The original documents are located in Box 12, folder "Health - Home Health Care (2)" of the Sarah C. Massengale Files at the Gerald R. Ford Presidential Library.

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Comprehensive Health Planning Council
of Whatcom, Skagit, Island and San Juan Counties

P. O. Box 39
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102 South Barker Street
Mount Vernon, Washington 98273

February 22, 1976

Recipients of the Home Health Services Development Guide

Dear Reader:

The Comprehensive Health Planning Council is pleased to send you the accompanying copy of the Home Health Services Development Guide. You are receiving this Council planning document either because you have requested the Guide prior to its publication or because the CHPC staff or Board believed that you or your organization would have use for it. Our sending it now as part of a bulk mailing permits the Council to distribute the Guide at no charge to the recipients.

Two related documents cited in the Guide are in preparation and will similarly be available at no charge if requests are received prior to their distribution. One is a Critical Analysis of Home Health Services Under Medicare and Medicaid. It is a document of general applicability to the problems of under-use and under-funding of home health services under these programs. The second document is a report on a Home Health Services Survey. This report is more locally oriented, but it may be of interest to agencies considering a local study of their own.

In presenting the Home Health Services Development Guide, the Council recognizes that it is making broad recommendations that require implementation at the local-regional level, the state level, and the national level. The CHPC cannot accomplish the necessary state and national changes unless we are able to enlist the agreement and support of like-minded agencies around the nation. We hope that wide distribution of the Development Guide and the Critical Study will promote that agreement.

The Council will welcome your comments, criticism, and suggestions on the Home Health Services Development Guide. We appreciate your interest in this plan document.

Sincerely yours,

Andrew J. Frank
Executive Director

AJF:lwj

Enclosure

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SCJ.

f - home health services

HOME HEALTH SERVICES DEVELOPMENT GUIDE

November 1975

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Comprehensive Health Planning Council
of Whatcom, Skagit, Island, and San Juan Counties
102 South Barker Street
Mount Vernon, Washington 98273

The program of the Council is made possible by a grant from the U.S. Public Health Service.

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Contents

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Foreword

The Comprehensive Health Planning Council is a non-profit corporation incorporated in 1968. The Council acts to identify community health needs and problems, to recommend goals and policies for the future improvement of health and health services, to improve the coordination of health services, to provide technical and planning assistance to community organizations, and to inform the public and various community agencies and groups of facts and recommendations. All of these activities occur as part of the process of "health planning."

The Health Planning Council is funded by a federal grant which is supplemented by funds from State, county, and local government. The Council's budget the past fiscal year was approximately $100,000.

The Health Planning Council is an open membership organization with over 350 members from Whatcom, Skagit, Island, and San Juan Counties. Anyone who applies for membership is accepted. Many of these members are active on specific committees or task forces or serve on the Board of Trustees. Supported by a staff of professionally trained health planners, the Council's citizen committees research health matters, identify problems and needs, and propose recommendations to the Council's governing body, the Board of Trustees, for adoption as health policy for the entire region. A consumer majority is usually maintained on committees, task forces, and the Board of Trustees to assure that consumers have an adequate voice in the design of future changes in the health system.

This Development Guide, the third component of the Council's overall health facilities and services plan, was developed over a period of several years of research and study by members of the Council's Home Health Services Task Force. Many members of the community participated at various times on the Task Force. Here follows a listing of the people who generously donated many hours of their time toward the development of this Guide.

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This Development Guide is one of three related documents on home health services published by the Comprehensive Health Planning Council. Many of the regional findings were generated by a survey conducted early in 1975 across the region. The findings of the survey are presented in detail in the Council's Home Health Services Survey (November 1975). State and national findings on Medicare and Medicaid are derived from the Council's Home Health Services Under Medicare and Medicaid: A Critical Analysis (November 1975). These documents should be consulted by the reader who wishes more detailed information or supporting data for the findings found in this document.

An Introduction to Home Care

Definitions

The National Association of Home Health Agencies has defined home health services as "that component of comprehensive health care whereby services are provided to individuals and families in their place of residence for the purpose of promoting, maintaining, or restoring health, or minimizing the effects of illness and disability."(1*) The National League of Nursing's Council of Home Health Agencies and Community Health Services uses this definition:(2)

> Simply stated, home health care is bringing health and assistive services needed by an individual or family into the home for the purpose of preventing illness, supporting optimum health, improving or restoring body functioning and enhancing life and living. It includes all of the professional and health services which may be needed for the practical and effective care of people at home, when the home is the appropriate and accepted environment for such care.

The terms "home care" and "home health services" are used synonymously this Guide.

Uses for Home Care

Home care has been used in many different ways in various parts of the world. Some of these uses include:

- Follow-up care after hospitalization.
- Restorative and maintenance-of-function care before or after instances of inpatient care.
- Prevention of inpatient care.
- Provision of post-operative care.
- Provision of post-natal care.
- Provision of screening or case-finding services in high-density housing projects.
- Assistance with household or personal care tasks.

The following paragraphs describe other situations in which home care is an appropriate method of treatment.(3)

- When a coordinated team including professionals as well as the "user" of services and the family decide together that home care is appropriate.

---

*References may be found at the end of this and all other chapters.

- When the "user" wants to receive care in the home environment and the family relationships are conducive to and supportive of proper care.

- When the home setting can contribute to a patient's recovery.

- When the home setting is both practical and effective in improving and/or maintaining the patient's health status.

- When the acutely ill patient, either non-institutionalized or post hospital, does not need the complex care provided by a hospital.

- When a patient, such as one with a cardiac disorder, requires a prolonged convalescence.

- When a patient recovering from a fracture or handicapped with arthritis is in need of rehabilitative measures.

- When a patient with a long-term illness or chronic illness is in need of supportive care.

- When a patient ill with a terminal illness would be happier and can be cared for adequately at home.

Types of Home Health Services

The Council of Home Health Agencies and Community Health Services has described two categories of "essential" services that should be provided by home health programs and paid for by health insurance programs.(4)

Basic Essential Services

Homemaker/home health aide
Medical supplies and equipment
Nursing
Nutrition
Occupational therapy
Physical therapy
Speech pathology services
Social work services

Other Essential Services

Services that should be provided by the program directly:

Home delivered meals
Housekeeping services
Information and referral services
Patient transportation and escort services
Prescription drug delivery
Respiratory therapy services

Services that should be arranged for by the program and facilitated, if necessary, by patient transportation services:

Audiological services
Dental services

Laboratory services
Ophthalmological services
Physician services
Podiatry services
Prosthetic/orthotic services
X-ray services

In addition to the two categories of essential services, a set of "desirable" home health services should also be available in the community:

Desirable Services

Barber/cosmetology services
Handyman services
Heavy cleaning services
Legal and protective services
Pastoral services
Personal contact services
Recreation services
Translation services

Organizational Models

Home health literature usually describes the organization of home health services according to two models. The more traditional model categorizes services into three groups according to the scope and intensity of services required by the patient. The most complex service category is called the Intensive Level. At this level, the program would be characterized by the provision and coordination of a broad range of professional and ancillary home health services. Patients receiving care at this level would probably require quite a variety of services in considerable quantity. At the Intermediate Level, more stable and less demanding patients would require fewer services and less patient care coordination than patients at the Intensive Level. The third level, the Minimum Level, would be characterized by the provision of the less skilled and less intensive home health services to relatively stable and healthy patients. Homemaker/home health aide services or housekeeping services are the services most likely to be needed by this group of patients. These three categories of home care parallel similar categories of hospital care: intensive, basic or general, and post-acute skilled nursing ("extended care") services.

A newer model proposed by the Council of Home Health Agencies and Community Health Services splits home care programs into two basic categories.(5) The "Home Health Program 1," the more comprehensive of the two categories, would provide home nursing and at least two of the other Basic Essential services. In addition, this type of program should provide patient care, consultative, administrative, and accounting and record-keeping services for the secondary program, the "Home Health Program 2." The latter program is characterized as providing nursing services directly while contracting or arranging for the provision of other Basic Essential services. Both types of Programs should attempt to provide or arrange for the provision of the Other Essential Services.

Administrative Locus

Home health services can be provided and administered by virtually any group, but services are usually provided by hospitals, health departments, independent non-profit agencies, or even nursing homes. In our region there is an independent non-profit home health agency in Whatcom County that will serve Medicare, Medicaid, and other patients, while the health department-based home health agencies in Skagit and Island Counties serve only Medicare patients. In addition, a new program funded by the Comprehensive Employment Training Act (CETA) has been organized in Bellingham to provide health aide/housekeeping services. Despite the program's successful performance, the program is likely to end with the termination of CETA funding unless other sources of funding are found. Attachment 1 shows some of the kinds of needs the CETA-funded program has been meeting.

Funding Sources

A variety of third-party payers will reimburse home health services.

National Programs

1. Medicare. Primarily designed for the elderly and the chronically disabled, the Medicare program will pay for a number of home health services: part-time skilled nursing, physical therapy, speech therapy, occupational therapy, home health aide services, medical social services, and medical supplies or appliances.

2. Medicaid. Designed for certain categories of needy or disabled persons, the Medicaid program pays for those home health services a participating state decides to include in its state Medicaid plan.

3. CHAMPUS. (Civilian Health and Medical Program of the Uniformed Services) CHAMPUS is a federal health insurance program for retired military personnel and the dependents of active duty military personnel. The program will pay the major portion of the charges for "medically necessary" home health services when ordered by the attending physician and provided by an "authorized provider of care."

State

1. Blue Cross of Washington/Alaska. Home health services benefits are routinely included in both major and minor medical insurance plans.

2. Workmen's Compensation. Injured workers eligible for Workmen's Compensation may have virtually any kind of home health service ordered by the attending physician reimbursed by the program.

Local

1. Whatcom County Physicians Service. Most contracts provide limited home health benefits.

2. Commercial Insurance Companies. A telephone survey of Skagit County commercial insurance companies conducted late in 1974 appears to indicate that they provide little coverage of home care services. Of the 18 companies contacted,

   4 provided no health insurance packages.

   14 provided health insurance packages:

   3 were known to provide coverage of home care,
   5 do not provide coverage of home care, and
   6 agents did not know whether home care was covered.

3. Skagit Medical Bureau. The Skagit Medical Bureau sells no contracts with home health services benefits.

References

1. National Association of Home Health Agencies, "Statement of the National Association of Home Health Agencies Before the Committee on Ways and Means, U.S. House of Representatives." Exhibit G. (mimeo), May 23, 1974.

