association's views pertaining to home care with the Senate Finance Committee. We believe that the existing home care legislation does not have necessary built in cost savings, a fact which ultimately leads to unnecessarily high expenditures for the Federal government. The 27,000 respiratory therapy practitioners the Association represents across the country feel strongly about this issue, and it is consistently identified as THE priority by our membership at meetings and in surveys we have conducted.

The concept of home care is surely a sound one. Take care of the patient in the home and save money that would have been spent on institutionalizing that patient if the home care would not be offered. But somewhere in that formula, years ago, things got tangled up and the result has been an array of programs to take care of the elderly and the disabled in the home and, frankly Mr. Chairman, it has been our experience that the right hand does not know what the left hand is doing.

Our statement concentrates on three areas, and we will briefly summarize those points for the Committee. First, I want to cite the reason that respiratory care is not a reimburseable service under the current statutes. When the original Medicare/Medicaid legislation was enacted in 1965, respiratory therapy was totally in its infancy. Ours is a profession that has evolved around new technologies and new discoveries, the development of mechanical ventilators being the most profound. Regardless, although our services are covered in the hospital setting, they are not covered in the home setting.

The AART firmly believes that home care services must be cost effective. Unfortunately, policymakers did not consider that as a major consideration when developing the initial legislation, but today it seems to be the only litmus test under which decisions are made. To that end, Loma Linda University Medical Center - in Loma Linda, California conducted its own research related to respiratory therapy home care in the late 1970°s. They took a very specific targeted population -- patients who are over 65 who had a record of prior hospitalization for chronic obstructive pulmonary disease. According to the National Institutes of Health, once an individual is diagnosed accurately as having COPD , it is a safe assumption that the chronic illness will lead to acute exacerbations, resulting in hospitalization to the sum of approximately 18 days per year. The study took patients with that kind of history and placed them in a home care program. Over a period of five years we saw dramatic reductions in their hospital stays, with reductions leveling off in the fourth and fifth years to around 3.5 days per year. This translated into specific dollar savings well into the hundreds of thousands of dollars. As a side bar, the Medical Center, until this summer, had continued the home care program underwriting the expenses itself. It has decided it can no longer offer that service without third party reimbursement, and it is now our understanding the program had ended because of a lack of reimbursement.

The Federal government funded a study almost simultaneously with the Loma Linda study, and we have developed two charts to illustrate how dramatic the savings are. This study, funded by the Department of Health and Human Services, took place at the South Hills Health System Home Health Agency in Pittsburgh, Pennsylvania, and examined again, a very targeted group of patients -- those with a record of prior hospitalization for COPD. At a cost of approximately $597 per patient per year for home care, and incidentally the Loma Linda costs ran approximately $603 per patient per year, the South Hills program reduced the hospital days per year from approximately 13 days per year to just over four days per year. That comes to a reduction of nine hospital days per year for a group of patients suffering from an acute exacerbation of a chronic illness. The cost of eliminating those days from the nation's heatlh care bill was an astronomical $600 per patient per year. We would like to emphasize that the situation we have here is very much like an old television commercial. You can pay now, or you can pay later. This very targeted group of patients will be hospitalized, and you have the option of keeping that to a minimum, through respiratory home care, or keep the stay high by doing nothing. The first chart shows what we are talking about in pure patient days, and the second chart is the one which I hope you would pay particular attention to because it translates those days into dollars. Note that for this small study group the savings were more than half a million dollars. Estimates are that there may be as many as 15 million people suffering from chronic obstructive pulmnary disease, with two thirds of this population in advanced stages of COPD. They are eating away at the health care dollar. To study this problem any more is to rack up more days, more dollars, and that is terribly discouraging to health care professionals who want to save the Federal government money, especially in a time when we experience annual Federal deficits surpassing $200 billion.

This is one segment of respiratory home care where we can clearly document savings. There is another area, however, where the savings are even more dramatic. I am referring to the area of ventilator dependent individuals. This first came to the nation's attention when President Reagan mentioned Katie Beckett during a press conference as an example of hide bound regulations. At that time, Katie was three years old and had spent the better part of her life in an Iowa hospital because she needs a ventilator to breathe. The technology that I mentioned at the beginning of our statement is quite fascinating, Mr.

Chairman, and the technology exists for Katie to go home. The bottom line is that Katie, although hospitalized right now, is spending most of her life at home, dependent on a ventilator at night. We did not know if Katie was the exception rather than the rule. We did not know if it was a phenomenon related to just young children, or if it crossed the spectrum. We are now very close to having the answers to those and more questions. Our Association conducted a nationwide survey to determine the answers to these questions and although the raw data have yet to be fully distilled by the statisticians, I believe even the raw data will impress you. There are more Katie Becketts out there than we thought, and they are of all ages. They are in hospitals across the country waiting to go home, and the primary reason they are not at home is that their hospital bills are paid for, and their home care is not.

The economics involved are almost mind boggling. A conservative estimate for the cost of hospital care that involves ventilatory support runs, on the average, $1,000 per day. If a child is on a ventilator for one year, and that is certainly not an unreasonable length of time for many situations, the cost can be upwards of $400,000 annuallly, per patient. Let us assume that home care, and these numbers are the numbers our survey indicate, costs approximately $1,000 per month. That is a savings of clearly more than $350,000 per patient, per year. How many of these individuals are there?

A study we ran across in Pennsylvania indicated that there were at least 279 children in this situation, and a minimum of 57 could go home at the time the survey was conducted. That study, conducted by the Pennsylvania Department of Health, clearly acknowledges the potential savings in this area. Taking just those children, it translates to nearly $20 million in health care costs for keeping those Katie Becketts in the hospital. And we have identified at least 60 ventilator dependent individuals in New Jersey who are medically able to go home. In Minnesota, the Chairman's home state, we were able to identify at least 24, with another 23 in Connecticut. Kansas has 14.

The numbers are dramatic, but there are certainly problems involved in this type of care. First, some families are very reluctant to bring their children home on a ventilator. They are fearful they will do something wrong and accidentally harm their child. Yes, there is that risk, just as there is risk in hospital care. But our survey asked the specific question to identify those who are MEDICALLY able to go home. Yes, there are certain social considerations to be made. In fact, we had hoped to have Julie Beckett, Katie's mother, join us in making a formal statement to the committee. But Katie is back in the hospital and Julie is devoted full time to her child at this time. In the event that addtional hearings are scheduled and you feel it appropriate, I think you will find her perspective most rewarding.

The facts are, for once, clear and simple. Respiratory home care for specific, targeted groups, is tremendously cost effective. To rely on the waiver process to deal with these cases, and we have learned recently that the Katie Beckett Task Force is scheduled to go out of business on December 31st of this year, is simply foolish. Federally funded studies show that savings can be achieved. Now is the time.

The Association wants to emphasize another point. The AART has run into quite a bit of frustration about certain aspects of home care that are covered under the current statutes. As you know, durable medical equipment is a reimburseable home care item, and respiratory related equipment accounts for a full 60% of that DME benefit. The system is being ripped off, and we are a little frustrated in our efforts to remedy the problem. The largest component of that 60% figure is attributable to Federal payments for oxygen and related equipment. It is being abused because there is simply no professional component involved to monitor its appropriate use. The supplier has a strong financial vested interest in maximizing utilization. For example, using current oxygen costs, if only 500,000 oxygen patients were to receive continuous oxygen, the increased cost would be $290 million more than if only nocturnal oxygen were used in these patients. More than four years ago HCFA proposed regulations, which would, if implemented, go a long way to correcting this major problem. But those regulations have never seen the light of day. There is a very simple test, a blood gas analysis, that is an excellent indicator of the need for supplementary oxygen in the home. We believe that is reasonable for the Federal government, if it is paying the bill, to require a blood gas at least once every six months, simply to assure appropriateness. We cannot understand a program which encourages maximizing utilization. As a matter of fact, the fact that respiratory therapy personnel are not reimbursed under the current Medicare statutes seems to exacerbate the problem. In many cases, truck drivers set up equipment and instruct patients in the use of oxygen, a potentially fatal drug if misused. There is little wonder the problems exist. Just as with certain targeted groups of patients, the present system encourages the maximum cost and maximum utilization. Our approach would be to reverse that.

We do know that there are at least three home care bills facing the Committee, and the Association would like to comment on S. 1614, S. 1301, and S. 1244. S. 1614 basically deals with benefits already available under the Medicare and Medicaid programs, and for that reason our Association believes it falls short of including what could be major financial incentives to the States and providers. Likewise, S. 1244 does not include respiratory therapy as a mentioned service. S. 1301 seems to be a worthy bill, and we support it.

One last comment. For the past several years we have been trying to prove cost effectiveness of respiratory home care. We have done that. We have done it with our own money, and it has been done with Federal grants. There is a great deal of frustration within our profession, becase we clearly see the cost effectiveness that can save the Federal government millions and millions of dollars. There are times we want the same scrutiny that is applied to us and other new benefits also applied to existing benefits. Years ago, home care was, by definition, cheaper than institutionalization. Not necessarily so today. For some reason, because older, more established services are firmly entrenched, they are not subject to important cost effective scrutiny. We are passing the test, and we think we are passing it extremely well. Now is the time for the Committee to act if it wants to save money and help people.

Thank you.

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
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STATEMENT OF

AMERICAN FEDERATION OF HOME HEALTH AGENCIES

TO THE

SENATE FINANCE COMMITTEE SUBCOMMITTEE ON HEALTH

NOVEMBER 3, 1983

BY

JOHN G. BEARD

PRESIDENT, AMERICAN FEDERATION OF HOME HEALTH AGENCIES

My name is John Beard. I am the President of the American Federation of Home Health Agencies. I am also President of Alabama Home Health Care, Inc., a home health agency in Birmingham, Alabama. I am very pleased to have the opportunity to present testimony before the Senate Fianance Subcommittee on Health, as members of this subcommittee look towards solutions to the long term care problem now facing our Nation. Within this context, AFHHA wishes to emphasize the vital role home health has to play as we come to grips with the spiralling cost of health care. We believe that home health care offers a humane alternative to institutionalization, both in terms of cost-effectiveness and from the perspective of the well-being of elderly or disabled Americans who prefer to remain in their homes, with dignity and independence, as long as possible.

AFHHA is a national trade association representing nonprofit and proprietary small business home health agencies across the United States. It represents a greater percentage of the small business sector than any other national organization representing the home health industry.

DESCRIPTION OF CURRENT ENVIRONMENT FOR PROVIDING HOME CARE

I believe it is important for the members of the Health Subcommittee to obtain a perspective on the current environment under which home care is provided. This information will provide a frame of reference for considering the recommendations AFHHA will present today for your consideration.

1. The Medicare provisions including the home health care portion of Medicare enacted in 1965 were designed to deal with a set of circumstances then facing the elderly that have changed dramatically. In 1965, America's elderly were faced with potential financial disaster caused by their inability to meet the growing costs of acute illnesses. Medicare was, and still is, designed to meet the costs of acute illness of relatively short duration. Thus, the Medicare model focused on institutional care--hospital and nursing home. Home health under Medicare, was envisioned as an extension of hospital and nursing home care. It was designed to reimburse for skilled care, of relatively short duration, on a part-time and intermittent basis, to patients who are homebound. The thinking of the Medicare planners was that home health care would enable patients to be discharged earlier, mostly from hospitals, and would be provided as an extension of hospital or skilled nursing home care care only until the patient recovered from the acute phase of his or her illness.

Overall, Medicare has succeeded remarkably well. By and large the elderly have a significant share of the costs of acute care paid for by Medicare although there are still some important areas that remain uncovered. But, since Medicare was enacted, the composition and the health needs of the elderly have changed extensively. Medicare has remained the same and this constitutes the essence of the problem.

Today, the over 65 population represents probably the fastest growing age cohort in the country. For example, between 1900 and 1980, the population of the US tripled, but the number 65 and over increased eight times. From 1970 to 1980, those 75 and over--those who are ill most often--increased by more than 37%. Demographers tell us that by the year 2030, 50 years from now, the over 65 age group will number 55 million, or 1/4 of our population.