2. Council of Home Health Agencies and Community Health Services of the National League of Nursing, Home Health Care. Publication No. 21-1497.

3. Ibid.

4. Council of Home Health Agencies and Community Health Services of the National League of Nursing, Proposed Model for the Delivery of Home Health Services. Publication No. 21-1550, pp. 2-3.

5. Ibid., pp. 3-8.

The Cost-Effectiveness of Home Health Services

Home visits may appear to be too expensive or too inefficient to be worth using in this age of reliance on sophisticated medical technology, but a number of reports and studies have demonstrated the real dollars and cents value of home care programs. The savings generated by home care derive mainly from reductions in the use of inpatient health facilities since home care can prevent admissions and readmissions and shorten lengths of stay. By reducing demand for inpatient facilities, home care also prevents the need for construction of additional facilities. The studies to be described have each shown the value of home care.

1. Study of Health Facilities Construction Costs(1)

In its 1972 report to Congress, the Comptroller General's office discussed the value of home care in preventing the need for construction of new inpatient health facilities.

> Patients on home care also pay a good deal less than the rate they would have to pay in a general hospital, and there is a growing sentiment among medical economists that a well-conceived home care program could make unnecessary the construction of a substantial number of new general hospital beds. One source estimated that a home care program with a caseload of 50 patients could be an adequate substitute for construction of an equivalent number of hospital beds occupied by patients who require home care but not hospital care.

The Comptroller General's report discusses a number of studies that have indicated the cost-effectiveness of home health services when substituted for inpatient services.

a. A 1970 study prepared by the Health Economics Branch of the Bureau of Health Services of the Public Health Service estimated that 2.6 percent of the nation's inpatient hospital days could be eliminated by transfer of bed patients to home care programs. Potential savings: 5.8 million hospital days, 20,000 freed beds.

b. Several studies cited by the Comptroller General compared cost per day for home care with cost per day for hospital care.

- Michigan Blue Cross, 1967.	$4 per day for home care, $51 per day for hospital care.
- Pennsylvania Blue Cross, 1961-1970.	$8 per patient day for home care. $1.3 million in inpatient care saved, about $330 per case.
- National averages, 1963 to 1969.	Hospital cost per day rose from $39 to $70. Home care cost per day rose from $3 to $8.

2. Home Health Services in the U.S.(2)

This report prepared for the Special Committee on Aging of the U.S. Senate discusses several instances of savings generated by the use of home care.

a. Home Care Association of Rochester, N.Y., 1970. 42 hospital beds released, 653 hospital admissions prevented.

b. Associated Hospital Services of N.Y., 1965. 5,000 cases of home care reduced the volume of hospital care by 113,000 inpatient days, about 22 days per case.

c. Denver Department of Health and Hospitals, 1970. For 292 hospital patients admitted to home care, there was a savings of 19.2 hospital days per patient.

d. Blue Cross of Greater Philadelphia, 1961-1970. Among 3,940 home care patients, there was a savings of 12.9 hospital days per patient. The reduction in patient days freed 6.6 hospital beds.

3. Reported Savings on Hospital Costs Through Home Care(3)

The studies included in this packet distributed by the National Association of Home Health Agencies describe seven different home care programs and the savings generated by each. See Attachment 2 for details.

4. Home Care and Extended Care in a Comprehensive Prepayment Plan(4)

This excellent study examined the impact of new home care and extended care facility (ECF) services in a Kaiser-Permanente prepaid health plan in Oregon during 1968. The study found that:

- When actual hospital utilization in 1968 was compared to the anticipated rates based on age-adjusted 1966 data, there was an apparent decrease of 14 percent (7,722 hospital days).
- The Medicare population had the greatest proportionate reduction in hospital utilization (27 percent, or 4,097 days), although the rates for the non-Medicare population were also reduced.
- It appears that much of the apparent reduction in hospitalization was a result of the availability of the home care and ECF services. Data suggest that most of these savings can be attributed to the ECF, rather than the home care service.
- The cost of the home care service for the entire health plan population was $1.78 per person per year; the cost per Medicare member per year was $13.10, and per non-Medicare member per year, $0.86. The cost per visit was $20.99; the cost per patient day, $5.26.

The authors discussed an interesting impact of the new home health and extended care services on Kaiser-Permanente's already low rate of hospital use:

> ...the home care and ECF services were added to a comprehensive medical care system with a history of low hospital utilization. Even in this setting, the addition of new services apparently brought about a reduction in hospital utilization. It seems reasonable to assume that a far greater reduction might be achieved if these services were added to a system where hospital utilization more closely approximated the national average.

5. Older Persons After Hospitalization: A Controlled Study of Home Aide Services(5)

This 1967 study attempted to determine the impact of health aide services provided to patients discharged from a geriatric rehabilitation hospital. Patients receiving health aide services constituted the experimental group while a similar group of patients receiving no health aide services was used as a control group. The study found that:

- There was no significant difference between the two groups' survival rates.
- The group receiving services displayed significantly greater contentment, defined as the patient's own assessment of his or her quality of life.
- The group receiving services required significantly fewer days of care in long-term care facilities.
- There was no significant difference between the two groups' rates of hospital admission.

This study shows that health aide services help reduce the use of long-term care facilities by the elderly and increase the contentment of persons receiving services.

6. Postoperative Care: In Hospital or at Home?

A study conducted at a teaching hospital at Cali, Columbia, attempted to determine the impact of providing post-operative care at home to patients receiving surgery for hernia repair, vaginal hysterectomy, or vein stripping. The study found that the duration of convalescence was significantly shorter for home care patients who had hernia repairs or hysterectomies compared to similar patients who received their post-operative care in the hospital. The cost of post-operative care at home was 75 percent less than the cost of post-operative care in the hospital.

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7. Home Care Services Through the University of Southern California Medical Center(7)

A program of home care operated during 1973 in conjunction with the University of Southern California Medical Center reported cost savings, improvements in the quality of care, and patient and physician satisfaction with the program. Six relatively complicated orthopedic patients alone, transferred to the program from the hospital, saved an estimated 270 days of hospital care, about $75,000. Two groups of home care patients studied, one with recurrent congestive heart failure, the other with chronic obstructive pulmonary disease, were found to show significant reductions in hospital admissions, hospital days, emergency room visits, regular clinic visits, and specialty clinic visits. Savings amounted to approximately $82,000 for these two groups of patients.

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1. Comptroller General of the U.S., Report to the Congress, Study of Health Facilities Construction Costs, Enclosure C. 1972, pp. 48-57.

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3. National Association of Home Health Agencies, "Statement of the National Association of Home Health Agencies Before the Committee on Ways and Means, U.S. House of Representatives," Exhibit C. (mimeo), May 23, 1974.

4. Hurtado, Arnold V.; Greenlick, Merwyn R.; Saward, Ernest W.; Home Care and Extended Care in a Comprehensive Prepayment Plan. Hospital Research and Educational Trust, Chicago, Illinois, 1972, pp. 96, 98.

5. Nielsen, Margaret et al., "Older Persons After Hospitalization: A Controlled Study of Home Aide Service." American Journal of Public Health, 62:1094-1101, August 1972.

6. Echeverri, O., "Postoperative Care: In Hospital or at Home?," International Journal of Health Services. 2:101-110, February 1972. Reported in Medical Care Review, May 1974, p. 666.

7. "Complementary Home Care Said to Cut Cost, Improve Quality of Hospital Therapy," Family Practice News, 5:1, May 1, 1975. Reported in Medical Care Review, June 1975, p. 688.

The Need for Home Health Services

This chapter first reviews a number of studies that have attempted to determine or estimate the need for home health services among various population groups. The need estimates contained in the studies are then applied to two population groups: persons under 65 years of age and persons over 65 years of age. In the next chapter the empirically-determined need for services by these two groups will be compared to historical patterns of utilization of services in order to determine the extent to which the need for services has been met.

A. Studies of Need

1. "Three Approaches to Estimating Need for Personal Care Services"(1)

This 1972 paper, written by Barbara J. Sproat, a staff member of the Levinson Gerontological Policy Institute, examines various National Health Survey statistics on age-related disability as a basis for predicting the need for personal care services among the non-institutionalized disabled elderly. Sproat used a figure of 13.8 percent of the non-institutional elderly as an estimate of need. This figure represents the proportion of non-institutional elderly unable to carry on major activity as determined by data collected in the National Health Survey between 1965 and 1967. Sproat's paper shows that this estimate of 13.8 percent is supported by data collected in a cross-national study conducted in Denmark, England, and the United States and published in 1968 which showed that 10 percent of the non-institutional elderly in these three countries were housebound or bedfast while another 5 percent experienced serious incapacity.

Since the Sproat paper was written, however, more recent data from the 1969-1970 National Health Survey have been published. These data indicate that 16.4 percent of the non-institutional elderly are unable to carry on major activity, such as working or keeping house.(2) Thus, using inability to carry on major activity as the basis for predicting need, we can estimate that 16.4 percent of the non-institutional elderly need some degree of personal care services.

In addition to the non-institutional elderly, the Sproat paper also considered personal care service needs among the institutionalized elderly. After reviewing 1964 data published by the Public Health Service which estimated that 39 percent of the residents of nursing and personal care homes may not need to be institutionalized, Sproat proposed a more conservative figure of 25 percent of the institutionalized elderly as an estimate of need for (non-institutional) personal care services.

Thus, the Sproat paper leads to a need estimate of 16.4 percent of the non-institutional elderly and 25 percent of the institutional elderly.

Sproat acknowledges, however, that her estimates may be too high in light of "home help" utilization rates reported in several European countries. (Home help services correspond to services provided by homemaker/home health aides.) She writes that five to six hours of home help services per week are reportedly provided to 15 percent of Sweden's pensioners each year, to 7 percent in Denmark, and 6 percent in Norway. Sproat reports that, "All three (European) counties have experienced either a slight decrease or at least stabilization of the rate of institutionalization among the elderly and handicapped since their home help program became widespread."

Among non-institutionalized persons under 65 years of age, the 1969-70 National Health Survey found that 1.4 percent are unable to carry on major activities.(3) This figure represents a need estimate for this age group when Sproat's criterion of inability to carry on major activity is used.

2. "Health Status of Older People, Cross-National Implications"(4)

This article reports findings of a study of the health status of non-institutionalized older people in Britain, Denmark, Israel, Poland, the United States, and Yugoslavia based on data collected during the 60's. The study found that from two to four percent of the non-institutionalized elderly in every country studied are bedfast at home. The author reports that, "From 4 to 8 percent of the elderly living at home, excluding the bedfast, appear to have marked needs for help with even the simplest physical tasks related to their self-maintenance." Including the bedfast, we could estimate that from 6 to 12 percent of the elderly need help at home.

This study also reports on the use of long term care facilities by the aged in Britain and Denmark, countries with well-developed home health services. In Britain in 1969 only 2.5 percent of the elderly were residents of long term care facilities. Denmark bases its planning of residential and nursing home facilities on a need estimate of 4 percent of the elderly.

3. "Home Health Services: A National Need"(5)

This position paper adopted by the Governing Council of the American Public Health Association in 1973 is a formal expression of the Association's viewpoint on the issue of home health services' need. The adopted paper provides additional support for the Sproat paper's estimates of need for services among institutionalized patients:

> Development of long-term care facilities has grown impressively in recent years, but there is considerable evidence that we are using many of them inappropriately. A list of studies on the subject is attached (see Appendix A), but in sum, they show that, in the nursing homes studied, from 20 to 50 percent of patients could have used less costly levels of care...

At least 10-25 percent of the population now in institutional homes of varying kinds could be cared for and remain in their own homes if organized services beyond episodic nursing and medical care were available.

4. "European Home Health Services"(6)

Home help services were reported to have been used by 11 percent of the elderly in Sweden during a typical week in 1969. Although level of use does not necessarily equate with level of need, this Swedish utilization figure provides an estimate of the volume of home care routinely provided to the elderly in the country.

5. "Assessing the Health Care Needs of the Aged"(7)

In this study a multi-disciplinary health team reviewed the appropriateness of residential and patient care placements among the elderly of Monroe County, New York, during 1964. The study found that 83.4 percent of the elderly could live independently at home. Another 6.7 percent of the elderly could live at home if provided with public health nursing services.

6. Home Care and Extended Care in a Comprehensive Prepayment Plan(8)

Perhaps the most carefully conducted, controlled, and documented study of the need for home care services was performed by the Kaiser-Permanente Medical Care System in Portland, Oregon, during 1967-68. Extended care and Medicare-eligible home care services were introduced into the Kaiser-Permanente prepaid group practice plan and carefully monitored for their impact on costs and utilization of other services. Elderly persons used Medicare-eligible services at the rate of 31.8 patients per 1,000 elderly enrollees, or 3.2 percent of the elderly population. It is important to note that home help-like services were not made available to the target group of the study. It should also be noted that the study was conducted prior to 1969 Medicare changes, still in effect, that restricted the use of Medicare home health services.

Other data reported in this study show that 5.7 percent of the elderly who were hospitalized over the course of the study subsequently used home health services.(9) Of the group receiving home care after hospitalization, 19 percent received home care immediately following hospitalization while the remaining 81 percent received home care subsequent to discharge from an extended care facility.

The study also found that its under-65 population was referred to home health services at the rate of 2.0 referrals per 1,000 persons under age 65.(10) Among under-65 persons who were hospitalized, 1 percent subsequently received home health care.

B. Summary of Need Studies

The following table lists need estimates by study.

Study Number	Need Among Persons Age 65+	Need Among Persons Under Age 65
1	16.4% noninstitutional 25% institutional 6% to 15% noninstitutional, Europe	1.4% noninstitutional
2	6% to 12% noninstitutional	
3	10% to 25% institutional	10% to 25% institutional
4	11% noninstitutional	
5	6.7% noninstitutional	
6	3.2% noninstitutional 5.7% hospitalized	2% noninstitutional 1% hospitalized
All	3.2% to 16.4% noninstitutional 10% to 25% institutional 5.7% hospitalized	1.4% to 2% noninstitutional 10% to 25% institutional 1% hospitalized

C. Demographic Profile of Persons Over Age 65

One's health status generally decreases with age. Attachment 3 shows that restricted activity days and bed disability days increase markedly between age 55 and 65. Attachment 4 shows that the prevalence of chronic conditions increases with age, as does limitation in activity. Attachment 5 shows that the low income elderly are at increased health risk compared to higher income elderly; activity-limiting chronic conditions are considerably more prevalent among the low income elderly.

It is important to note that 25 percent of the region's elderly (over 4,800 persons) were estimated by the 1970 Census to have incomes less than poverty level.(11) On the average, a poverty income level for a person age 65 or more was defined in 1970 to be $1,498 per year for a farm resident, $1,757 per year for a non-farm resident.(12) (These figures imply a monthly income between $125 and $146.) Thus, at least 25 percent of the elderly in our region fall on curve (A) of Attachment 5, the curve of greatest prevalence by age of activity-limiting chronic conditions. This particular group of elderly persons, the low income elderly, has the greatest need for health care services and the least ability to pay out-of-pocket expenses connected with that care.

Attachment 6 shows the distribution of elderly in this region and the State between 1970 and 1975, and Attachment 7 shows expected numbers of elderly in 1980. Attachment 8, which shows enrollment in Part A (Hospital Insurance) of Medicare, should be compared with Attachment 6. Such comparison shows that in 1970, 97 percent of the region's elderly were enrolled in Part A of Medicare. These three tables establish population data to be used in considering the need for home health services among the elderly in this region and the State of Washington.

D. Demographic Profile of Persons Under Age 65

Attachment 9 shows population figures for the under-65 population for this region and the State as a whole. Attachment 10 shows population estimates for 1980.

E. Computation of the Need for Home Health Services

Combining need and population estimates, this section computes estimates of numbers of persons in need of home health services. The tables which show these estimates begin on the following page.

Region, Over 65

Area and Year	Patient Category	Target Population	Need Estimate	Persons in Need of Services
Region				
1974	Noninstitutional, over 65	19,601[a]	16.4%	3,126
1980 low		22,583[b]		3,704
1980 high		25,048[c]		4,108
1974		19,601	3.2%	627
1980 low		22,583		723
1980 high		25,048		802
1974	Institutional, over 65	1,429[d]	25%	357
1974		1,429	10%	143
1974	Hospitalized, over 65	6,414[e]	5.7%	366

Region, Under 65

Area and Year	Patient Category	Target Population	Need Estimate	Persons in Need of Services
Region				
1974	Noninstitutional, under 65	149,471[f]	2%	2,989
1980 low		156,012[g]		3,120
1980 high		168,156[h]		3,363
1974		149,471	1%	1,495
1980 low		156,012		1,560
1980 high		168,156		1,682
1974	Institutional, under 65	299[i]	25%	75
1974		299	10%	30
1974	Hospitalized, under 65	19,214[j]	1%	192

Footnotes for Regional Need Estimates

a. Figure is the difference between the number of aged persons present in the general population (21,030) and the number in nursing homes (1,429). Latter figure is taken from the Comprehensive Health Planning Council's Nursing Home Development Guide, May 8, 1975, p. 34.

b. This figure is based on estimates shown in Attachment 7. Four percent of the elderly are assumed to be nursing home residents in 1980. In 1974, 6.8 percent of the region's elderly were in nursing homes.

c. Ibid.

d. Comprehensive Health Planning Council of Whatcom, Skagit, Island, and San Juan Counties, A Nursing Home Development Guide, Mount Vernon, Washington, May 8, 1975, p. 34.

e. State of Washington, Office of Planning and Health Facilities. Hospital Utilization Report, Olympia, Washington, 1974.

f. Figures is the difference between the number of persons present in the general population (149,770) and the number in nursing homes (299). Latter figure is taken from the Comprehensive Health Planning Council's Nursing Home Development Guide, May 8, 1975, p. 34.

g. This figure is based on estimates shown in Attachment 10. The same proportion of under-65 persons is assumed to be present in nursing homes in 1980 as in 1974.

h. Ibid.

i. Comprehensive Health Planning Council of Whatcom, Skagit, Island, and San Juan Counties, A Nursing Home Development Guide, Mount Vernon, Washington, May 8, 1975, p. 34.

j. State of Washington, Office of Planning and Health Facilities, Hospital Utilization Report, Olympia, Washington, 1974.

State, Over 65

Area and Year	Patient Category	Target Population	Need Estimate	Persons in Need of Services
State				
1974	Noninstitutional, over 65	328,282[a]	16.4%	53,838
1980 low		381,592[b]		62,581
1980 high		417,291[c]		68,436
1974		332,149	3.2%	10,629
1980 low		381,592		12,211
1980 high		417,291		13,353
1974	Institutional, over 65	23,198[d]	25%	5,800
1974		23,198	10%	2,320
1974	Hospitalized, over 65	124,032[e]	5.7%	7,070

State, Under 65

Area and Year	Patient Category	Target Population	Need Estimate	Persons in Need of Services
State				
1974	Noninstitutional under 65	3,091,688[f]	2%	61,834
1980 low		3,269,696[g]		65,394
1980 high		3,575,581[h]		71,512
1974		3,091,688	1%	30,917
1980 low		3,269,696		32,697
1980 high		3,575,581		35,756
1974	Institutional, under 65	4,932[i]	25%	1,233
1974		4,932	10%	493
1974	Hospitalized, under 65	429,898[j]	1%	4,299

Footnotes for State Need Estimates

a. Figure assumes that 93.4 percent of the elderly are non-institutional. See note d below.

b. Figure assumes that 4 percent of the state's elderly will be nursing home residents in 1980.

c. Ibid.

d. Source: Washington State Office on Aging, "An Action Program to Serve the Elderly in Washington State." (mimeo) The Program Summary states that 6.6 percent of the state's elderly are in nursing homes.

e. Source: State of Washington, Office of Planning and Health Facilities, Hospital Utilization Report, Olympia, Washington, 1974.

f. Figure found by subtracting estimated institutional population (4,932) from 1974 population shown in Attachment 9.

g. Figure assumes that 0.15 percent of the under 65 population will be institutionalized in 1980. Base population obtained from Attachment 7.

h. Ibid.

i. Figure derived from average daily nursing home census for 1974 less the number of elderly patients estimated in footnote a above. The 4,932 under-65 patients represent 20 percent of the total nursing home population.

j. Source: State of Washington, Office of Planning and Health Facilities, Hospital Utilization Report, Olympia, Washington, 1974.