And, while the number of elderly have increased and will be increasing dramatically, their health care problems have changed in a dramatic way. They are still susceptible to acute illness episodes. But, as a result of the exciting developments in medical technologies over the past two decades and the ability to obtain access to these technological advances at little or no out-of-pocket costs, mainly due to Medicare, most elderly live for many years after the onset of an acute illness. Today, of those 26 million who are over 65, almost 40% experience one or more chronic physical or mental handicaps. More people die now of chronic diseases; but, as I have indicated Medicare is principally oriented to the reimbursement of acute illnesses. It does not pay for custodial care, which is the type of care most chronically ill patients require. And, it is not geared toward maintaining people at home, which is where practically all chronically ill people wish to be.

2. At the same time that our aged population is undergoing this increase in numbers and change in age composition, and experiencing an increase in incidence of chronic impairments, the support system in our society has changed drastically. This latter results from a major change in the nature of the American family. Today's elderly grew up in the depression and, of necessity, had fewer children. This has resulted in fewer offspring to care for them at the very time that they are living longer and experiencing severe chronic impediments that require supportive services, but which need not be at the level of intensity normally provided in an institutional setting. Additionally, economic changes over the past 10 to 15 years have resulted in more and more wives working, further reducing the ability of families to care for their elderly members. The extensive inflation experienced over the past decade has also resulted in families occupying smaller homes and apartments making it more difficult to take in elderly family members. The result of all of this has been that a large proportion of the elderly with chronic conditions could be maintained out of institutions if adequate support systems were available, but economic and social factors ironically reduce the availability of such systems.

3. The Congressional Budget Office projects that the Medicare trust fund will be depleted by 1989, with a potential $300 billion deficit looming by 1995. The annual report of the trustees of the Medicare Trust Fund indicates depletion by 1996. According to the CBO, the principal reason for the extremely shaky financial position of the Trust Fund is the continuous increase in hospital costs. The dilemma faced by the government in dealing with this situation can best be underscored by the fact that hospital benefits comprise the bulk of Medicare outlays. For 1983, the Health Care Financing Administration estimates Medicare payments to hospitals will

be $37.4 billion out of a total Medicare outlay of $56.8 billion, or 66% of total Medicare outlays. Medicare expenditures for hospital services have increased anually 19.2% from 1979-1982. While this points up the need to control hospital expenditures it also points up the institutional bias of Medicare. By way of contrast, expenditures of home health agencies in 1983 are estimated to be $1.3 billion or 2% of total outlays. Since home health care can be provided at lower cost than expensive hospitalization, clearly it is the government's advantage to encourage the use of home health services.

4. HCFA, perhaps reflecting the institutional bias that permeates the Medicare program, rather than encouraging the use of home health services under the present limited benefit has taken various actions to restrict even further this valuable service. For instance, we have found that a number of physicians still are not familiar with the potential of home health care. One way to get physicians knowledgable about what home health services can do is to get them active in home health agency operations by serving on home health agency boards of directors. Yet, HCFA has issued a regulation that bars any physician who is an officer or director of a home health agency from certifying to the agency on whose board he serves as an officer or director any of his patients for home health services. This discourages physicians from serving as directors or officers of home health agencies. I alluded to the requirement that home health services can only be furnished on a part-time or intermittent basis. HCFA has established an extremely narrow definition for "intermittent" so that except for short periods of time (Two-to-three weeks) daily skilled nursing or home health aide visits are precluded. I will discuss the implications of this position a little later. And, HCFA takes an extremely narrow position when determining the coverage of services under Medicare's home health benefit. As a result, tens of thousands of visits to furnish needed skilled nursing, physical therapy and other home health services

are denied each year. The extremely conservative HCFA approach to covering home health services is well illustrated by the fact that most cases that are appealed to administrative law judges of the Social Security Administration, when patients or members of their families are able and willing to pursue the appeals process, are approved for reimbursement. Regrettably, many patients lack the ability to pursue the appeal process or have no one willing to do it on their behalf.

5. Finally, in discussing the environment for home care I must mention that while home health services constitute only a small portion of expenditures for Medicare and Medicaid, (it constitutes a little over 2% of Medicaid outlays in 1981), outlays for these services have increased along with outlays for all Medicare and Medicaid Services. As of the close of 1982, there were 3639 home health agencies approved to participate in Medicare. I cite this latter figure to point out that the agencies are in place and ready to care for additional patients if the Medicare and Medicaid home health benefit is liberalized. I must also caution members of this Committee that we are not saying that home health services can solve all of the problems our society faces in assuring adequate care for the elderly. What we are saying is that given the aging of our population, the significant increase in numbers of people with chronic conditions, the diminished support network existing now and likely to be present in the future, home health services is the treatment of choice for maintaining large numbers of the chronically impaired out of higher cost institutions and in their homes.

WHAT HOME HEALTH CAN ACCOMPLISH

It is appropriate at this point to summarize for the Health Subcommittee what home health care can accomplish for patients. One specialist in providing home care has stated that a coordinated home care program can:

- furnish comprehensive medical, nursing, social work, therapy and related care to patients in their homes,
- furnish "better" care in the home for selected types of patients than would be possible in institutions,
- furnish comprehensive care at lower cost than the institutional setting by using the home for treatment,
- shorten the hospital stay, or prevent hospitalization or rehospitalization of selected patients
- improve utilization of existing facilities and reduce demand for more beds by releasing hospital beds for those who need them, and
- expedite recovery, prevent or postpone disability, and maintain personal dignity by restoring patients to normal family living and useful functional activity.

NEED TO ADJUST FOR CURRENT ENVIRONMENT

Given this environment, AFHHA urges interpretive changes in the current Medicare program as well as legislative changes to permit expanded home care services. Under the current Medicare statutory provisions, to qualify for home health benefits, a beneficiary must be confined to his home, be under the care of a physician, in need of skilled nursing services on an intermittent basis, or in need of physical of speech therapy. A beneficiary who requires one or more of these services in the treatment of his illness or injury and otherwise qualifies for home health benefits is eligible to have payment made on his behalf for the skilled nursing, physical and speech therapy he needs, as well as for any other home health services specified in the law. These services include part-time or intermittent services of a home health aide, medical social services, occupational therapy, and medical supplies. It is important to note that it the patient does not require skilled nursing, physical, or speech therapy, he cannot have payment made under Medicare. AFHHA maintains that to deal with the current and future health problems the elderly face, the following changes are needed in the Medicare home care provisions.

MODIFY DEFINITION OF INTERMITTENT - Congress, in enacting the original Medicare legislation did not define "intermittent", the term describing the frequency with which home health services could be paid for under Medicare. Medicare did define it initially as meaning services provided several times a week but less than daily. Under this definition, patients requiring daily skilled nursing visits or daily home health aide visits to assist with personal care were denied these visits. More recently, in recognition that home health agencies were receiving more seriously ill patients, Medicare modified its policy on intermittent services to permit daily skilled nursing care or home health aide services seven days a week for up to three weeks.

The effect of this Medicare policy is to require that patients who are sick enough to need daily skilled nursing care or home health aide services for periods longer than 2-3 weeks be institutionalized. We do not believe this makes sense from either the patient's or society's standpoint. As indicated by GAO recently "...individuals who receive expanded home health care services live longer than others who use the currently available health services. They also report feeling more satisfied with their lives."

We believe that a more accurate interpretation of what Congress had in mind in using the adjective "intermittent" was to convey that Medicare would reimburse for daily nursing and home health aide services for a period of time but not indefinitel. This interpretation is in accord with the dictionary definition of intermittent as connoting stopping and starting again at intervals. (See Webster's New World Dictionary of the American Language). It would be in keeping with the commonly understood definition of intermittent to permit daily skilled nursing and home health aide visits for up to a stipulated period of time when medically necessary as certified by the patient's physician on the patient's plan of treatment. AFHHA recommends that up to 60 daily visits for nursing and home health aide services be permitted for any one illness when approved by the patient's physician. This would permit significant numbers of patients to be maintained at home during acute illnesses instead of having to be placed in higher cost institutions.

REMOVE HOMEBOUND REQUIREMENT

To receive home health services under Medicare patients must be confined to their homes, i.e., "homebound." Homebound has been defined very restrictively. The effect of Medicare's definition of homebound is that patients who are ambulatory and who can leave their homes even with assistance are precluded from receiving home health services. These patients are forced to be institutionalized to receive Medicare coverage. Most patients with chronic impediments and many acutely ill patients are ambulatory and are able to leave their homes without the aid of supportive devices. Those patients still require skilled nursing, therapeutic and/or home health aide services. But, currently these services would not be covered by Medicare because the patients are ambulatory.

COVER DRUGS AND BIOLOGICAL

Medicare covers certain medical equipment for the home under the home health benefit. Drugs and biologicals are not covered. Patients who could be maintained at home are forced to be institutionalized to have their drugs and biologicals covered by Medicare. This seems to us to be "Pennywise and pound foolish."

EXPAND COVERAGE OF HOME HEALTH AIDE - HOMEMAKER SERVICES

As I have indicated, home health aide services are covered under Medicare only if skilled nursing, physical or speech therapy is needed. This reflects Medicare's emphasis on treating acute illnesses. Yet as I mentioned earlier, the major problem facing the elderly today and in the future is long-term chronic illness. Large numbers of the elderly could be maintained with dignity in their places of residence if they could obtain home health aide-homemaker services on a regular basis to assist them with personal needs such as dressing and bathing, or help in moving around outside the house.

There are large numbers of the elderly with chronic conditions such as arthritis or diabetes that can cause severe functional impairments. Possibly the most perplexing chronic illness now faced by the elderly is Alzheimer's disease, the fourth most frequent cause of death among the elderly, affecting 15% of persons over 65. Alzheimer's disease presents the patient with long term degeneration of memory function. Now, it most often leads to nursing home placements, since it requires ongoing supportive care which Medicare does not pay for. Many individuals with these and similar conditions usually do not require skilled nursing services but if they could have home health aide-homemaker care paid for they would be able to remain out of institutions. We urge that these services be provided under Medicare in those situations where if homemaker-home health aide services were available, it would avoid the need for institutionalization. Nursing supervision or evaluation of the aide services would be required as well as a patient assessment program to identify patients for whom aide services would preclude institutionalization.

This single change in Medicare would probably do more to prevent unnecessary institutionalization of the elderly than any other change that could be made in the program.

ADDITIONAL INCENTIVES FOR HOME CARE

Adoption of the above recommendations would significantly strengthen and stimulate home care. We would also propose that the Senate Finance Subcommittee on Health consider the following additional means of encouraging the use of home care as an alternative to institutionalization.

1. Institute assessment and referral mechanisms for all elective admissions to institutions to identify patients who could be treated more effectively through home care programs.
2. Provide tax credits for persons who take care of elderly family members at home.
3. Reduce institutional reimbursement for those diagnoses for which home care is an appropriate alternative following the acute phase of the illness. This incentive would be applied to

stimulate hospitals to move patients to home care as soon as appropriate.

Summary

APHHA has made several recommendations for expanding home care to meet the changing health care needs of our elderly population. These recommendations are aimed at dealing with the historical and social changes that have created new constraints on families. Demographic changes have reduced by a significant degree the support of family available to assist an elderly person. Economic changes have made it more difficult for children to support parents. Various forces affecting the family, e.g., social legislation giving individuals greater independence, greater mobility, more emphasis within the family on raising children, more mothers working, have changed in dramatic fashion the interdependence and cohesiveness formerly existing within families. Possibly, the one greatest socio-economic change has been the extraordinary increase in the number of working women. Approximately 60% of women between 18 and 64 work outside the home and this figure is still increasing. With more women working, there is a corresponding reduction in the ability to care for one's parents.

Finally health care needs of the elderly have changed dramatically since Medicare was enacted in 1965. Medicare was designed to deal with acute illnesses. Accordingly, the so-called Medicare model focused on short institutional stays and on acute illness.

Hence the emphasis on providing skilled nursing or therapeutic care, less than daily visits, except for brief periods of time, and services only to the homebound.