Summary of Need Estimates: Four County Region

(All estimates over 100 rounded to nearest hundred)

Year	Patient Category	Persons in Need of Services: Institutional and Noninstitutional (A+B)	Noninstitutional Only (A)	Institutional Only (B)	Former Hospital Patients
1974	Over 65	700 to 3,500	600 to 3,100	100 to 400	400
1980 low			700		
1980 high			4,100		
1974	Under 65	1,500 to 3,100	1,500 to 3,000	30 to 75	200
1980 low			1,600		
1980 high			3,400		
1974	All Ages	2,200 to 6,600	2,100 to 6,100	100 to 500	600
1980 low			2,300		
1980 high			7,500		

These figures show that home health services should have been provided to between 2,200 and 6,600 persons in our region in 1974. The 2,200 person figure represents a minimum based on the most conservative need estimates. About 600 former hospital patients should have received home health services. By 1980, home health services will be needed by 2,300 to 7,500 persons.

Summary of Need Estimates: State of Washington

(All estimates rounded to nearest hundred.)

Persons in Need of Services

Year	Patient Category	Institutional and Noninstitutional (A+B)	Noninstitutional Only (A)	Institutional Only (B)	Hospital Patients
1974	Over 65	12,900 to 59,600	10,600 to 53,800	2,300 to 5,800	7,100
1980 low			12,200		
1980 high			68,400		
1974	Under 65	31,400 to 63,000	30,900 to 61,800	500 to 1,200	4,300
1980 low			32,700		
1980 high			71,500		
1974	All Ages	44,300 to 122,600	41,500 to 115,600	2,800 to 7,000	11,400
1980 low			44,900		
1980 high			139,900		

Home health services should have been provided to between 44,300 and 122,600 persons across the State in 1974. Over 11,000 former hospital patients should have received services. By 1980, between 44,900 and 139,900 persons should receive home health services.

References

1. Sproat, Barbara J., "Three Approaches to Estimating Need for Personal Care Services." Levinson Gerontological Policy Institute, Brandeis University, Waltham, Massachusetts (mimeo), June 1972.

2. National Center for Health Statistics, Limitation of Activity Due to Chronic Conditions. Vital and Health Statistics, Series 10, No. 80, U.S. Government Printing Office, p. 5.

3. Ibid., pp. 5, 17.

4. Shanas, Ethel, "Health Status of Older People, Cross-National Implications." American Journal of Public Health, 64:261-264, March 1974.

5. American Public Health Association, "Home Health Services: A National Need." American Journal of Public Health, 64:179-183, February 1974.

6. Trager, Brahna, Home Health Services in the United States, A Report to the Special Committee on Aging, United States Senate, U.S. Government Printing Office, 1972, p. 40.

7. "Berg, Robert L. et al., "Assessing the Health Care Needs of the Aged." Health Services Research. Spring 1970, pp. 36-59.

8. Hurtado, Arnold V.; Greenlick, Merwyn R.; Saward, Ernest W., Home Care and Extended Care in a Comprehensive Prepayment Plan. Hospital Research and Educational Trust, Chicago, Illinois, 1972, p. 40.

9. Ibid. Derived from Tables 3, 5, 13, and 21.

10. Ibid., p. 40

11. U.S. Department of Commerce, Bureau of the Census, General Social and Economic Characteristics, Washington. U.S. Government Printing Office, Washington, D.C., 1972, Table 124.

12. Ibid., Appendix B, p. App-30.

The Use of Home Health Services

A. Use of Services by the Elderly

The following table shows the number of Medicare patients served by home health services in our region over the past five years.

Medicare Beneficiaries Served, Region[1]

Year	Regional Total	Whatcom	Skagit	Island
1970	308	183	125	0
1971	255	98	141	16
1972	301	131	140	30
1973	268	107	131	30
1974	280	95	158	27

As we saw on page 21, between 700 and 3,500 elderly persons in the region (depending on the estimate used to predict need) should have received home health services in 1974. The 280 persons served met, at best, only 40 percent of the most conservative estimate of need. In comparison with the more liberal estimate of 3,500 persons in need, however, the 280 persons served met only 8 percent of the need. Thus, only 8 to 40 percent of the need for home health services among the elderly was met in 1974.

Aside from the large unmet need for home health services among the region's elderly in 1974, the five-year utilization figures above also show that there has been essentially no change in the number of elderly served between 1970 and 1974. This no-growth pattern of home health services utilization stands in rather sharp contrast to increases in the size of the aged population in the region and increases in the aged population's use of institutional health services over the same period:

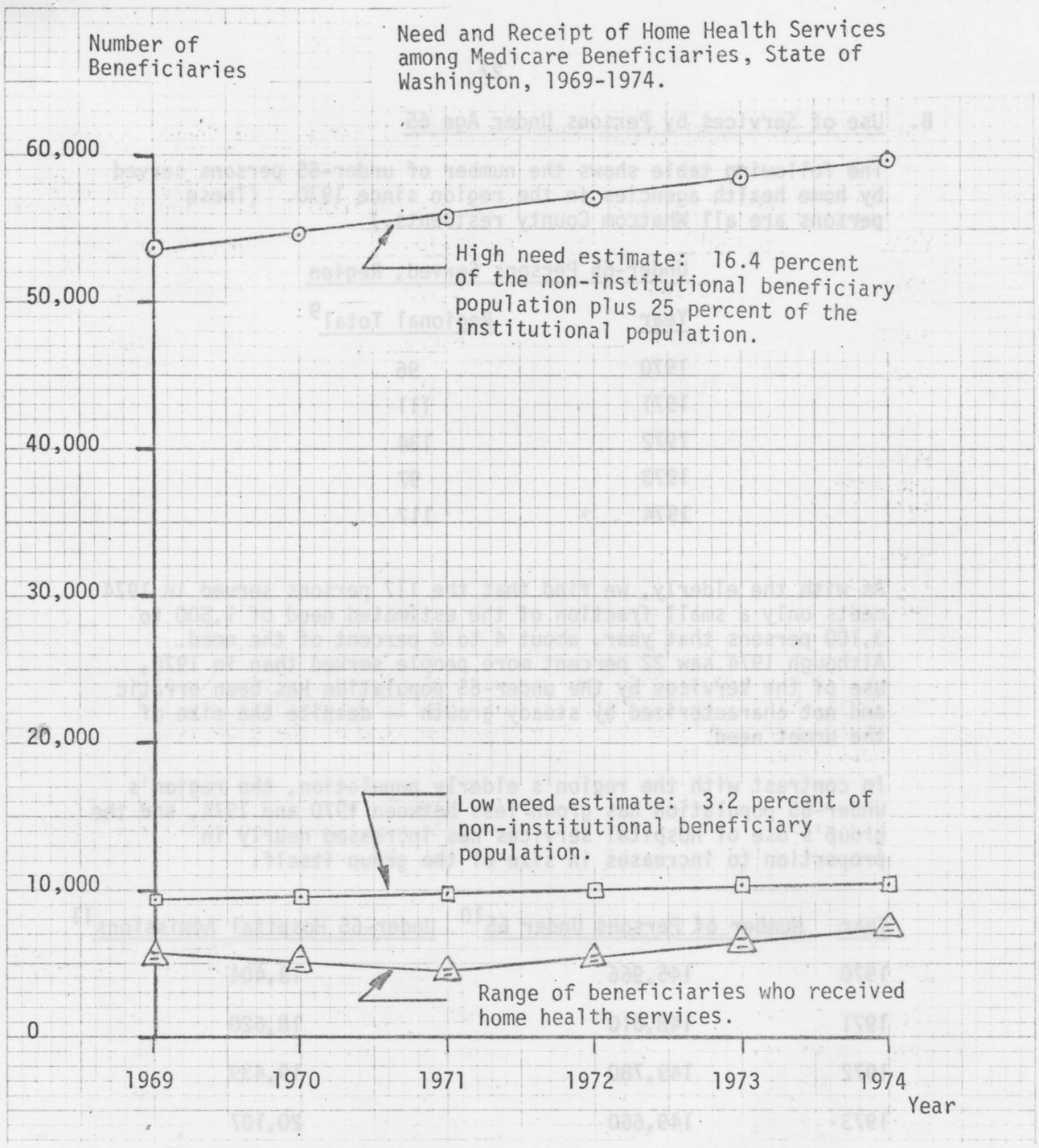
Use of Institutional Health Services by the Elderly, Four County Region

Year	Number of Persons Age 65+[2]	Medicare Hospital Admissions[3]	Elderly Title XIX Nursing Home Patients per Month[4]
1970	19,265	5,173	706
1973	20,540	6,078	780
1974	21,031	6,414	?
Percent Increase, 1970-73	6.6%	17.5%	10.2%
Percent Increase, 1970-74	9.2%	24.0%	?

Unlike the use of home health services, the elderly's use of institutional health services has increased substantially since 1970, considerably more than the size of the elderly population itself.

Use of home health services by Medicare beneficiaries across the state has also been routinely lower than minimum need estimates. The following table and chart show this pattern.

Year	Need for Services Maximum[5]	Need for Services Minimum[6]	Persons Receiving Services[7]	Percent of Minimum Need Met[8]
1969	53,785	9,474	5,300 to 5,700	60%
1970	54,703	9,653	4,900 to 5,600	58%
1971	55,943	9,854	4,200 to 4,500	46%
1972	57,075	10,054	5,100 to 5,300	53%
1973	58,538	10,311	6,100 to 6,800	66%
1974	59,895	10,371	7,300 to 7,700	74%



The Medicare beneficiary population in Washington State is characterized by consistent unmet need for home health services.

Need estimates assume that 6.6 percent of the beneficiary population is institutionalized each year.

Utilization data taken from home health agency Medicare cost reports.

B. Use of Services by Persons Under Age 65

The following table shows the number of under-65 persons served by home health agencies in the region since 1970. (These persons are all Whatcom County residents.)

	Under-65 Persons Served, Region
Year	Regional Total[9]
1970	96
1971	111
1972	134
1973	97
1974	117

As with the elderly, we find that the 117 persons served in 1974 meets only a small fraction of the estimated need of 1,500 to 3,100 persons that year, about 4 to 8 percent of the need. Although 1974 saw 22 percent more people served than in 1970, use of the services by the under-65 population has been erratic and not characterized by steady growth -- despite the size of the unmet need.

In contrast with the region's elderly population, the region's under-65 population has grown less between 1970 and 1974, and the group's use of hospital services has increased nearly in proportion to increases in size of the group itself.

Year	Number of Persons Under 65[10]	Under-65 Hospital Admissions[11]
1970	145,966	18,404
1971	148,610	18,620
1972	149,780	19,439
1973	149,660	20,107
1974	149,770	19,241
Percent Increase,		
1970-74	2.6%	4.5%

Comparable data on use of services by the under-65 population are not available for the state as a whole.

References

1. Data source: Medicare cost reports from home health agencies within the region.

2. Source: Attachment 6.

3. Data sources:

1970-1973	Comprehensive Health Planning Council of Whatcom, Skagit, Island, and San Juan Counties, Health Indicators Report, 1968-1973. Mount Vernon, Washington, August 1975, Table 26.
1974	State of Washington, Office of Planning and Health Facilities, Hospital Utilization Report. Olympia, Washington, 1974.

4. Comprehensive Health Planning Council of Whatcom, Skagit, Island, and San Juan Counties, A Study of the Title XIX Program, Whatcom, Skagit, Island, and San Juan Counties, and the State of Washington, 1968-1973. Mount Vernon, Washington, February 1975, Table 7.

5. Maximum need is defined as 16.4 percent of the noninstitutional beneficiary population plus 25 percent of the institutional beneficiary population. The institutional population is assumed to include 6.6 percent of the total beneficiary population each year. Beneficiary population figures are taken from Medicare enrollment figures shown in Attachment 8.

6. Minimum need is defined as 3.2 percent of the noninstitutional beneficiary population. The noninstitutional population includes 93.4 percent of the total beneficiary population each year. Beneficiary population figures are taken from Medicare enrollment figures shown in Attachment 8.

7. These figures are derived from Medicare cost reports from home health agencies across the state. Exact figures on persons receiving services are not available because several agencies reported no data. Estimates were generated for these agencies from other data provided by them on numbers of Medicare visits and amounts of Medicare reimbursement. The methodology is shown below for 1974.

   Total visits, agencies not reporting number of patients: 33,675
   Visits per patient, agencies reporting number of patients: 8.9
   Estimated patients: 33,675 ÷ 8.9 = 3,784
   Reported patients: 3,924
   Total patients: 3,784 + 3,924 = 7,708

Total reimbursement, agencies not reporting number of patients: $732,887
Reimbursement per patient, agencies reporting numbers of patients: $218.91
Estimated patients: $732,887 ÷ $218.91 = 3,348
Reported patients: 3,924
Total patients: 3,348 + 3,924 = 7,272

Persons receiving services: 7,300 to 7,700

8. Figures were calculated by dividing high estimate of persons receiving services by minimum number of persons estimated to need services. For 1974, 7,700 ÷ 10,371 = 74%.

9. Data supplied by the Visiting Nurse Association, Bellingham, Washington.

10. Source: Attachment 9.

11. Data sources:

1970-73	Comprehensive Health Planning Council of Whatcom, Skagit, Island, and San Juan Counties, Health Indicators Report, 1968-1973. Mount Vernon, Washington, August 1975, Tables 23 and 26.
1974	State of Washington, Office of Planning and Health Facilities, Hospital Utilization Report. Olympia, Washington, 1974.

System: A Useful Planning Tool

Recent federal legislation (Public Law 93-641) created "health systems agencies" to develop plans for the "health system." The law did not, however, define "health system." This Development Guide has used a functional definition of "system" as a way of identifying problems (analysis) and as a way of grouping solutions to the problems (synthesis). As an analytical tool, the model was used to identify problems connected with Medicare and Medicaid. As a synthetic tool, the model was used to organize regional, state, and national recommendations into an understandable and rational arrangement. The model was not used at the regional level to identify problems because (1) the Task Force used a goal-related planning process and (2) the development of the model occurred too late in the planning process to be used as an analytical tool. The model is, however, compatible with a goal-related planning process, provided that the goals used correspond to the system's major components.

As used in this document, "system" has been defined to have four functional components. These four components appear to be the minimum set of attributes that can be used to characterize a system comprehensively. The four components are administration, resources, service delivery, and inter-coordination.

The first component, administation, encompasses such functions as management and supervision, planning and policy development, definition and interpretation of performance data, organization of resources, and internal coordination.

Resources are, of course, the raw materials out of which services are provided: personnel, money, time, buildings, equipment. The resources component of a system performs such functions as acquiring, maintaining, improving, or providing resources.

Service delivery, the third component, is the productive part of the system, the part that involves the using of resources to conduct activities or provide services. Performance data, costs, and health benefits are some by-products generated by this component of the system.

The fourth component of a system, inter-coordination, encompasses those activities which link the system to other systems. In the field of health care, the biomedical delivery "system" links or coordinates itself with individual and collective human systems (patients and communities), political systems, religious systems, labor systems, etc. Inter-coordination involves such things as public information, public relations, public accountability and responsiveness, planning coordination, and activity coordination with other systems.

There are a number of reasons to use this model as a health planning tool. Its major asset is its simplicity. Its key

characteristics can be described in just a few paragraphs. The model is also comprehensive. Unlike many other planning models, for example, this model immediately suggests that such things as policy development and public accountability are legitimate considerations for planners. The model is rational. It identifies key functions that must be performed by a system if it is to be or remain a system. The model is versatile. It can be applied to virtually any identifiable system. For all these reasons, the model system described and used in this Guide appears to be a useful tool as the art of health planning moves into its second decade.

Findings and Recommendations

The bulk of the remaining portion of the Development Guide contains findings and recommendations made by the Task Force. The findings and recommendations are divided into three groups according to geographic area: regional, state, or national. In each of these groups, the findings are listed first and are followed by relevant recommendations. At the regional level, findings are based on a research tied to a set of "indicators" developed by the Task Force as a means of applying the Health Planning Council's overall goals for health services to a particular health service, i.e., home health services. Regional findings are displayed opposite appropriate indicators from pp. 32 to 57. Regional recommendations have been grouped according to elements of the system model discussed on pp. 30 to 31. At state and national levels both findings and recommendations are directly related to elements of the system model. At the national level both findings and recommendations are also separated according to type of national program.

Regional Level: Findings

This section shows health services goals and associated indicators used by the Task Force to study home health services in the region. The indicators are found at the left side of the pages that follow. Findings related to specific indicators are listed in either the column labeled "Areas of Strength" or the column labeled "Areas for Improvement." Following this listing of goals, indicators, and findings is a section showing regional recommendations.

Goal 1.a. The need for acceptable services: Clients need services that are comfortable, punctual, non-discriminatory, understandable, personalized, responsive to individual and special needs, courteous, and confidential.

Indicators	Areas of Strength	Areas for Improvement
1. Whether supervisory visits are made to access care received.	1. Supervisory visits are made by home health agency personnel to assess care provided to patients.	
2. Whether patient care methods are understandable to the patient and/or the patient's family.	2. Patient care methods appear to be understandable to the patient and/or the patient's family.	
3. Whether access to home care services for physicians is as easy as possible.	3. Physician access to existing home health services appears to be generally satisfactory.	
4. Whether the patient meets home care personnel prior to being discharged from an institution.		4. Two out of three patients do not meet health agency personnel prior to receiving home health services.
5. Whether the home care program evaluates the characteristics mentioned in the goal (1.a.).		

Goal 1.a. (continued)

Indicators	Areas of Strength	Areas for Improvement
6. Whether care is provided by someone the patient already knows, or whether the provider of care already knows the patient.		
7. Whether care is personalized through the use of managing physician's personnel at home.		
8. Whether patients can report adverse experiences in a non-face-to-face manner.	8. Patients are able to report adverse experiences through the use of anonymous letters or telephone calls. Patients are well-satisfied with home health services they have received.	
9. Whether the services use several different methods to evaluate their success in meeting each of the client needs listed.	9. Home health agencies have developed and currently use a number of methods to monitor the acceptability of care provided to patients.	
10. Whether utilization review respects individual patient needs that mitigate for or against rapid discharge.		

Goal 1.b. The need for alternatives: Citizens need to be able to choose from among places and methods of care.

Indicators	Areas of Strength	Areas for Improvement
1. Extent to which patients can choose home care prior to admission or prior to discharge.		1. Home health services are seldom discussed by physicians and patients prior to non-emergent hospitalizations.
2. Whether a patient can choose to receive home care instead of or in addition to institutional care or outpatient care.		2, The patient's choice of 3, home care as an option is 4. limited for a number of reasons: home health services are not adequately available in three of the region's four counties; many patients are unfamiliar with their insurance policies' provisions for home health services or unaware of home health services available in the community; a significant proportion (about half) of patients have little or no input into medical care decision-making processes.
3. Whether the patient has the choice to stay at home if is at all medically feasible.		
4. Whether the patient has a voice in deciding the kinds of services to be provided and where they are to be received.		

Goal 1.b. (continued)

Indicators	Areas of Strength	Areas for Improvement
5. Whether boarding homes or halfway houses are available for the elderly who need minimal care or supervision (less care than that in a hospital or nursing home).		5. Boarding homes, halfway houses, congregate care facilities, low income housing, and similar residential facilities appear to be inadequately available as "alternatives" in the region. Intermediate care facilities and adult foster homes may also be inadequately available.
6. Whether a patient can choose from among a number of alternative living arrangements.		6. The absence of "alternative" residential facilities limits consumer choice in living arrangements.
7. Whether physicians can choose (for their patients) from among places and methods of care.	7. Physicians believe "places" (facilities) for continuing, post-acute patient care are adequately available.	
8. Whether the service has developed methods of enabling a patient who lives alone to go home anyway.		
9. Whether a variety of service choices are available.		

Goal 1.c. The need for competence and appropriateness: Clients need services that are medically and technically competent and appropriate.

Indicators	Areas of Strength	Areas for Improvement
1. Extent to which providers of care are adequately qualified and trained.		1. Consistent under-use of home health services in the region raises questions about physician knowledge of the kinds of circumstances in which home care should be used.
2. Whether patients already in nursing homes are periodically identified on the basis of their suitability for home care.	2. Medical assistance nursing home patients are periodically reviewed relative to their suitability for home care.	
3. Whether nurse and physician education in this region and State provides for training regarding home care.		
4. Whether home care personnel, including physicians, receive adequate continuing education.		
5. Extent to which patients who need skilled nursing care are correctly placed in a skilled nursing facility or in a home care program.		
6. Extent to which Medicare or other administrative requirements promote appropriate patient placement.		