Since 1965 though, the health needs of the elderly have changed significantly. Today, partially as a result of Medicare's services and the great strides medicine has made, most elderly survive the acute phases of their illness and face relatively long periods of chronic illness marked by ongoing debilitating conditions. Home care is remarkably designed to meet the needs of a large elderly population who do not require the technologically oriented high cost care provided in the institutional setting. Unfortunately, because of the way Medicare is structured most elderly who are unable to meet the restrictive Medicare home health requirements,have little choice but to be institutionalized to have their medical expenses reimbursed. This constitutes an inefficient use of public funds and contributes to the startling increase being experienced in Medicare expenditures, leading to estimates by the CBO that the Medicare trust funds will be bankrupt by the end of the decade.

Clearly, the social economic and medical factors now present call for a new approach to the way we provide services to our elderly citizens. While we certainly do not profess that home care is the panacea for solving all of these problems, we do maintain that it isan extremely important tool that is in place now in the form of more than 3600 home health agencies across our nation. Home health can provide the services required by a burgeoning elderly population with a broad spectrum of chronic impairments. It can maintain people at home and out of expensive institutions for relatively long periods. And, it is a more humane and dignified treatment modality than the impersonal institutional setting. As a consequence it is the treatment of choice of our elderly population.

For all of these reasons we urge members of this Subcommittee to support the following recommendations:

1. Modify the present definition of intermittent skilled nursing and home health aide services to permit up to 60 daily visits for each of those services for each illness. This will permit larger numbers of patients with acute illness to be maintained at home instead of placed in institutions.
2. Remove the requirement that a patient be confined to his residence to receive home health services under Medicare. Countless patients with ongoing chronic impediments who could benefit from home health services but who are ambulatory are denied reimbursement under Medicare for services in the home.
3. Cover drugs and biologicals in the home setting for patients under a home health plan of treatment.
4. Cover home health aide and homemaker services without the prerequisite that patients require skilled nursing, physical or speech therapy where provision of home health aide and homemaker-services would prevent institutionalization. This would require

a statutory change in the Medicare law. It would enable chronically ill patients to stay in their residences and probably do more to prevent unnecessary institutionalization of the elderly than any single change that could be made in Medicare.

5. Finally, provide for added incentives for home care including adoption of patient assessment and referral mechanisms for all elective institutional admissions, tax credits for persons who care for elderly family members at home, and reduce Medicare institutional reimbursement for those diagnoses that can be handled through home care.

Thank you for the opportunity to present the AFHHA views to the Health Subcommittee of the Senate Finance Committee.

STATEMENT TO SUBCOMMITTEE ON HEALTH UNITED STATES SENATE COMMITTEE ON FINANCE

HEARING ON PENDING LONG-TERM CARE LEGISLATIVE PROPOSALS AND OTHER POSSIBLE APPROACHES TO PROVIDING ACCESS TO NEEDED LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED

Submitted by Leon Frazier, Commissioner, State of Alabama
Department of Pensions and Security

The Alabama Department of Pensions and Security administers a program of Optional Supplementation to aged, blind, and disabled persons. Direct cash payments are made monthly to persons who, due to physical and/or mental limitations, require personal care services to help them function as independently as possible outside an institution. In most cases, the client must add to the relatively small supplementation payment from other income to pay the service provider. Many times one cannot afford the need for care or cannot find even minimum quality care for the payment one is able to make. Subsequently, the unmet need causes the condition to worsen at an accelerated pace and/or the client is forced into an institution at greater cost.

In exploring alternatives to direct cash payments for providing services to aged, blind, and disabled persons to help them live as independently as possible, Alabama has been faced with two interrelated realities: first, the limitation on State funds available for Optional Supplementation, and, secondly, the restriction of "pass-through" requirements resulting from the definition of State supplementary payment as provided in Section 1616(a) of the Social Security Act. In other words, the State must spend "X" dollars in the Supplementation Program to maintain payment levels or total expenditures, and the only dollars which will count in this effort are those which are spent in the form of direct cash assistance.

To permit States the greatest flexibility in pursuing other possible approaches to providing access to needed long-term care services for the elderly and disabled, in view of budgetary constraints and anticipated substantial increases in the number of individuals requiring long-term care, the definition of State supplementary payments must be expanded to include, at least, vendor payments and State funding to draw Federal matching for similar services, such as those provided for in the proposed "Senior Citizens Independent Community Care Act," H. R. 3710.

In summary, we respectfully request that Congress, in its work toward developing "an integrated long-term care delivery system which provides more appropriate and humane long-term care services," adopt legislation which expands the definition of State supplementary payment in the Social Security Act to include other forms of assistance, in addition to direct cash payments, to help elderly and disabled individuals secure necessary long-term care services.

We encourage the adoption of legislation to provide a tax credit for expenses incurred in the care of an elderly or disabled relative who would otherwise be eligible for nursing home care. Such tax credit should not be tied to the IRS definition of dependent status of the elderly or disabled relative. For example, this would allow a credit for the middle to lower income family that pays $400 per month for care to supplement the $450 per month that the disabled relative pays from the Social Security check.

A sliding scale formula similar to that used to compute the child care tax credit would be acceptable.

Expanded use of waivers for Home and Community Services under Title XIX of the Social Security Act could fill many gaps in long-term care. Current requirements encourage States to use waivers to serve very small target groups. The "need methodology" for Title XIX waivers could be based on a formula such as percentage of SSI recipients or percentage of elderly persons in the state. This would enable Title XIX waivers to be used to develop more comprehensive solutions to the problem of long-term care.

With primary funding through Title XX of the Social Security Act, homemaker service, adult foster care and adult day care are among the (most effective) services that enable persons to remain in their own homes and communities. An increased Title XX appropriation could help expand those services.

STATEMENT

OF

American Physical Therapy Association

ON

LONG TERM CARE REFORM

To

Subcommittee on Health
of the
Finance Committee
U.S. Senate

November 29, 1983

The American Physical Therapy Association welcomes this opportunity to submit the following statement for the record of the hearings held by the Senate Finance Subcommittee on Health on November 14, 1983. The American Physical Therapy Association (APTA) is a national professional membership organization representing approximately 40,000 licensed physical therapists and physical therapist assistants. Physical therapists function in a variety of settings. The highest proportion of our members do most of their work in hospitals. A significant number work for extended care facilities such as nursing homes as well as for home health agencies. Many others are in private practice.

Physical therapists frequently treat individuals over 65 years of age as well as younger persons with developmental disabilities, many of whom qualify for coverage under Medicare or Medicaid. These patients typically need physical therapy for rehabilitation whether from a congenital disability, spinal cord injury, arthritis, coronary disease, or post-operatively.

We applaud the subcommittee's efforts to reform the Medicare and Medicaid programs to enable certain elderly and disabled patients to be served in their homes and communities rather than in institutions, when such service is appropriate. From our perspective, we know that the ability of patients to receive physical therapy in their home can make it possible for them to leave the hospital earlier, thus reducing hospital and nursing home stays. Treatment in the home also facilitates training of the patient's family members so that they may participate more constructively in the rehabilitation effort.

We take this opportunity, then, to bring to the attention of the Subcommittee the following recommendations which we believe would improve pending legislation as well as existing Medicare law.

Assessment of and caring for patients in their home must be considered a specialty practice. The home environment is very different from the clinical setting. A number of unique factors in the patient's home need to be assessed: the physical layout, structural obstacles, and accessibility to the necessities of daily living. The level of the patient's physical and mental function, the patient's attitude toward rehabilitation and the type of personal assistance that can be counted on from family members are major factors that impact on developing the plan of care. Physical therapists are trained to be sensitive to environmental factors and to find ways to adapt the patient's home to meet his/her needs and to involve family members in the patient's rehabilitative process. Considering that the bills under consideration call for patient assessment and case management, we believe that it would be essential, therefore, to include a physical therapist as part of the patient assessment team organized by the state-designated entity to provide screening and case management services for the population at risk of institutionalization.

In recognition of the fact that health care may be effectively and efficiently delivered in the home setting, we feel that, wherever reasonable, artificial barriers to the provision of home care should be removed. One such barrier currently exists in the repeated refusal of the Medicare program to allow reimbursement for the purchase of self-help, safety and other durable equipment upon the recommendation of a licensed physical therapist or other qualified health care professional to enable elderly and disabled persons to function at home. Examples of such necessary but currently nonreimbursable items include bathroom grab bars, bathtub seats, modified commode seats and adaptive equipment for feeding, dressing and hygiene.

In this regard, the Health Care Financing Administration (HCFA) has arbitrarily taken the position that coverage should be denied because the items do not meet the statutory definition of durable medical equipment in that they are not primarily and customarily used to serve a medical purpose and that, therefore, there is no statutory authority for coverage. We urge the Congress to remedy this situation by recognizing that the lack of coverage for these items often represents a very real barrier to effective long term care in the home setting and by acting accordingly to remove this barrier to the delivery of health care in the noninstitutional setting.

Additional improvements upon the Medicare program would also facilitate patient access to appropriate care.

For example, under current law, services rendered by home health agencies must be supervised by a physician or a registered professional nurse in order to be covered by Medicare. The APTA believes that this provision §1861(O)(2)(42 USC 1395x(O)(2))should be amended to additionally permit other qualified professionals, such as physical therapists, to supervise professional services in a home health agency. Such an amendment would permit home health agencies the flexibility to secure the best professional expertise and managerial skills available to supervise services furnished by the agency. There is the real possibility that the best person to oversee such services at a given home health agency may be a physical therapist or other qualified professional. Furthermore, neither the express language of the current law nor its legislative history specify any practical or legal reason why home health agency supervisors should be limited to physicians and registered nurses. In fact the state-of-the-art of delivery of home health services has expanded dramatically since Sec.1861(0)(2) was enacted, and physical therapists have become integrally involved in various home health care systems. This suggestion would also apply to community nursing centers such as described in S.410, should that bill be enacted.

Furthermore, we believe that current requirement (§1835(a)(2)(C)) for a physician to establish a plan of treatment for outpatient physical therapy is unrealistic considering current practice where the physical therapist usually creates the plan and the physician simply endorses it. For the physical therapists in home health care this requirement creates logistical problems and unnecessary paper work surrounding physician accessibility. We therefore recommend a change in the law to permit physicians <u>or</u> physical therapists to establish plans of treatment for outpatient physical therapy. The physician would still be required to periodically review the patient's medical needs in their entirety and recommend program changes. Such a provision was incorporated into H.R.4170 which passed the House Ways and Means Committee in October, 1983.

We also request your consideration of allowing a waiver of the federal cap on Medicare reimbursement for outpatient physical therapy services provided by independent practitioners. Currently, there is a $500 per patient/per year limit. Instead, we recommend that states be allowed to devise a system for periodically reassessing the physical therapy needs of individual patients. S.1614, for example, calls for periodic reassessment of health care needs of each individual enrolled in the state program and encourages alternative methods of provider reimbursement by states. Those patients who need more than $500 worth of outpatient physical therapy, such as those with debilitating rheumatoid arthritis, developmental disabilities, severe strokes, head trauma, or spinal cord injury, should be permitted to continue treatment under the state program to assure complete rehabilitation.

Yet another impediment to home care physical therapy lies in the requirement that, to be certified as a Medicare provider, a licensed physical therapist in independent practice must maintain an office despite the fact that this licensed physical therapist may treat patients in their homes exclusively and, consequently, never use that office. The arbitrariness of this requirement was recognized by the Congress in its enactment of P.L.96-499, yet HCFA has chosen to ignore the intent of Congress.

Specifically, P.L.96-499 recognized that there are situations in which this office requirement is inappropriate, and the House Report accompanying that legislation cited the case of the physical therapist who is engaged primarily in teaching as one such situation. HCFA, however, has settled on this one example as the only situation where the office requirement is inappropriate. While we appreciate the recognition of the fact that a therapist who is primarily engaged in teaching physical therapy in a university may, in fact, also be considered to be in independent practice, we, nontheless, hasten to point out that this example cited by the Congress in its enactment of P.L.96-499 was merely one example which was clearly not meant to be exclusive of other circumstances. Certainly all other licensed physical therapists are qualified to provide patient care as independent practitioners, and there are, just as clearly, other situations in which the office requirement as currently applied is inappropriate.