Goal 1.c. (continued)

Indicators	Areas of Strength	Areas for Improvement
7. Extent to which services are appropriately provided in the home.		
8. Extent to which utilization review committees have developed and use criteria to identify patients eligible for home care.		8, Utilization review committees
9. Extent to which patients with diagnoses appropriate for home health care do not remain in the hospital unnecessarily long.		9. have not developed and do not use systematic criteria or procedures to identify patients eligible for home care. Such identification is not performed because the utilization review committee functions only to identify patients who no longer need institutional care. Identification of potential home care patients in hospitals appears to be spotty in quality and generally not systematic or routine.
10. Whether services are provided in the home when desired by the patient.		10. Home health services are not always provided when desired by the patient because (a) the services are not available, or (b) the services must be ordered by a physician, or (c) the patient's insurance will not pay for the services needed and the patient can't afford to pay for them out-of-pocket.

Goal 1.c. (continued)

Indicators	Areas of Strength	Areas for Improvement
11. Whether the appropriate level of skill provides the requested services.		
12. Whether patients who do not need to go into a nursing home are identified prior to admission.		

Goal 1.d. The need for comprehensiveness: Clients need care that provides a full range of services, orients toward the whole person, and provides for coordination and continuity.

Indicators	Areas of Strength	Areas for Improvement
1. Whether the following services are adequately available for use in the home: a. Volunteer home visitors. b. Homemakers. c. Health aides. d. Speech therapy. e. Physical therapy. f. Occupational therapy.	1. With the exception of age- and residence-related service availability problems previously mentioned, the following home health services appear to be adequately available for use in the home: nursing, physical and speech therapy, medical supplies/equipment, oxygen, and laboratory services.	1. A reasonably adequate set of home health services is available only in Whatcom County. Home health services are available only to Medicare patients in Skagit and Island Counties. No home health services are available in San Juan County except through public health nurses.

Goal 1.d. (continued)

Indicators	Areas of Strength	Areas for Improvement
g. Meal services. h. Inhalation therapy. i. Medical supplies. j. Equipment transportation. k. Child birth services. l. Public health nursing. m. Skilled nursing. n. Caseworker or medical social services. o. Equipment loan. p. Medications. q. Oxygen. r. Intravenous therapies. s. Laboratory services. t. Patient transportation. u. Home maintenance services.		Services that appear to be inadequately available across the region for use in the home include occupational therapy, homemaker/health aide services, chore services, meal delivery services, and medical social services. Health aide services appear to be the most needed type of service not adequately available. Live-in housekeepers or companions also appear to be needed but not adequately available.
2. Extent to which continuing or maintenance-type care is provided in the home.		2. Medicare patients generally do not receive needed health maintenance or homemaker/health aide services at home because Medicare will not pay for the services or will not pay for the services in the kinds of situations in which they are most needed by patients.
3. Whether the patient is trained in self-care.	3. Patients generally receive training in self-care. The training is provided by	

Goal 1.d. (continued)

Indicators	Areas of Strength	Areas for Improvement
	physicians, hospital personnel, and home health agency personnel.	
4. Whether home care services are available to people of all ages.		4. Home health services are not available to people of all ages. Only Whatcom County has home health services available to people of all ages.
5. Whether standards exist for referral to home care from the hospital.		5. Uniform standards have not been developed in any community in the region for the referral of hospital patients to home health services.
6. Whether continuity between the patient and hospital therapy or rehabilitation personnel is achieved.		6. Continuity between patients and hospital therapy or rehabilitation personnel is achieved for only about half the patients who continue to receive such services after discharge from the hospital.
7. Whether continuity between the patient and the managing physician is maintained.		

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Goal 1.d. (continued)

Indicators	Areas of Strength	Areas for Improvement
8. Whether physicians have access to a full range of home care services.		8. Physicians generally do not have access to a full range of home health services for their patients because some types of needed services, such as health aide services, are not adequately available.
9. Whether referrals to home care are made on an individual basis (because of complexities involved).	9. Referrals to home health services are made mostly on a case-to-case basis. This mode of referral provides considerable flexibility for both patients and providers of care.	9. Referrals to home health services are made mostly on a case-to-case basis. This mode of referral provides considerable potential for the non-identification of possible home care patients.
10. Whether citizen information and referral services for one's vocational, recreational, social, and physical needs are available.		
11. Whether an adequate number of professional and non-professional referral sources are available.		

Goal 1.e. The need for convenience and accessibility: Clients need services that are not too far away in either time or distance.

Indicators	Areas of Strength	Areas for Improvement
1. Whether home health services are available in one's county of residence.		1. Home health services are not conveniently available to persons under age 65 in three of the region's four counties.
2. Whether physician access to home health services is convenient in both time and distance.	2. Physicians generally have convenient access to the home health services that currently exist.	
3. Whether home health personnel are available in isolated areas.		3. Home health personnel are generally not available in isolated areas within the region.

Goal 1.f. The need for economy: Clients need services that are affordable and need to be protected from financial disaster resulting from the costs of services.

Indicators	Areas of Strength	Areas for Improvement
1. Whether home care fees are competitive with those of an extended care facility.		
2. Whether long-term care services to maintain patients in their homes are affordable to the patients.		

Goal 1.f. (continued)

Indicators	Areas of Strength	Areas for Improvement
3. Whether charges for services are low enough to permit use of services by all people regardless of income.	3. Home health services included under Medicare's benefit package are quite affordable to patients who receive services.	3. Charges for services are generally not low enough to permit the use of services by all people reagrdless of income.
4. Whether home care fees are low enough to induce physician support for the services.		4. Charges for services are generally not low enough to induce physician support for the services. This finding may be due to the fact that home health agency charges are based on numbers of visits provided instead of numbers of days of care provided. Use of visits as the mode of charge has a concentration effect on charges. As a result, charges appear high. On a cost-per-day basis, however, home health services are considerably less expensive than care in a health facility.
5. Whether costs are low enough to permit home care services to be offered through Skagit County Hospitals.		

Goal 1.f. (continued)

Indicators	Areas of Strength	Areas for Improvement
6. Whether transportation of the patient to a source of care is available when the total cost of such service is less than that of a visit in the home.		

Goal 1. g. The need for maintenance of health: Citizens need services that emphasize maintenance of good health, including information, education, and prevention services.

Indicators	Areas of Strength	Areas for Improvement
1. Whether preventive services are adequately available in the community to prevent unnecessary use of institutions or therapeutic home care services.		
2. Whether there is early patient and family involvement in preparations for continued patient care prior to discharge from an institution.	2. Early patient and family involvement in preparations for continued care after hospitalization appears to occur for about 3 out of 4 Medicare hospital patients.	

Goal 1.g. (continued)

Indicators	Areas of Strength	Areas for Improvement
3. Whether community and intra-institutional information and education services are adequately available.		3. Community and intra-institutional information services appear to be inadequate. The extent of consumer knowledge about home health services is generally very low. The home health services survey found that two out of five former home health patients learned of the existence of home health services only after they left the hospital.
4. Whether a full range of preventive health services are available for persons of high risk. Such services should include nutrition, well-clinics, dental care, immunization services, eye and ear examinations.		
5. Whether adequate liaison is available between providers and lay caretakers.		
6. Whether there are reasonable restrictions on the provision of continuing or maintenance-type care.		6. Medicare's home health services benefit package contains unreasonable restrictions on the provision

Goal 1.g. (continued)

Indicators	Areas of Strength	Areas for Improvement
		of continuing or maintenance-type home health care. Maintenance-type home care is generally not provided to Medicare patients.
7. Whether physicians receive adequate information or education on home care services.		
8. Whether maintenance-type care is provided in the home.		
9. Whether home care services are available for prevention of dependency, such as the dependency that forces some people into nursing homes.		9. The kinds of home health services needed to prevent dependency and admissions to health facilities are generally not adequately available.

Goal 1.h. The need to know: Citizens need to know what services are available, what is occurring during the process of care (including procedures, risks, diagnoses, and alternatives), what costs are involved, and what is being done with their tax dollars for health.

Indicators	Areas of Strength	Areas for Improvement
1. Whether patients understand the extent of their insurance coverage in relation to home care services upon entering an institution.		1. Prior to hospitalization, between 50 and 85 percent of the patients are not familiar with the extent to which their insurance provides home health services benefits.
2. Whether citizens have access to information on how much tax money is spent for the provision of home care services.	2. Two out of three home health agencies publish annual reports containing information on tax funds spent to provide home health services.	2. About 9 patients in 10 have never seen information on the extent to which tax money is spent for the provision of home health services.
3. Whether all medical procedures, including risks, diagnoses, and procedures, are explained to the patient and his or her family before treatment begins.		
4. Whether patients are adequately informed about home care services available prior to entering an institution.		4, Prior to hospitalization, 5. about 4 patients in 5 are not familiar with the extent to which home health services are available in their community, including costs and financing methods.

Goal 1.h. (continued)

Indicators	Areas of Strength	Areas for Improvement
5. Whether citizens are generally well informed about the availability of home care services, including financing and costs of the service.		4, Prior to hospitalization, 5. about 4 patients in 5 are not familiar with the extent to which home health services are available in their community, including costs and financing methods.

Goal 1.i. The need for participation: Citizens and clients need to be able to affect, via their participation in decision-making processes, the nature and distribution of health services and the definition of quality of care.

Indicators	Areas of Strength	Areas for Improvement
1. Whether both physicians and former home care patients are represented on home care boards and committees.	1. Physicians serve on home health agency governing boards as either official board members or as ex officio members. Physicians serve on committees maintained by home health agencies.	1. Former home health patients do not serve on committees or governing boards of any of the home health agencies.
2. Whether the patient is given a choice between home care services and alternative types of services.		2, About half the Medicare 3. patients participating in the home health services survey reported that they had little or no involvement in medical care decision-making

Goal 1.i. (continued)

Indicators	Areas of Strength	Areas for Improvement
3. Whether the patient participates in the decision on the place of further care.		processes. As a result, these non-participating patients have little choice between home health services and other methods of treatment. Their non-participation, coupled with their ignorance about home health services, makes them very dependent on providers of care, such as physicians, for the ordering of the services.

Goal 1.j. The need for person-centered and family-centered services: Citizens need services that consider the whole person, not just the complaint or problem at hand.