As the House Report (H.R. Report No. 96-1150 at p. 41) states "...in most instances, such a requirement is necessary to assure that the therapist has an established private practice, maintains proper patient records, and has available properly maintained equipment. There are circumstances, however, where the Committee believes that exceptions to the office requirement are appropriate." The Report then cites the teaching example and goes on to say, "The Committee expects that in <u>this</u> <u>and</u> <u>other</u> <u>circumstances</u> the Secretary determines to be appropriate, where it is evident that the physical therapist is engaged in the practice of physical therapy on a regular basis and where any other appropriate requirements are met (e.g., access to appropriate equipment), such a therapist will be recognized as an independent practitioner for the purposes of Medicare reimbursement."

This leads us to the point of indentifying other appropriate circumstances for the waiver of the office requirement. And it is in order to emphasize that it is a waiver which is at issue here and not an elimination of the office requirement. At no time has the APTA sought such an all-inclusive exemption.

It has been the experience of the APTA that the instance in which the office requirement is most patently unnecessary is in the situation where the independent practitioner treats only home care patients.

In the case of home care patients, an adequate program of physical therapy most often is provided through the professional expertise of the physical therapist by means of hands-on treatment which may be complemented by the use of certain necessary assistive devices. When modalities involving such devices are required, they are mostly available in portable form. Examples include, but are not limited to, all forms of electrical stimulation, ultrasound and therapeutic exercise equipment. Other modalities which might be indicated, such as heat and cold packs, are readily available and can be provided by the therapist in the patient's home. Examples of patients in whose cases this situation applies include, but are not limited to, post CVA, patients with disabling arthritis, amputees without specific complications and restorative therapeutic programs for Parkinson patients.

Consequently, in the instances of these independently practicing physical therapists who treat patients in the home, the requirement of an office in which to maintain equipment which is unused is clearly inappropriate. Insofar as the devices used by these therapists are available in portable form or can readily be fashioned on-site in the patients'homes, an office for these independently practicing therapists should merely be defined as a space in which to house the protected files of patient records in compliance with Medicare regulations.

Although the Congress has already spoken on this matter, we urge that it reinforce its determination to assure that HCFA respond to its legislative intent.

Finally, in any legislation that the Committee drafts, we question the desirability of restricting physical therapy to certain institutions. We note a provision in S.1539 and S.1540, bills before the Committee on Labor and Human Resources, that outpatient physical therapy could be provided in a hospital, long term care facility, or rehabilitation center if it involves the use of equipment which cannot be made readily available in the individual's home. It would appear, then, that physical therapy in a free-standing clinic or in a physical therapist's office would be excluded from the program. This would unnecessarily limit the patient to receiving care in a setting that may not be convenient geographically for the patient.

Thank you for your attention to the above-mentioned concerns of our organization. We trust that adding the suggested Medicare amendments to bills such as S.1614 will further facilitate patient access to appropriate care in her/his home and community.

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STATEMENT OF

NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS (NAMES)

BEFORE THE

SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

ON

LONG TERM CARE

November 14, 1983

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STATEMENT OF

NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

BEFORE THE

SENATE FINANCE SUBCOMMITTEE ON HEALTH

NAMES is a national trade association representing suppliers of durable medical equipment (DME) for use in the home. In 1982, we estimated that NAMES 1000 members supplied medical equipment to over two million patients in their homes throughout the United States.

Most NAMES members are small businesses serving local communities or small geographic areas. They work closely with physicians, hospital discharge planners, therapists, nurses and the patient's family to provide quality medical products and services for the patients rehabilitation in the home at reasonable and competitive prices. The DME industry is heavily oriented toward service. NAMES estimates that the typical DME supplier spends less than 35% of their total cost of doing business on the purchase of equipment. The remaining cost of doing business is for service related and other overhead expenses (e.g. rent, salaries and benefits, insurance, utilities, vehicles, maintenance, fuel, repairs, freight).

Most NAMES members who deliver and maintain respiratory equipment provide monthly house calls by a respiratory therapist or other trained employee. This individual checks the equipment, sees if the patient is following the doctor's orders and answers any question the patient or their family may have. Patients and their family often develop a very close relationship with the supplier.

SUMMARY STATEMENT

The term "durable medical equipment" (DME) is used by the Health Care Financing Administration (HCFA) to refer to equipment which has the following characteristics:

a) can withstand use;
b) primarily and customarily used to serve a medical purpose;
c) generally not useful in the absence of illness or injury;
d) appropriate for use in the home.

The Supplementary Medical Insurance portion of Medicare (Medicare Part B), reimburses Medicare beneficiaries for a portion of the rental or purchase cost of DME. Items of DME include respiratory equipment, oxygen equipment, oxygen, hospital beds and accessories, wheelchairs and accessories, walkers, commodes, and ambulatory aides such as canes and crutches.

This list of DME is extremely varied. For example, on one end of the scale the list includes a cane. While at the other end, the list includes modern, technologically advanced oxygen and respiratory equipment and computer-operated power-driven wheelchairs.

A long term care patient may need one or a combination of more than one item of DME to aid them in activities which range from locomotion to breathing. Also, a patient's need for a particular item of equipment may change as the patient's condition changes. For example, take the case of a stroke patient. If recovery progress well and motor skills improve a wheelchair may be replaced by a walker or a walker with a cane. By contrast, if there is continued deterioration of motor skills, the standard wheelchair may be replaced with an electric wheelchair or a change in the patient's weight may necessitate the refitting of the wheelchair. The advent of DRG's is likely to result in the treatment of more acute care patients in the home with a corresponding need for more sophisticated equipment.

The DME supplier is an important component of the team of health experts which assist the long term care patient in receiving equipment which is appropriate for their needs. As you consider legislation before the subcommittee and review alternatives for the Medicare and Medicaid programs we urge you to think of durable medical equipment as a separate component, and not treat it as a minor appendage to hospital , nursing home, or home health agency services. The DME supplier plays a significant role in the proper selection of appropriate equipment and continued maintenance of equipment to assure patient benefit. The supplier's particular health expertise is not duplicated by physicians, hospitals, home health agencies, nursing homes or hospices.

Throughout the subcommittee's consideration of various alternatives, the following goals for DME must be pursued:

a) create a more competitive environment in health care with lower costs and higher quality care through the separation of DME suppliers from hospital, nursing home, and home health agency control;
b) insure beneficiary freedom of choice to promote competition and restrict overutilization;
c) encourage expansion of cost effective DME in the home.

PROMOTE COMPETITION THROUGH BENEFICIARY CHOICE

Mr. Chairman, NAMES supports the effort to constrain health care costs by targeting patients in institutions and those who are ready to be admitted to institutions for cost effective services provided in the home. Identifying patients in risk of being admitted to institutions and substituting cost effective services that can be provided in the home is absolutely essential. However, NAMES is concerned with problems that may result from the case management or assessment team function prescribed in certain legislation.

This case management function is responsible for coordinating the home and community based DME and other services that are provided to elderly and disabled patients. When the case manager actually selects the provider of DME services their is an opportunity for subjective, faulty decisions to be made. This is exactly the opposite of what should be achieved. NAMES recommends that safeguards to assure that the beneficiary is able to select the provider of their choice be clearly stated or that the case manager makes a decision based on reasonable objective criteria.

It is important that the selection of a provider should be based on reasonable criteria that encourage competition and discourage overutilization. To do it otherwise would impede competition by not providing an opportunity for better products and services to be found which are lower priced or of superior quality, or if a DME supplier exists which can provide better service or more professional expertise. If the case manager abrogates beneficiary freedom of choice the DME supplier and other providers would be measurably constrained in their ability to compete. To quote Thomas Jefferson: "I know no safe depository of the ultimate powers of the society but the people themselves; and if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion". The beneficiary should be provided with sufficient information to allow them to participate in the selection of the supplier of their choice.

RESTRICT CONTROL OVER DME SUPPLIERS

NAMES vigorously supports competition provided it is fair and based on the traditional concepts of reasonable price and quality of service and care. However, the DME suppliers have found that competition is often short circuited as hospitals and home health agencies refer their patients directly to DME companies owned or controlled by the hospital or home health agency. This control over the patient when a need for DME develops is both unfair and improper. NAMES is concerned that, without safeguards to assure competition the case management function could result in a situation similar to hospitals and home health agencies controlling the selection of DME suppliers for their patients.

NAMES recommends that where a hospital, home health agency or other provider is related to the durable medical equipment company by way of common ownership or control, neither Medicare nor Medicaid should reimburse the hospital, home health agency, other provider or equipment supplier unless there is a full disclosure to the patient and family of all available medical equipment suppliers in the area, the services they offer, the relationship between the hospital or home health agency and the commonly owned or controlled DME supplier and any other information competing suppliers wish to furnish the patient, their family or physician for consideration in making an equipment purchasing decision. If the patient, family or physician, wish to meet with an individual supplier they should be allowed to do so without the consent of the hospital. The recommended measures are designed to increase competition and eliminate potential overutilization. There ~~is~~ a risk of overutilization when the hospital knows that their controlled DME supplier will be receiving revenue and that no competitive factors constrain the use of unnecessary DME. Like the related organization principal embodied under Medicare Part A regulations the objective of separating DME from the other services is to assure that competition will not be constrained.

CONTINUED EXPANSION OF COST EFFECTIVE DME IN THE HOME

Expanded home care services clearly are preferred by beneficiaries and their families, and with proper targeting constrain costs and avoid unnecessary institutionalization.

"Another area of importance in the expansion of home health care is the potential for improving both the physical and the mental well-being of the elderly...Improvements in client outcomes are generally expected whenever the elderly are able to receive care in settings they choose." GAO Report, December 7, 1982.

It is important to assure that existing biases which encourage institutionally based care are not retained in any new long term care programs. There are many developing technologies which, with proper incentives, may be designed for in home use. Any institutional bias--reimbursement, referral or coverage--would jeopardize the benefits to be gained from targeted home care services.

CONCLUSION

Mr. Chairman, NAMES commends you for holding hearings on long term care and exploring cost effective services provided in the home. NAMES looks forward to working with you and other committee members on legislation that will assure competition and the ability of DME suppliers to continue to provided needed services to this nations elderly and disabled population.

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
P.O. Box 17675, Washington, D.C. 20041 • (703) 556-8848
James A. Cox, Jr., Executive Director

STATEMENT SUBMITTED BY

JOHN L. MELVIN, M.D.
MEDICAL DIRECTOR
CURATIVE REHABILITATION CENTER
MILWAUKEE, WISCONSIN

ON BEHALF OF THE

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

BEFORE THE

COMMITTEE ON FINANCE
U.S. SENATE

ON LONG TERM CARE

NOVEMBER 14, 1983

Mr. Chairman:

I am John Melvin, and I am the medical director of the Curative Rehabilitation Center in Milwaukee, Wisconsin. My statement is submitted on behalf of the National Association of Rehabilitation Facilities (NARF) of which I am the immediate past president. NARF is the national voluntary membership organization of community based rehabilitation facilities. Our members include rehabilitation hospitals, rehabilitation units of acute care hospitals, outpatient rehabilitation centers, vocational centers and sheltered workshops serving over 400,000 elderly and disabled people annually. Many of these clients are Medicare, Medicaid, SSI and SSDI beneficiaries. The rehabilitation process employs a multidisciplinary team approach to restoring disabled people to a higher level of functional capacity and maintaining that functional level of function.

There is a growing need for community based services for the elderly and disabled in order to provide an alternative to costly institutionalization. We commend the sponsors of S. 1244, the Senior Citizens Independent Community Care Act and S.1614, the Health Care Coordination Act of 1983 and S.410, the Community Nursing Centers Act of 1983 for addressing these issues and the committee for holding these hearings. My comments are focused on the needs of the nondevelopmentally disabled and elderly. I understand the committee intends to hold separate hearings on the problems that face the developmentally disabled and we encourage it to do so.

Our present medical support programs (primarily Medicare and Medicaid), social services and public assistance programs (Titles II, XVI and XX) encourage institutionalization by reimbursing for services only when delivered within an institutional setting. For example, under Medicare Part A skilled nursing services are limited to 100 days for each spell of illness. A Medicare beneficiary is eligible for such services only after a minimum three day hospital stay. Home health services include skilled nursing care and a limited number of therapy services. They do not include homemaker-housekeeper services, personal care services or transportation for outpatient services. Instead these services are covered, if at all, only in the more expensive skilled nursing or hospital settings.