Indicators	Areas of Strength	Areas for Improvement
1. Whether an adequately comprehensive evaluation of all relevant factors that affect the patient's health or ability to regain health is made prior to the patient's entrance into a home care program.	No indicators were studied under this goal.	
2. Whether the pre-home care evaluation provides information on the needs that will be generated		

Goal 1.j. (continued)

Indicators	Areas of Strength	Areas for Improvement
within the family while the patient receives home care.		
3. Whether the home care program acts upon the pre-home care patient evaluation in order to minimize all factors detrimental to the patient's health.		

Goal 1.k. The need for responsiveness: Citizens need individual and organizational providers willing to modify their methods to respond to individual and community needs.

Indicators	Areas of Strength	Areas for Improvement
1. Whether providers modify their methods in accordance with Task Force or Council recommendations.	Responsiveness of providers cannot be determined until after the Home Health Services Development Guide is published.	
2. Whether home health services have become more readily available or more extensively used.		

Goal 2. Resources of sufficient quantity and quality should be available to meet health needs. Resources include personnel, funds, facilities, equipment, and finances.

Indicators	Areas of Strength	Areas for Improvement
1. Whether adequate private and public reimbursement mechanisms are available for preventive and health maintenance home care services.		1. Adequate private and public mechanisms for reimbursement of home health services, including services provided for prevention or health maintenance are not available. See Attachments 11 and 12. Also see p. 8.
2. Extent to which reimbursement regulations are reasonable and applied fairly and consistently.	2. Home health agencies believe insurance-related reimbursement regulations are generally applied fairly and consistently.	
3. Whether there is an adequate number of social worker-type personnel for needed counseling, planning, and supportive services to patients in institutions.		3. The adequacy of availability of social worker-type personnel in health care institutions is questionable.
4. Whether services are provided and reimbursed despite a patient's inability to pay.		4. Home health services are provided and reimbursed despite a patient's ability to pay only in Whatcom County. Such reimbursement occurs there through the Comprehensive Employment Training Act, United Way

Goal 2 (continued)

Indicators	Areas of Strength	Areas for Improvement
		Funds, or revenue sharing obtained from local government. Home health services in Skagit and Island Counties are provided only to persons who can afford to pay, i.e., Medicare patients.
5. Whether the methods of financing home care services create incentives for the appropriate use of services by both consumers and providers of care.		5. Current methods of reimbursement based on cost per visit create disincentives for appropriate use of services because of the concentration effect such a payment method has on charges.
6. Whether an adequate number of physicians refer patients to home care programs.		
7. Whether there is an adequate number of personnel (such as health aides, homemakers, therapists, nurses, etc.) available to patients who require home care services.	7. There is an adequate number of nurses, speech therapists, and physical therapists available to patients who have access to home health services. The number of personnel employed can be readily expanded to meet demand.	7. Homemakers and health aides are not adequately available to patients who require such home health services. While there is large consumer demand for these services, there is little provider demand for the services. Consumer demand for the services that do exist in Whatcom County surpasses supply by a factor of two or three.

Goal 3. Providers of health services should function with coordination, flexibility, and foresight.

Indicators	Areas of Strength	Areas for Improvement
1. Whether the hospital develops and maintains an effective mechanism for the identification of patients potentially suitable for home care and for their prompt referral to the program.		1. Some hospitals have not developed effective mechanisms for the identification and prompt referral of patients potentially suitable for home care.
2. Whether there is orderly, systematic, and coordinated planning for patient discharge between the hospital, the family, home health care services, and other post-hospital resources.		2. Some hospitals have not developed adequate procedures for orderly, systematic, and coordinated planning for patient discharge. Only 60 percent of the Medicare patients participating in the home health services survey thought that they received both adequate advance preparations for discharge and satisfactory arrangements.
3. Whether home health care is available and used as preventive care prior to hospitalization and is not restricted just to those who are discharged from acute care.		3. Some home health services are available for use as preventive services, but they are seldom used for this purpose, mainly because third party payors will not pay for such care.

Goal 4. Health services provided by programs and organizations should be evaluated by both consumers and providers.

Indicators	Areas of Strength	Areas for Improvement
1. Whether the home care program adequately uses such methods as patient interviews, patient-completed evaluation checklists or utilization review committees to evaluate its services.	1, 2 Home health agencies use patient interviews, supervisory visits, utilization review committees, case review or team conferences, and professional advisory committees as methods of evaluating services or determining the quality of program functioning. In addition, agencies are periodically audited and recertified by other organizations, such as Blue Cross. Physicians participate on the utilization review committee of one agency and on the professional advisory committee of two agencies.	
2. Whether home care programs use utilization committees or medical advisory committees to determine the quality of program functioning.		
3. Whether committees which determine quality of program functioning are		3. Former patients do not serve on any of the home health agency committees

Goal 4 (continued)

Indicators	Areas of Strength	Areas for Improvement
partly composed of former users of home care services, including physicians.		responsible for evaluating the quality of program functioning.
4. Whether committees which determine quality of program functioning provide physicians with the results of their assessments.		4. Home health agencies hardly ever report the results of evaluations of home health agency functioning to physicians in the agency's service area.

Goal 5. Programs and organizations providing health services should provide the public with information about achievements and associated costs, services offered, and the charges for services offered.

Indicators	Areas of Strength	Areas for Improvement
1. Whether both patients and physicians know the kinds of health conditions for which home care services are available and most appropriate, and the costs of such services.		1. The consuming public is largely ignorant of most aspects of home health services: what services are available and for whom, what their own health insurance benefits are relative to home health services, what costs and charges are connected with home health services, how tax funds are spent for home health services.

Goal 5 (continued)

Indicators	Areas of Strength	Areas for Improvement
		None of the eight board--certified and board-eligible physicians interviewed in the home health services survey estimated "last year's" home health agency charges accurately. Collectively, the eight physicians identified many of the kinds of health problems that can be successfully treated via home health services, but, individually, physicians mentioned few kinds of problems that are generally appropriate for home health services. As discussed in the "Home Health Services Survey," physicians also appear to be less informed about the intricacies of Medicare reimbursement regulations than home health agencies. These findings all create the impression that physicians are not adequately informed about some aspects of home health services.

Goal 5 (continued)

Indicators	Areas of Strength	Areas for Improvement
2. Whether home care programs make periodic reports to service and civic groups and the general public regarding home care program achievements and costs, services offered, and charges for services offered.	2. Two agencies make periodic reports to the general public on program achievements, program charges, and services offered. The third agency publishes an annual report which is distributed to mayors, city councils, and county commissioners in its service area.	

Regional Level: Recommendations

A. Administrative Recommendations

Introduction

Home health services should generally be organized within the region as hospital-based services. The development of shared hospital-based services is recommended because of the kinds of benefits that would be likely to occur under such an arrangement:

a. Improved convenience for physicians.

b. Improved acceptance of home health services by physicians because of the existence of hospital-based quality control procedures.

c. Improved efficiency of operation because of the existence of support services within the hospital and because of the likelihood that utilization will increase.

d. Increased visibility and availability of services within the community.

e. Improved continuity of care because:

- Physician-home health agency interactions and communications will be made more convenient.
- Patients are more likely to meet home health personnel prior to discharge from the hospital.
- Hospital personnel from whom the patient received care in the hospital may be able to continue to provide care to the patient at home.
- Patient medical records will be concentrated at a single facility.
- The development of an adequate range of home health services by the hospitals will assure that patients continue to receive needed care, whether hospitalized or not, in a setting most appropriate to their medical condition and social situation.

f. Improved ability to conduct research or develop innovative programs, such as rotation of hospital nursing personnel through the home health department.

g. Improved joint planning activities by hospitals.

h. Improved acceptance of home health services as a legitimate method of treatment by insurance carriers. Such acceptance should lead to increased availability of insurance benefits for home health services.

i. Improved opportunities for staff education.

1. Organization of Resources

Whatcom County

Home health services in Whatcom County should be organized as hospital-based services. To accomplish this recommendation, the two Bellingham hospitals should:

a. Contract with existing home health agencies or programs to provide home health services for the hospital. (Similar arrangements already are used by the hospitals for the provision of medical services and alcohol detoxification services.) As with other contractees, these agencies should be provided with adequate facility space to conduct their activities. The two hospitals' contracts should be as similar as possible in order to assure uniformity of services and procedures at both hospitals.

OR

b. In the event existing agencies decline to contract with the hospitals, the hospitals should each develop a home health service department and operate the two departments as a single shared service in competition with other home health services agencies that may be present in the community. As part of the procedures used to develop such a shared service, the hospitals should discuss and agree upon such things as common organizational structures, operational variables (departmental policies and procedures), accounting and data-keeping methods, services to be provided, and public relations programs.

This recommendation should be accomplished by November 1977.

Skagit and Island Counties

Home health services in Skagit County should be organized as hospital-based services. To accomplish this recommendation, the following activities should be undertaken:

a. United General Hospital and Skagit Valley Hospital should each develop a home health service department and operate the departments as a single shared service. As part of the procedures used to develop such a shared service, the

hospitals should discuss and agree upon such things as common organizational structures, operational variables (departmental policies and procedures), accounting and data-keeping methods, services to be provided, and public relations programs. This recommendation should be accomplished by November 1977.

b. Island Hospital and Whidbey General Hospital should each develop a home health service department and operate the departments as a single shared service. As part of the procedures used to develop such a shared service, the hospitals should discuss and agree upon such things as common organizational structures, operational variables (departmental policies and procedures), accounting and data-keeping methods, services to be provided, and public relations programs. This recommendation should be accomplished by November 1977.

c. In designing their programs, the hospitals of Skagit and Island Counties should draw upon the knowledge and experience of employees currently affiliated with County Health Department home health programs. In addition, the hospitals should advise the Health Departments of progress being made in the development of the hospital-based home health services.

d. With the initiation of hospital-based home health services in Island and Skagit Counties, the respective Health Departments should terminate their home health programs.

San Juan County

Because of their geographic proximity to San Juan County, hospitals in Bellingham and Anacortes should discuss ways in which their home health services programs could be organized to assure the availability of services to residents of San Juan County.

Health Systems Agency

Health systems agencies across the State of Washington are urged to take actions to encourage the state to place a high priority on improving home health services.