The result of this approach is inappropriate institutionalization and excessive care for some and inadequate or unavailable services for others. Because of the structure of the programs, these people experience an erratic, exhaustive cycle of care. Usually after hospitalization they may be referred for home health care under Medicare or to a skilled nursing facility. When they are no longer eligible to receive the services, but still need less intense services, their health declines. More than likely they are readmitted to a hospital and the cycle begins again.

Also, as noted in the introductory statements, our population is aging at an ever increasing rate and has an increasing need for home and community based services. At the same time, there has been a strong push to deinstitutionalize the disabled and elderly as a result of the civil rights movement on behalf of the disabled which we support, prodding by the federal government, and state financial economies.

However, there are problems with rapid, unplanned deinstitutionalization of any population which include community hostility, inadequate community resources such as housing, transportation, medical and social services and inadequate funds to pay for them.

Any legislation addressing long term care must be comprehensive in its approach to the nature of and delivery of these services. Long term care is not solely nursing-level or nursing home care. It involves a range of services which include comprehensive rehabilitation services to help people become and maintain the ability to function independently.

Independence is the major goal of rehabilitation. Physical independence is vitally important to people as well as fiscal independence. Independence also has psychological benefits. People who can stay in their own homes and communities retain the self esteem and confidence frequently lost in a dependent care setting. If the person _feels_ useless, and dependent, they become so. Our elderly and disabled people in large part do not suffer from acute illness. Instead they suffer from chronic illness, or injury, or debilitation resulting in a functional disability, impairing their ability to perform activities of daily living - dressing, eating, cooking. If these needs are met, at home, by community based service providers, needless institutionalization in a hospital or nursing home and the concomitantly greater expense is not required.

Our nation has made a commitment to provide a minimum level of needed health care services primarily through the Medicare and Medicaid programs. These services have proven more costly than anticipated. We are all aware of the financial problems facing the Medicare trust funds. However, we still honor that commitment. In order to fulfill it, comprehensive community based services must be provided under Medicare and Medicaid. In the long- run, we all stand to save financially in terms of shorter hospital stays and nursing home stays and personally and socially in terms of a more independent, alert and healthy elderly and disabled population.

In this vein, Congress has provided for the Medicaid home and community based services waiver which was enacted as part of the Omnibus Budget Reconciliation Act of 1981. The bills pending before the committee will expand on this step by assuring provision of these services for the elderly and disabled in a cost effective manner. And, these services can be easily provided by existing Medicare providers especially comprehensive outpatient rehabilitation facilities and home health agencies.

I. S.1244 - Senior Citizens Independent Community Care Act

S.1244 would add a new Part D "Long Term Care Program" to the Medicare program. For the first four years, only four states could participate. Payment would be made on a per capita basis to service providers in order to encourage cost effective delivery of all Medicare services.

This graduated approach to providing alternative services to the elderly and disabled may avoid the problems of too rapid a shift in emphasis without adequate planning. As I noted above, when people leave a hospital or nursing home, they may need a whole range of services which include transportation and housing which a community may not be prepared to provide without adequate lead time.

We have several general concerns with the bill. First, we are concerned that a state may emphasize to the Preadmission Assessment Team (PAT) that deinstitutionalization and provision of services at home is preferred over the patient's medical status. These factors may result in a person going from intensive to sporadic services solely because he or she is determined to be medically stable. However, it may be detrimental to the person's long term recovery to receive only sporadic services. Any program should include an option for comprehensive, integrated services on an outpatient basis as opposed to providing services only if the person is at home. Existing Medicare providers especially comprehensive outpatient rehabilitation facilities have expertise in providing all needed services.

Second, all decisions should be made on the basis of clinical need, not dollars saved by the state. These determinations must be made in a judicious as opposed to a wholesale manner. All feasible services and alternatives should be included in the PAT and the final assessment plan.

Our specific comments on the bill are outlined below:

A. Section 1891: Scope of Benefits

1. (c)(3)(B)(ii) Definition of homemaker-home health aide.

   The bill appears to limit homemaker-home health aide services to patients needing physical, occupational or speech therapy. The list of services of patient needs should be amended to include other comprehensive rehabilitation services, audiology, recreational, social and psychological services in addition to physical, occupational, and speech therapy.

2. (c)(4) Definition of adult day services.

   We support the list of services included in this definition. It recognizes the full range of services a person may need. In addition, we recommend the words "to develop or" be inserted prior to "to maintain." Many people will benefit from services that will help them obtain an independent functional status, which can then be maintained. If they have to rely on the current system to develop an independent functional level and need these adult day services, they may not be able to do so.

3. (c)(6) Definition of "service coordination."

We recommend that "rehabilitation" after the word "educational" be added to assure that people will obtain the full continuum of services, thereby bringing them to their full functional level.

B. Section 1892: Eligibility for Benefits

In order to participate in the program a person must meet the seven requirements as outlined in section 1892(a)(1)(7). One of these is that the person must be at least 65 years old. Therefore the program is focused only on the frail elderly with functional limitations. It does not appear to include the disabled who are Medicare beneficiaries and who are not 65 years of age or more. We recommend that this small sector of Medicare beneficiaries be made eligible to participate in the program in that they usually experience the impairments listed, and they can be very independent if services are available at home.

C. Section 1893: Preadmission Screening and Assessment: Service Providers

1. (c)(2)(A) Designation of providers of services and establishing PATs

The last sentence of this paragraph describes the type of entities that may establish preadmission assessment teams (PATs) in the area. It should be amended to add comprehensive outpatient rehabilitation facilities in addition to hospitals, SNFs, HMOs and rural health issues. Such facilities are providers under Medicare. They have extensive experience in serving the frail elderly and disabled and providing the services proposed at the community level.

2. (c)(3)(B) Composition of PATs

We recommend that a rehabilitation specialist be required to be a member of each PAT described.

II. S.1614 Health Care Coordination Act of 1983

The purpose of S.1614 is to coordinate services available under

Medicare and Medicaid to provide expanded home and community based services to the approximately four (4) million people eligible for both Medicare and Medicaid. Payment would be made on a capitated basis under Medicare for both the frail and nonfrail elderly. Any excess cost of services would be paid by Medicaid.

People electing to participate in the program would receive Part A and Part B medicare services, all services provided under the state Medicaid plan, case management and case assessment services, homemaker and home health aide services and adult day health care services. Unfortunately these terms are either not defined or not defined in a comprehensive manner under the Medicare or Medicaid program. We recommend that the bill be amended to define these services. Such definitions should include comprehensive rehabilitation services in order to assure that patients are able to obtain and then maintain their optimal functioning.

III. S.410 - Community Nursing Centers Act of 1983

This bill proposes to establish community nursing centers (CNC) to serve people requiring well baby care, home health care under Medicare, and those, who without the services, would have to be institutionalized and require three months of CNC services.

S.410 proposes to establish such centers as providers under Medicare. There are already a number of other providers who deliver the same services proposed. A comprehensive outpatient rehabilitation facility provides most of the services proposed to be provided by a CNC. These include nursing, comprehensive rehabilitation services including physical, occupational or speech therapy, psychological and social services, medical supplies and medical appliances among others. Additionally, home health agencies provide home health services, skilled nursing services, physical and speech therapy. Rehabilitation agencies provide offsite physical therapy.

One of the objectives of these bills is to prevent institutionalization of our frail elderly and disabled. To obtain this objective, the Medicare program should be amended to recognize the abilities of existing providers to do so. One of the requirements for a comprehensive outpatient rehabilitation facility (CORF) is that all services be delivered on site. Only one home visit is allowed for. A rehabilitation agency, however, can deliver physical and speech therapy offsite. Occupational therapy cannot be delivered offsite. If a rehabilitation agency becomes a CORF, it can no longer deliver these services offsite under the CORF regulations. Comprehensive outpatient rehabilitation facilities should be allowed to provide these services offsite, particularly physical and speech therapy, as well as onsite. Additionally, we would recommend that CORFs and home health agencies be allowed to provide homemaker and home health aide services, adult day health care services and respite care services as are proposed to be provided in the Senior Citizens Independent Community Care Act.

A second concern of ours with the proposed act is the method of payment for long term patients as described in the introductory statement. It states that in the case of long term patients the center would be paid a monthly inclusive fee covering all services. "The amount of the fee would vary depending upon a given patient's classification in terms of diagnosis, severity of illness, age cohort and other cost inducing variables."

At this time there is not adequate information available to develop a fair fee based on these variables. In fact, the Social Security Amendments of 1983 excludes rehabilitation hospitals and rehabilitation units of acute hospitals from the DRG based prospective payment system. They are excluded because the research and methodology underlying the DRG system simply does not include information and data from the medical rehabilitation industry including costs associated with or adequate measures of various levels of the severity of illness of these patients.

Therefore, we recommend that the committee, in its efforts to provide a program of long term care services for our elderly and disabled, utilize existing providers in a more efficient manner rather than establishing another provider system and another payment system. We are well aware of the excellent services provided by the nation's nurses including the Visiting Nurses Association and would suggest that the Committee consider ways by which to encourage existing providers to contract with and utilize their services, as well as providing adequate payment for them.

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MARY E. ACKER, *President*

November 29, 1983

The Honorable Robert Dole
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

The National Federation of Licensed Practical Nurses is pleased to submit testimony on long-term health care for the elderly.

The National Federation of Licensed Practical Nurses, the professional association for licensed practical/vocational nurses, estimates that there are 750,000 licensed practical/vocational nurses (LP/VNs) in the United States and that twenty percent (20%) of these provide nursing home care.

The number of citizens over age 65 requiring long-term health care is increasing and will continue to do so. The National Federation of Licensed Practical Nurses recognizes the urgency of the long-term health care situation and applauds this Committee's efforts to formulate a more comprehensive long-term health care policy. We view Senate Bill 410 and the development of Community Nursing Centers as providing a viable alternative to the cost and often unnecessary burden of institutionalization.

The National Federation of Licensed Practical Nurses is eager to assist this Committee in its efforts to increase the proficiency of long-term health care. We feel that S.410 can be strengthened even further by allowing licensed practical nurses to play a more active role not only in providing health care but also in formulating long-term health care policy.

The National Federation of Licensed Practical Nurses believes that there is overwhelming evidence that there is under utilization of LP/VNs who are educationally prepared and permitted under the Nurse Practice Acts in the various states to do some of the tasks now performed by registered nurses. Proper utilization of the LP/VN would make registered nurses available to do the more skilled tasks that LP/VNs are not educationally perpared to do.

The LP/VN cannot, nor does she want to, do the tasks performed by the registered nurse. The LP/VN has defined functions as a member of the health care team, as does the registered nurse (RN). Together, both groups of licensed nurses should be the providers of nursing care in a variety of settings, such as hospitals and nursing homes.

The National Federation of Licensed Practical Nurses believes that there is a serious misunderstanding by RNs, hospital administrators and the Joint Commission on the Accreditation of Hospitals (JCAH) and other as to the level of education and competencies needed to become an LP/VN, and that this misunderstanding is preventing the LP/VN from being properly utilized.

Today's LP/VN is a trained provider of nursing services who has graduated from a state-accredited practical nurse program and has passed the state nurses' examination.

The National League for Nursing completed a study of competencies of new graduates of the four types of nursing education programs now in existence. In May of 1979, the National League for Nursing (NLN) adopted the competencies which they consider as the minimal expectations of the new graduate of an educational program in practical nursing. In October of 1979, the National Federation of Licensed Practical Nurses (NFLPN) adopted a resolution to endorse these competencies. Licensed practical/vocational nurses are competent in the following areas:

A. <u>Assessing</u>.

1. Contributes to the identification of basic physical, emotional and cultural needs of the health-care client.

2. Identifies basic communication techniques in a structured care setting.

3. Interviews health-care clients to obtain specified information

4. Makes significant observations of the health-care client and communicates these to the health team.

5. Identifies overt learning needs of the health-care client.

6. Identifies appropriate resources in some other agencies within the health-care delivery system.

B. Planning.

1. Contributes to the development of basic nursing care plans in an institutional setting.

2. Contributes with assistance, to the development of health plans for health-care clients and/or families.

C. Implementing.

1. Safely performs basic therapeutic and preventive nursing procedures, incorporating fundamental biological principles in giving individualized care.

2. Shows respect for the dignity of individuals.

3. Applies basic communication techniques in a structured health care setting.

4. Demonstrates the ability to do incidental teaching during routine care.

5. Assumes shared responsibility for the health-care delivery system in structured situations.

D. Evaluating.

1. Seeks guidance as needed in evaluating the care given and making necessary adjustments.

2. Identifies own strengths and weaknesses and seeks assistance for improvement of performance.

E. Role as a Member Within the Profession of Nursing.

1. Recognizes own role as an LP/VN in the health-care delivery system.

2. Seeks out and takes advantage of learning situations and opportunities for own continuing education.

The National Federation of Licensed Practical Nurses, realizing that nursing entry-level competencies must be maintained and further developed through experience, adopted in October of 1979 Nursing Practice Standards for LP/VNs which include a code for (1) education, (2) legal/ethical status, (3) practice, (4) continuing education, and (5) specialized nursing practice, for which the scope of practical nurses has extended.

The role of the LP/VN, as that of the RN, has been changed dramatically in the past years. Many experts believe that the role of the LP/VN has changed even more significantly than the RN because the educational preparation has become more standard throughout the United States and now all 50 states require one year of practical nurse education.

Sadly, many have not kept up with the educational changes of the LP/VN and still think of him or her as a nursing assistant without formal education.

The fact of the matter, however, is that the practical nurse of 50 years ago has developed from an untrained person who performed relatively unskilled tasks for the sick in the home to a fully responsible, specially skilled and licensed member of the health-care team.

No longer do licensed practical/vocational nurses do the household chores such as cooking and cleaning, along with administering unskilled health care. Now she/he has studied for more than a year and has both an extensive theoretical and practical training period. It should be understood that this preparation is not as extensive as the RN programs but there are similarities in preparation for the various levels of nursing.

It is evident that LP/VNs are ready to play an expanded role in providing health care to the elderly. S.410 vests the primary responsibility for developing long-term policies to registered professional nurses but does not specify the role other health-care providers, particularly LP/VNs, will play in the formulation of health-care policy. The NFLPN feels that in limiting the development of policy to RNs, the valuable experience of LP/VNs is not being fully utilized.

In comprising the majority of nursing home health-care providers, LP/VNs are exposed to and become expert in providing care for our Nation's senior citizens. The National Federation of Licensed Practical Nurses believes that our members can provide valuable insight to aid in the development of health-care policy and could work closely under the supervision of RNs to assure that this is done.

It is our belief that successful health-care policy and its administration is best instituted when input into its development can be maximized from caregivers across all sectors of health-care providers and this necessitates the inclusion of LP/VNs into the process.

We do not view our position as being contrary to the scope of S.410 or to the position of the American Nursing Association. We want to stress cooperation as a means of maximizing the efficiency of long-term health care. We feel that by allowing other health-care providers to play an active role in the development as well as the administration of long-term health care policy, S.410 and Community Nursing Centers will be able to attain the comprehensive health care that we all so desire.

Again, I would like to commend the efforts of this Committee and thank you, Mr. Chairman, for the opportunity to submit this testimony.

Sincerely,

Mary E. Acker

Mary E. Acker
President

MEA:cdd

National HomeCaring Council Serving the Homemaker-Home Health Aide Field

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A nonprofit
national
standard-setting
organization

November 30, 1983

Senator Robert J. Dole, Chairman
Subcommittee on Health
Finance Committee
U. S. Senate
Washington, DC 20510

Dear Senator Dole:

RE: Hearing on Long-Term Care

The National HomeCaring Council, the national, non-profit, tax exempt organization promoting homemaker-home health aide services of good quality, appreciates this opportunity to present a statement on long-term care. We are grateful to your Committee for holding these important Hearings on long-term care, one of the current major social issues facing our country. As is clearly indicated by the papers presented at the Hearing held November 3, 1983, the issues regarding long-term care are pressing now, especially with regard to the aged, but they are going to become progressively more serious.

Support Intent of S.1244, S.1614, S.410, HR.3616

In light of the urgency of this situation, we are grateful indeed to Senators Inouye, Packwood, Bradley, Heinz and Hatch for their continuing support of the development of home care in this country because quality home care is a key solution to the long-term care problem. We support the overall intent of S.1244, S.1614 and S.410 to increase the level of government support for home care. We support HR3616 and look for a companion Senate Bill.

Concern Regarding Quality of Care

A point or grave concern to the National HomeCaring Council is the quality of home care particularly homemaker-home health aide services. The National HomeCaring Council strongly supports the expansion of home care programs for the elderly, families with children, and the disabled, but we are equally concerned about the quality of home care to vulnerable people.

Title XX

There was scant reference to the role of Title XX of the Social Security Act in the papers presented on November 3, 1983 regarding the delivery of home care, including long-term home care. Yet, in a state like California, enormous sums are being spent on home care through

Title XX, with little or no reference to the quality of the care provided. Please see the attached September 25, 1983 copy of a Parade Magazine article entitled "When the Elderly Are Victims." This deplorable situation exists in substantial measure because the Federal legislation for Title XX does not include standards, and consumer protections are not built into this program.

The Department of Human Services in the state of Maine is one agency that has taken a stand. They require agencies receiving Title XX contracts to hold an accredited status from the National HomeCaring Council. In contrast to this, the National HomeCaring Council's Approved Agencies in the state of Oregon have lost nearly all their state contracts for Title XX services because standards required by the state are almost non-existent and contracts are awarded primarily on the lowest cost per hour.

Title III, Older Americans Act

The same points made about Title XX can also be made about Title III of the Older Americans Act.

Titles XVIII and XIX of the Social Security Act

Standards for "home health aide service" are built into the Medicare and Medicaid programs. The application of these standards is being weakened because of fiscal constraints and because of the rapidity with which for-profit agencies are becoming certified home health agencies. In Texas, for example, in 1982 there were under 100 Medicare certified home health agencies. Today, there are approximately 400, most of which are for-profit agencies.

For close to two years the Health Care Financing Administration has been reporting orally that it is going to require the use of sections of the Department of Health and Human Services' Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide in its Conditions of Participation. We urge that this plan be implemented immediately. The paraprofessional service known as "home health aide service" under Medicare and Medicaid would be strengthened substantially by the required use of a nationally prepared standardized training text.

Support National Thrust for Homemaker-Home Health Aide Services

Homemaker-home health aide programs offer enormous potential for meeting the long-term care needs of the elderly, the disabled and families with children. These services are provided through single service and multi-service agencies. A large number of these programs are becoming Medicare certified. Yet, we are told that becoming certified for Medicare escalates an agency's costs of the service by 25%, particularly because of the extensive cost reporting requirements.

We recommend that a special national thrust be adopted and funding provided for homemaker-home health aide services in their own right. This way they would be recognized as a key component in meeting the growing long-term care needs. And these services must meet basic national standards, such as careful selection of the paraprofessional worker and a requirement that they be trained and professionally supervised. Homemaker-home health aide services of good quality make maximum use of the informal support system and the nationally approved service they provide, on a case basis, is less costly than in-home services which do not meet basic national standards. These points need to be understood by administrators and the general public.

The National HomeCaring Council has been developing materials to establish costs of homemaker-home health aide services. Early in 1984, it will have ready for use a *Handbook for the Computation of an Hour of Homemaker-Home Health Aide Service.* Data from agencies computing costs according to this *Handbook* will be comparable, a situation that we have not had heretofore. We will be glad to share these data as soon as they are available.

Skilled Care Under Medicare Be Expanded

The National HomeCaring Council urges that the present level of skilled care under Medicare including the work of "home health aides", not only be maintained but expanded. We are concerned about the current moves on the part of the Health Care Financing Administration to interpret the terms "intermittent care," "homebound" and "skilled nursing" in a more restricted fashion. This will curtail the already limited care currently available under Titles XVIII and XIX of the Social Security Act and force increasing numbers of people either to seek expensive institutional care or to be grossly neglected at home. Meanwhile, more should be done by HCFA to stress the quality of care.

Consumer Education Required

In addition to the home care programs provided under the three Titles of the Social Security Act and Title III of the Older Americans Act, there is an enormous amount of home care provided to individuals on a private pay basis. For the most part these people are in a "buyer beware" situation. In recognition of this, the National HomeCaring Council, with the Council of Better Business Bureaus, has launched a home care Consumer Education and Protection Program. A booklet entitled *All About Home Care: A Consumer's Guide* is the centerpiece of the program and is being promoted nationally.

Thank you for this opportunity to present our comments.

Sincerely,

Dr. Ellen Winston, Chairman
Social Policy and Legislation Committee

EW/mw

LONG-TERM CARE FOR THE ELDERLY AND DISABLED:

Statement Prepared for

SENATE FINANCE SUBCOMMITTEE ON HEALTH

HEARINGS ON LONG-TERM CARE

November 1983

by

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My name is Anne Somers. I am a professor in the Departments of Environmental and Community Medicine and Family Medicine at the University of Medicine and Dentistry of New Jersey-Rutgers Medical School. For three decades I have been involved in the study of health economics and in the organization and financing of health care programs. I was a member of the Health Insurance Benefits Advisory Council to Medicare, 1972-1975, and with my husband, Herman Somers, co-authored the first major study of the program, Medicare and the Hospitals, published by the Brookings Institution in 1967. We anticipated most of our current problems, including the unacceptable rise in costs.

Now we are both Medicare enrollees. And we have had a great deal of personal experience with the heartbreak and catastrophic costs of long-term care - the most urgent and most neglected area of U.S. health policy today. The tragic irony of this neglect is evident in the plight of millions of frail and dependent elders, rejected by both Medicare and Medicaid, as well as most private health insurance, even as the costs of these programs spiral upward.

Even among those who recognize the importance of long-term care (LTC), some appear prepared to settle for a second-class program, separate in both organization and financing from the acute-care mainstream. Given the centrality of chronic disease in the American health picture today, especially for the elderly, and the importance of professional continuity in prevention, diagnosis, treatment and long-term management, such separation is inappropriate and inconsistent with the goals of health-effectiveness and cost-effectiveness. Even a well-funded LTC program, if separate from the acute-care mainstream, will never achieve the same level of quality. It will remain a "stepchild," as Medicaid has been from the beginning. "Separate but equal" will not be equal in this area any more than in education. In the inevitable rationing of resources it will be much easier to shortchange LTC if it is organizationally and financially separate from acute care.

This statement is in five parts. The first three consist of proposals for remedial action; the last two provide background information and rationale for the proposals.

I. A New Proposal: Incorporation of LTC into Medicare

To meet the growing need for health-effective and cost-effective LTC, it is essential that it be incorporated into Medicare.[1/] This will require substantial adjustments in benefits, reimbursement, and other financial and administrative provisions. However, the basic eligibility provisions would remain as they are now - most persons 65 and over and the seriously disabled. The major adjustments would include:

1. Section 1862 of the Social Security Act should be amended to eliminate the ban on "custodial care" - a euphemism for LTC. The need for continuity between primary,* acute, and long-term care should be explicitly stated in the law along with a defined schedule of LTC benefits - both institutional and community- or home-based.

2. The Secretary of Health and Human Services should develop new conditions of participation for LTC providers.

3. Federal funds, currently budgeted for long-term care of the elderly and disabled under Medicaid and other programs, as determined, should be transfered to Medicare for the same purpose.

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*Good primary care includes preventive health services which are also barred for reimbursement under Section 1862. This also needs to be corrected - a subject I have dealt with elsewhere (Somers & Weisfeld, "The Challenge of Health Promotion for the Elderly." <u>Business and Health</u> 1 (November 1983): 10-14) but will not be discussed in this statement.

4. All Medicare providers - individual as well as institutional, those providing acute care as well as long-term care, should be paid on the basis of fixed or prospective rates, to be negotiated periodically between Medicare or its fiscal agents and the major provider associations.

5. Reasonable, non-deterrent patient cost-sharing formulas should be developed by the Secretary for both acute and long-term care.

6. A new federal/state/community program to coordinate the provision of long-term and acute-care benefits should be established. Actual administration would be at the community or county level, by an appropriate public or private body, within guidelines established by federal and state governments. It would have two principal functions: (a) to ensure maximum feasible coordination among health-care institutions, agencies, and programs involved in care of the elderly and disabled; and (b) to provide comprehensive assessment, appropriate placement, and cost-effective care management of individual long-term Medicare patients, under the general supervision of a responsible primary physician or group and through some appropriate interdisciplinary mechanisms, with opportunity for patient/family input.

While such a proposal envisions a substantial reorientation of U.S. health care resources, in line with changing health care needs, it is evolutionary, not revolutionary with respect to existing institutions. It builds on the strengths of our principal financing program - Medicare. Current Medicare eligibility - 95 percent of those over 65 plus those entitled to Social Security disability benefits for at least two years and most persons with end-stage renal disease - while very conservative with respect to disability, provides a practical framework for reaching the most vulnerable groups.

The proposal also reaffirms the Medicare requirement for physician responsibility, its quasi-insurance type of financing, and its high standards of quality. It builds on the momentum started by the 1980 expansion of Medicare home-care benefits (removal of the requirement for prior hospitalization under Part A and the 100-visit limit under both Parts A and B) and the 1982 hospice amendment.

At the same time, it recognizes the special complexities inherent in good long-term care - complexities relating both to the interdisciplinary nature of such care and to the length of time over which it may have to be sustained. A community-based coordinating and case-management service is proposed, but medical and legal responsibility for the individual patient remains in the hands of the primary physician or a legally defined surrogate, and eligibility for benefits is based on the same general Medicare criteria used for acute-care patients. Financial resources would play a role in determining individual patient cost-sharing but not in defining basic eligibility.

With respect to costs, the proposal primarily envisions a transfer of existing expenditures, personnel, and other resources, rather than any large additions. By transferring responsibility for long-term care of the poorest elderly and disabled from Medicaid to Medicare, it should cut Medicaid expenditures by nearly half and contribute substantially to solving the states' "Medicaid problem." The over $15 billion currently being spent by Medicaid and other public programs for nursing-home services - a figure projected to rise rapidly under existing arrangements - would constitute the near-term financial underpinning for the expanded benefits. Also, if necessary, eligibility could be limited, for the first few years, to those 75 and over and to those disabled adults of any age, who currently qualify for Medicare.

Using 1982 figures, the result would have been about 13.5 million eligibles - about 10.5 million over 75[2] and 3 million younger disabled on Medicare. The figure could be further reduced by limiting initial coverage of the elderly to those over 85, about 2.5 million.

Although total costs will inevitably rise with the increase in the number of elderly persons and continuing progress in acute care - the well-known "paradox of medical progress" - the rise should be substantially moderated by the change in methods of provider payment, appropriate use of cost-sharing provisions, better public and professional information respecting alternative therapies and settings, and continuous professional monitoring, with an emphasis, insofar as possible, on noninstitutional care.

II. Interim Steps

Despite the urgency of the LTC problem, some time is probably required for adequate public and professional education as to the need for, and goals of, the new program as well as additional experience in the organization and administration of long-term services. I suggest two kinds of interim steps:

1. Reexamination, at the highest level, of the entire Medicare program - benefits, financing, and administration. The review must be thorough, with special emphasis on the changing health needs of enrollees. Clearly, the the new focus must be chronic disease - how to prevent or postpone it where possible, how to assure early diagnosis and appropriate treatment, how to manage residual disability and minimize complications, how to provide the most humane possible death when this is inevitable - and how to do all this as cost-effectively as possible.

If the appropriate Senate and House Committees are prepared to undertake such review in the second session of the 98th Congress, so much the better. If not, then preparatory work could be undertaken though establishment of a bipartisan public/private Commission, perhaps along the lines of the recent Social Security Commission, reporting to Congress and/or the Executive in time for the 99th Congress.

In view of the importance and complexity of the issue, it would also be useful if various private or semi-public groups or foundations would undertake parallel and perhaps complementary studies and reports.

2. Gradual reorientation of existing programs and institutions away from the existing overemphasis on acute institutional care and the discontinuity between acute and long-term care financing programs, especially Medicare and Medicaid. The two bills currently before the Senate Finance Subcommittee on Health - S. 1244 and S. 1614 - are important contributions to this evolutionary development and have my enthusiastic support.

S. 1614, the more modest of the two, would amend Title XIX to authorize up to 20 states to obtain federal waivers to permit coordination of acute and long-term care for those individuals who are eligible for both Medicare and Medicaid. Although this would benefit only that relatively small minority of elderly who are eligible for Medicaid - about 13 percent in 1980 - it would not only be extremely helpful to those individuals, about 3.4 million, but would encourage the states and various provider organizations to begin tooling up for an eventual coordinated program.

S. 1244 is more ambitious in that it applies to all Medicare beneficiaries 65+. It extends the Medicare benefit package to include a significant number of LTC services. It seeks to control costs by limiting payments to providers willing to operate on the basis of capitation and through a sliding scale of patient copayments. For the first four years, it is limited to no more than four states but anticipates moving gradually to a national program.

Specific provisions of both bills should be debated. With respect to S. 1244, for example, should provider payment be limited exclusively to the capitation method? Is the specific formula provided - a monthly payment not to exceed 60 percent of the average monthly rate in free-standing skilled nursing facilities in the relevant state - too restrictive? Omission of long-term nursing home services from the new benefits is sure to raise questions as is the specific schedule of copayments. But these seem to me minor points compared to the generally positive concept. Both bills could help us move from the LTC deadend where we find ourselves today to where we want to be a decade from now.

III. Complementary Proposals

Certain changes in the institutional and professional environment must also be effected if the new LTC program is not to experience many of the same problems as the original Medicare, especially the expansion of medical technology at a rate too fast for appropriate assimilation into clinical medicine or medical ethics, with serious consequences both for costs and the best interests of the patients. The following measures should be undertaken more or less simultaneously with expansion of Medicare LTC benefits. Both are intended to help patients and their physicians arrive at considered judgements with respect to various interventions in the case of serious illness.

1. A national high-level instrumentality for objective assessment of new biomedical technologies in terms of both health and cost outcomes. It

would not have authority to ban the introduction of new procedures or devices but would have the obligation to publicize its findings.

National experience with technological assessment has been mixed. The National Council on Health Care Technology was killed in 1981 after only three years. However, the Office of Technological Assessment remains a highly respected body. The new Prospective Payment Assessment Commission, set up under P.L. 98-21, with primary responsibility for advising the Secretary of HHS with respect to payment for new procedures under Medicare, should begin to fill this need - although the issues go well beyond the question of Medicare reimbursement. Fortunately, the climate with respect to technology assessment appears to have changed substantially in the past couple of years.

2. <u>Every hospital and nursing home participating in Medicare should have in place a Patient Advisory Committee</u> to consult, on request, with seriously ill patients, their families, and physicians, with respect to certain therapeutic or diagnostic procedures as well as alternative settings of care, e.g. nursing home, home care, hospice, etc.

This proposal is in the line with New Jersey experience in establishing hospital Ethics or Prognosis Committees, as ordered by the state's Attorney General following the Quinlan Case. A 1983 survey of New Jersey hospitals reports that 64 percent of all hospitals in the state now have functioning committees.[3/] Also in 1983 the American Academy of Pediatrics and the American College of Physicians announced support for a similar recommendation by the President's Commission for the Study of Ethical Problems in Medicine, Biomedical, and Behavioral Research.[4/]

Although neither of these bodies would have any compulsory authority, their presence would help to assure more cost-effective as well as health-effective decision-making and thus contribute to the minimization of inappropriate or unnecessary services.

IV. The Growing Need for Long-Term Care

Among the many factors dictating greater attention to chronic disease and long-term care, two - the rising life expectancy of the elderly and their increase as a percentage of population - are now so well known that they need little further documentation. Although there is debate as to how long the recent striking decline in mortality among the elderly will continue, the Census Bureau's "middle" assumptions anticipate that average life expectancy at birth for women will continue to rise from 78.3 years in 1981 to 81.3 in 2005 and 83.6 in 2050.[2/] For men, the Bureau projects a rise from 70.7 in 1981 to 73.3 in 2005 and 75.1 in 2050. Already life expectancy for women of 65 is nearly 19 years; for men, about 14.5.

The Bureau also projects that the 65+ population will rise from 26.8 million in 1982 to 35 million in 2005 and 67 million in 2050. Also using "middle" assumptions as to future fertility and immigration rates, the Bureau projects that the proportion of the population, that will be 65 or more, will increase from 11.6 percent in 1982 to 13.1 percent in 2005 and 21.7 in 2050. Moreover, an increasing proportion of these will be the "old old." Those 75+ will rise from 4.6 percent of the total population in 1982 to 12 percent in 2050; those 85+ from 1.1 percent in 1982 to 5.2 percent in 2050.

Commonsense alone should have alerted us to the significant change in the national morbidity and mortality picture resulting from the aging of the population. In contrast to nations with younger populations and our own past history, the major health problems of our senior citizens are chronic - arthritis, hypertension, heart conditions, dementia, stroke, cancer, dental, hearing, orthopedic, and visual impairments, depression and other mental illness. Alzheimer's Disease, a name not even known to most Americans a decade ago, has increased in prevalence to become the most dreaded form of dementia and perhaps the fourth leading cause of death among the elderly. Significant mental illness is reported to affect 18-25 percent of those 65+.[5/] About 5 percent of the elderly are institutionalized with a rate rising to 10 percent of those 75+ and 22 percent of those 85+.[6/] Among the non-institutionalized, about 12 percent need the help of another person in one or more activities of daily living - dressing, walking, eating, toileting, etc. This figure rises to nearly 40 percent for those over 85.

The health care problems of an aging population have been exacerbated in recent years by a second and parallel demographic revolution - the "shrinking" of the American family. Multiple trends have contributed to this development - later marriages, more divorces, fewer children, more working women, smaller housing units, more geographic and socioeconomic mobility, fewer servants. Between 1970 and 1981, the size of the average household dropped from 3.14 persons to 2.73.[7/]

In 1981, 19 million individuals - 23 percent of all households - lived alone. This was a 75 percent rise over 1970. This rise in "singles" has been greatest for the younger age groups, e.g. for those 25-34, about 300 percent. The latter figure presages the future. The result is diminished family resources to help meet the increasing health needs of an aging population.[8/] There is often no one "at home" to care for the elderly widow recovering from a broken hip or the widower with paralysis after a stroke.

Add to all these problems the continuing poverty among most of our elderly. In 1982, the median income of all Americans 65+ was $6,593; for women, only $5,365.[9]

V. Inadequacy of Existing LTC Programs

Far more money is being spent on long-term care today than is generally realized. According to an estimate by the Office of the Inspector General for the Secretary of Health and Human Services, the long-term care industry accounted, in 1980, for some $32 billion, concentrated in three general sectors - nursing homes - $20.5 billion (63 percent); community or home based - $6.5 billion (20 percent); and hospitals - $5.3 billion (17 percent).[10] Assuming an increase of 15 percent per year, the 1983 figure would be close to $50 billion.

Nearly one-third of these huge funds are paid for by patients or their families out-of-pocket. The next largest segment is paid by Medicaid, mostly for nursing home care. Medicare and private health insurance (PHI) contribute primarily by default - by paying for long-term patients "backed up" in acute care hospitals because no appropriate placement is available. The balance is spread over a maze of large and small programs - V.A., Title XX, Older Americans Act, state and local government programs, private philanthropy, etc. The result is duplication and waste along with a tremendous amount of unmet need.

Following is a brief summary of the major LTC financing programs. I start with Medicare only because it is still synonymous with U.S. health policy for the elderly. It is impossible to understand or even to discuss such policy intelligently without recognizing the void that Medicare created by failure to cover LTC, a void that can only be corrected when Medicare assumes its rightful responsibility in this area.

Medicare

Following the PHI pattern, dominant in the early 1960s, Medicare focuses, almost exclusively, on short-term acute care. Section 1862 of the law specifically prohibits payment for "custodial" care as spelled out in the official Medicare Handbook:

> "Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine."

Obviously, these skills, which Medicare dismisses so contemptuously, are precisely those needed by the long-term stroke patient, the patient with Alzheimer's, or Parkinsons, multiple sclerosis, terminal cancer, or any number of other chronic conditions. The tragic irony, of course, is that Medicare will, and does, pay generously for the same patient after he/she has developed an infected bedsore, a circulatory blockage, or pneumonia, from failure to ambulate to whatever limits are possible. This is justified as a separate "episode of illness" - a concept that is increasingly obsolete in a context of chronic disease.

Not only does Medicare prohibit reimbursement for nursing home care beyond 100 days, but this is only available following hospitalization, only in a skilled nursing facility, and only when the patient is in need of skilled nursing care, which is arbitrarily and inconsistently interpreted by both the administrative intermediaries and DHSS.[11/] More and more it appears that the difference between "custodial care" and "skilled nursing care" has little to do with the degree of skill required, but a great deal to do with the patient's disease and prognosis. The Medicare message to the seriously ill patient is clear, "Get well fast, die, or get lost - unless you can qualify for another acute 'episode'"!

Spokesmen for Medicare are defensive on this point. They point out, that the program is a Godsend not only to elderly patients experiencing a first stroke or heart attack but whenever there is an acute exacerbation of a chronic condition. That is correct. But what distinguishes chronic disease from most acute disease and trauma is not the absence of acute episodes but the usually slow and insidious onset and the frequently lengthy period of disability. By definition the condition is never "cured." But if the now generally-accepted goal of good LTC is maximum functional independence for the patient, then the incentives to the system and to individual professionals should be continued improvement, rehabilitation, and the prevention of acute episodes - not just meeting them when the need arises, in at least some cases precisely because continuing care was denied.

Only in the field of home health has Medicare demonstrated some sensitivity to the growing needs of the chronically ill and the importance of linkage between acute and long-term care. From the beginning, both Parts A and B authorized up to 100 home health visits per year by a parttime skilled nurse or therapist, under physician supervision. Also, in a departure from PHI norms, Medicare permitted use of a home health aide - if one of the skilled professionals was also needed. Then, starting in 1981, the home health benefit was liberalized - at least on paper. The Part A prior-hospitalization requirement was eliminated and the 100-visit limit removed, although the limitations inherent in the requirement for skilled nursing remain. For-profit home health agencies are now permitted to qualify.

It is too soon to evaluate the impact of the new home health amendments.

Home health personnel claim that regulations have been tightened to the point that the statutory liberalization has been more than cancelled out. At least in concept, however, Medicare has now recognized the need for long-term home health services.

Despite failure to cover LTC, as well as preventive services - which many feel could help to prevent or postpone the incidence of a great deal of chronic illness and disability - and despite repeated Administration efforts at cost control - Medicare expenditures soared at an average annual rate of over 17 percent to over $52 billion in 1982.[12/] The Hospital Insurance (Part A) Trust Fund is expected to be bankrupt within a decade. In the effort to stem the rise, drastic changes in the program are now being effected and more proposed without in anyway addressing the problem of LTC.

Medicaid --

Along with direct patient or family payment, Medicaid is the primary source of funding for LTC in the U.S., especially nursing home care. As of 1980, some 1.8 million individuals, over 8 percent of all Medicaid recipients, were receiving one of the three principal long-term services - in a skilled nursing facility (SNF), intermediate care facility (ICF), or home health care, and this does not include the mentally retarded or those receiving only prescribed drugs.[13/] In 1982, Medicaid paid nearly half of all U.S. nursing home expenditures.[12/] Some authorities maintain that the American nursing home is largely a creation of Medicaid and its predecessor, Kerr-Mills Medical Assistance for the Aged.

However, this is clearly a hen-and-egg relationship. Just as the nursing home has been molded by Medicaid's welfare orientation, Medicaid itself has been vastly changed by the impact of its LTC patients. In fact, it is now widely acknowledged that Medicaid is not one but two or even three programs, depending on the category of recipient. Those 65 and over constitute only 16 percent of total recipients but account for 37 percent of the cost.[14/]

Although poor, nearly 40 percent of these elderly are not on welfare and this 40 percent accounts for nearly 3/4 of all Medicaid expenditures for this age group. This is primarily the nursing home population - formerly self-supporting individuals forced to "spend down" to the level of penury that qualifies them for a Medicaid nursing-home bed. Add the under-65 disabled and the total is still less than 30 percent of recipients but accounts for over 67 percent of all payments. By contrast, the AFDC families, the stereotypical "welfare patients," account for almost 2/3 of all recipients but less than 30 percent of payments.

Despite Medicaid's contribution to long-term care, many deep-seated problems remain. Most obvious is the fact that the program covers only the very poor - as already noted only about 13 percent nationwide. In New Jersey, the figure is only 5-6 percent. Closely related is the inconsistency in eligibility and benefit provisions among the 54 jurisdictions. For example, 20 states limit eligibility to those on SSI. Of those that do cover the "medically needy," income limits vary as much as 3:1.

Second, there is the persistent problem of political, financial, and qualitative instability, inherent in a welfare program. Despite recent success in some states in restraining costs, Medicaid remains the fastest growing financial burden for many and the LTC segment the fastest growing part of that burden. Now freed of many of the original federal requirements re. mandatory benefits, provider payment, and patient free-choice, and faced with the federal cuts of recent years, most states feel forced to cut and pinch still further. This creates hardship not only for recipients but for the providers, e.g. responsible nursing home operators or home health agencies who find advance planning and quality maintenance extremely difficult, if not impossible.

It is not surprising that a large proportion of providers, especially the better ones, refuse Medicaid patients altogether. For example, there is wide variation in the number and proportion of participating physicians in the different states. A 1982 survey reported that the ratio of participating physicians per 1000 Medicaid recipients ranged from 7.13 in Pennsylvania to 39.39 in Wyoming.[15/]

An earlier study, using 1976 data, found that nearly 60 percent of all Medicaid patients treated in private practices were seen in less than 15 percent of all such practices.[16/] While the authors rejected the allegation that most of these large Medicaid practices were "Medicaid mills" in the sense of flagrant abuse or exploitation, they did find a substantial "credentials gap." "The Medicaid market is dominated by less qualified physicians....older, non-board certified, and graduates of foreign medical schools."

Third, there is the basic incompatibility between Medicaid and the goal of a good LTC program - maximum functional independence for the patient. By limiting eligibility to those who are already seriously dependent, both medically and financially, or those who make themselves dependent for this purpose - this is called "targeting the at-risk population" - the program not only fails to encourage independent functioning but actually promotes dependency of both types. A 1974 survey by the Congressional Budget Office found that nearly half of Medicaid nursing home patients were not initially poor by state definitions but were forced to deplete their resources in order to qualify as "medically needy."[17] This percentage has almost certainly increased since that time.

A 1980 study by the former Assistant Commissioner of Health of New Jersey notes that:

> "Children are not financially responsible for the care of parents...but spouses are; hence the phenomenon of couples married 50 years divorcing to enable one of them to get nursing home subsidy without totally impoverishing the other.
>
> "The spend-down for nursing home care presents many middle-class families with an excruciating dilemma. Either they violate the law by covertly attempting to transfer the parent's assets before admission to the nursing home...or they can watch passively an inheritance go up in smoke. For those families unable or unwilling to transfer assets covertly, nursing home services have thus become the most effective barrier to intergenerational transfer of income ever seen in this country."[18]

Despite all these supposedly cost-saving limits and many more, the costs of Medicaid increased, at least through 1979, at an average annual rate of 13.6 percent. Since 1981, the rate of increase has declined slightly. Nevertheless, total 1982 expenditures were $34 billion.[12] No wonder that many states are grappling with a terrible dilemma - how to cut the costs of Medicaid while assuring that basic essential services are available to the poor and the elderly.

Private Health Insurance

Although private health insurance in the U.S. preceded Medicare by over three decades and greatly influenced the philosophy and benefit structure of the public program, once Medicare became law the two programs were neatly fitted together in a mutually complementary relationship. The basic definition of covered benefits in most private insurance, including "major medical," is the same as in Medicare. Both share the same acute inpatient bias.

The widely held "Medicare supplementary" or "Medigap" policies, sold both by the Blues and the insurance companies, are intended primarily to fill the gaps resulting from Medicare deductibles and co-insurance and an occasional uncovered benefit such as private duty nursing. The Medigap experience is significant in demonstrating the widespread public craving for comprehensive coverage and the difficulty of relying on patient cost-sharing as an effective method of cost control. As presently conceived and marketed, however, private insurance is simply not a significant factor in the financing of LTC for the elderly. In 1982, for example, it paid for 0.7 percent of nursing home expenses.[12/]

There are those who now feel that some new and "creative" financial instruments might enable private insurors to enter the market successfully. Among the suggestions, probably the best-known is the Social Health Maintenance Organization (S/HMO).

My own feeling is that the carriers are well advised to be cautious. It was their inability to successfully underwrite acute care for the elderly and disabled that led to Medicare in the first place and I can see no reason to expect any better experience with LTC. There is, I feel sure, a significant role for the private carriers and plans in the LTC field but on a subsidiary basis. A recent article in Inquiry, the Blue Cross Association Journal, challenges Blue Cross/Blue Shield to innovation in this broad area, perhaps on a joint-venture basis with some of the religious multi-hospital systems.[19/]

As another example, the insurance industry could decide to assume some responsibility for financing the exciting lifecare or continuing care retirement community concept, which could probably profit from some additional managerial and actuarial expertise.

A recent review of developments in the European health care systems, most of which have been experiencing the same financial problems as in the U.S., and proposed modifications in such systems concludes that the future belongs to a public/private mix. The following refers specifically to The Netherlands but, by implication, to most of the Continent:

> "It seems probable that the division of the population into two groups according to income level will be abolished, implying one uniform system for all people. At the same time it can be expected that market forces will be incorporated into the system. The most likely outcome will be a uniform public insurance scheme covering a minimum set of benefits, to be accompanied by regulated private insurance.[20]

In my view, such a formula could apply equally to the U.S. If agreement could be reached on such a fundamental issue, the policy debate could then focus on the nature of the appropriate mix, and financial arrangements relating thereto.

Community-Based LTC Demonstration Projects

The need for a more coordinated and efficient approach to LTC has been recognized for several years. The January 1981 Report of HCFA's Office of Policy Analysis identified many of the relevant issues and outlined a series of options and strategies for reform.[21] The change in Administration and the growing federal budgetary difficulties precluded strong federal leadership along any of the suggested lines. Aside from the VA, which has pursued an innovative but isolated LTC program of its own, the major federal contribution to the growing challenge of LTC has been the funding of several series of demonstration projects. First were the 15 Medicaid/Medicare LTC "waiver" projects; second, the National LTC Channeling Demonstration Project with ten sites. A number of other programs have been initiated by states and foundations.

Results from the "waiver" projects are discussed in a recent report by the GAO. It concluded that: "Expanded home health care can reduce nursing home use only for some subpopulations of the elderly; the effect of expanded home health care on hospital use is still unclear; some client outcome measures have shown improvement; while individual nursing home or hospital costs may have been reduced, total health care costs increased; methodological problems hamper the existing research results."[22] The report concludes: "The critical policy issue may not be whether one service is less costly than another but, rather, how new services should be organized to insure maximum efficiency and effectiveness."

* * *

The challenge of an aging population, chronic illness, and long-term disability is probably the most difficult domestic problem facing the U.S. in the next few decades. It will not be solved overnight. It will not be solved on the cheap. The proposals in this statement are not presented as panaceas. But they do provide a basis for serious study and debate. Any attempt to run away from the issue can only result in disaster. In the words of one physician:

"Unless the needs of present and future cohorts of the dependent elderly are soon addressed, a policy crisis of awesome economic, political, and moral dimensions will occur. It is past time for society to decide how it will provide for its elderly members who are delivered by modern medicine into an unprecedented and uncertain state of survivorship with extreme impairment."[23]

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