2. Patient Care Decision-Making Process

Role of the Physician

a. Physicians should increase the extent to which they involve patients in medical care decision-making. When medically possible and practical, patients should be

encouraged and invited to discuss treatment alternatives, such as home health services.

b. To help remedy consumer ignorance about home health services, physicians should discuss home health services as a treatment alternative with their patients or their kin before hospitalization or during hospitalization.

Role of the Hospital

c. Hospitals, via representatives of the medical and nursing staffs and other appropriate personnel, should develop acceptable and systematic procedures and criteria for the timely identification and referral of patients who should receive home health services following hospitalization.

Similar criteria should be developed for the screening of non-hospital patients for whom home health services have been ordered. Ideally, the procedures and criteria developed should be uniform within the four county region. If this uniformity is not possible, procedures and criteria should be uniform for each pair of hospitals offering shared home health services. See Attachment 13 for an example of a patient identification protocol already in use.

d. To the extent possible, the patient identification procedures described in the preceding paragraph should be designed to serve, too, as a means by which systematic discharge planning activities can be assured. See Attachment 13 for an example of such a patient identification protocol.

e. Hospitals should consider developing small, specialized, multi-disciplinary discharge planning committees to conduct the patient identification and discharge planning activities described in the preceding two paragraphs. Such committees would help upgrade the quality and effectiveness of such activities, provide an expanded supply of personnel within the hospital knowledgeable about discharge planning activities, and provide opportunities for in-service training for various types of hospital personnel via a system of rotating committee membership. (Such rotating membership now occurs among physicians who serve on the hospital's utilization review committee.)

f. The hospitals should generate data from their discharge planning activities on the success with which patients receive appropriate kinds of care after hospitalization. The data should be used by the hospital, the community, and/or the health systems agency to identify problems

(such as the inability to place some patients appropriately because a needed facility is not available) and to develop, subsequently, plans and initiatives to solve the problems.

3. Consumer Participation in the Evaluation of Home Health Services

Where appropriate and feasible, non-professional personnel and former home health services patients should participate in methods used by the hospital to monitor or assess the performance of the home health services program.

4. Definition and Interpretation of Performance Data

Hospitals should develop uniform data sets as part of the development of their home health services programs. These data sets should be designed to monitor quality of care and program performance as well as to generate epidemiological data for purposes of research. The health systems agency should assist hospitals in the development of these data sets.

5. Coordination of Activities

The hospitals should consider hiring a qualified consultant(s) to assist them develop their home health services programs, their request(s) for federal funds, or their proposal(s) to the Social Security Administration for the funding of a demonstration project.

B. Recommendations on Research

1. Funding of Home Health Services

a. To support hospital-based home health services recommended for development in Skagit and Island Counties, the Skagit County Medical Bureau should offer insurance packages providing reimbursement for the use of such services. Home health services should be an automatically and explicitly insured hospital service, as automatically insured by the Bureau's hospital insurance plans as inpatient medical/surgical services. The development of these benefits should be coordinated with the hospitals' efforts to develop and offer home health services by November 1977. The reimbursement of the services should occur via a prospective payment method based on a flat rate per home care admission or a flat rate per period of home care. The managing physician's prerogatives in ordering types of home health services for patients should not be restricted by a payment method based on types of services covered; such a method will prevent the development and use of those home health services for which payment is not available. Utilization review activities, the hospoital's

systematic patient identification protocol, and the built-in financial limits of the prospective payment method should, in combination, adequately serve to prevent excessive utilization of home health services.

b. The Whatcom County Physicians Service, which now offers coverage of certain types of home health services, should also move toward prospective payment methods as outlined in the preceding paragraph. Consumers' copies of their insurance plans should contain explicit information relative to the extent to which their policies provide coverage of home health services. These changes should be coordinated with the Bellingham hospitals' efforts to develop and offer home health services by November 1977.

c. In the event local insurers find it impossible to develop prospective payment methods for the reimbursement of home health services, reimbursement should be linked to charges for service.

d. Hospitals, in developing charge structures for their services, should develop sliding scale charge structures based on the patient's ability to pay. Such a charge structure will help assure that access to care is based more on need for care than ability to pay.

e. In no case should payment for home health services be linked to the number of type of visits received by a patient. Charges should be linked to admission to the home care program or length of stay in the program. But because patients may differ in their needs for service, it may be appropriate to develop two or three charge structures to reflect the intensity or complexity of services being received (see p. 5).

f. Because of the rural nature of the region, the number of elderly persons living here, the relatively high rate of use of nursing homes by Title XIX patients, the lack of needed home health services, and the absence of Medicare reimbursement for needed homemaker services, providers in the four county region should develop, with the assistance of the health systems agency, a demonstration project under Section 222 of Public Law 92-603, the Social Security Amendments of 1972, which would explore alternative methods of funding home health services under Titles V, XVIII, or XIX of the Social Security Act and/or seek reimbursement of homemaker services.

g. The assurance of adequate funding and delivery of home health services is increasingly becoming a national and state priority. But until these priorities are translated

into dollars and cents, some funding problems are likely to occur. To help assure that hospital-based home health services maintain financial solvency, each hospital offering home health services should have a hospital guild for home health services. These guilds should not only help raise funds for the home health program, but also help provide information to the public about home health services available in the community.

h. Hospitals, in developing their home health programs, should attempt to acquire federal funds available for the development of such programs under Section 602 of Public Law 94-63.* The health systems agency should assist hospitals in their attempts to acquire such funds.

i. One or more of the region's State Legislators serving on the Legislature's Social and Health Services Committee should introduce a bill in the next session of the Legislature that would require health insurance carriers in Washington to offer a minimum set of home health services insurance benefits for sale to the public as part of the carriers' hospital insurance plans. The region's Legislators should review similar legislation now in effect in Connecticut, New York, and Arizona prior to submitting such a bill.

j. Between 1976 and 1978 the health systems agency should use a reasonable portion of its health services development funds to assist hospitals in their home health services' development and implementation activities.

k. Elected officials in the four county region should contribute toward the development and initiation of hospital-based home health services by responding to requests for revenue sharing funds by hospitals developing the home health services programs recommended in this Guide.

2. Home Health Services Personnel

a. To assure the availability of competent and adequately trained personnel for home health services programs that will be developed by hospitals in the region over the next two years, Whatcom Community College and Skagit Valley College should develop curricula for the training of homemaker/home health aides. Because distinctions

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* The Nurse Training and Health Revenue Sharing and Health Services Act of 1975.

made between "homemakers" and "health aides" are not valid, community college curricula should be geared toward the training of a hybrid paraprofessional: the homemaker/home health aide. To the extent possible the colleges' homemaker/home health aide curricula should be integrated with other nursing education programs in order to promote career advancement of the homemaker/home health aides. The development of these training programs will assure a supply of needed trained personnel in the region to perform tasks now performed by homemakers, health aides, chore service workers, and live-in housekeepers or companions.

b. To reduce travel times of home health agency personnel, hospitals should explore the possibility of using on a part-time or intermittent basis indigenous health personnel living in relatively isolated areas to provide home health services to patients in those areas.* If appropriate, hospitals should draw upon listings of health personnel maintained by the health systems agency as a means of recruiting needed personnel in these outlying areas.

c. Other personnel deficiencies noted in this Development Guide are likely to be solved with the advent of adequate funding mechanisms and increased utilization of services.

3. Facilities

a. As part of its future planning activities relative to long term care, the health systems agency should plan for the development of residential and patient care facilities that appear to be inadequately available in the region: adult foster homes, boarding homes, congregate care facilities, halfway houses, intermediate care facilities, and low income housing.

b. Agencies in the region that may have roles to play in the development of the facilities listed in the preceding paragraph should begin to quantify the need for these facilities in their service areas and begin taking action to eliminate identified deficiencies. Included in this recommendation are such agencies as the Department of Social and Health Services, county governments, city or county housing authorities, county mental health or mental retardation programs, and county senior services programs. The development of these kinds of facilities

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* This kind of approach would probably be the best method of providing home health services to patients in San Juan County.

will promote consumer choice in and satisfaction with living arrangements, improve the range of treatment choices available to providers of care, and reduce unnecessary and inappropriate institutionalization of patients.

C. Service Delivery

1. Availability of Services

a. In the organization of their home health services programs, hospitals should prepare to deliver a variety of different kinds of home health services, particularly if insurers are able to develop prospective payment methods which permit flexibility in the kinds of services that can be provided. Hospitals should assure that all home health services eligible for reimbursement under Medicare will be available through their programs. Homemaker services should be made available via homemaker/home health aide personnel. All these services should be available to persons of all ages and source-of-payment categories in the hospitals' service areas. This recommendation will assure that an adequate set of services will be available to persons of all ages and sources of payment in at least three of the region's four counties.

b. In reviewing the adequacy with which hospitals implement the recommendations in this Guide, the health systems agency should permit hospitals to establish reasonable limits on the size of the service areas established for their home health services programs. The service radius, however, should not be less than 15 miles for each hospital. See map, Attachment 14.

D. Inter-Coordination

1. Public Information

a. Hospitals should periodically advertise the availability of home health services through their facilities. Because the lack of consumer information is a serious problem preventing the appropriate use of home health services, and because similar advertising costs by proprietary nursing homes are currently reimbursable by Medicaid and Medicare, reasonable hospital home health service advertising expenses should be reimbursed by Medicare, Medicaid, and other third party payers.

b. Hospitals should release periodic reports to the public on quantities of home health services provided, types of patients served, amounts of tax funds spent, benefits

derived from the program, etc. to assure public accountability of the programs and to help inform the public of activities occurring. The news media have a responsibility to the public to disseminate these reports in a timely and accurate manner.

c. The news media should publish periodic reports or feature stories on the success with which home health services are developed by hospitals within the region. Such reporting will promote the public accountability of the region's hospitals and serve to provide the public with needed information on home health services.

d. The news media should prepare and disseminate a series of reports on the status of long term care in the region. Such reporting will improve the public's awareness of problems that exist and thereby improve chances that the problems will be more readily solved.

e. The availability of home health services should be discussed in the patient information brochures distributed by the hospitals to incoming patients.

f. In their publicity efforts, hospitals and home health services hospital guilds should pay particular attention to potential patient referral sources, such as employees of the Social Security Administration, Department of Social and Health Services, county health departments, or county senior services programs. For their part, these agencies should cooperate to the maximum extent possible with the hospitals' efforts to publicize their new programs.

2. Physician Information

As part of their home health services development activities, hospitals should take appropriate measures to assure that their medical staffs are kept informed of progress being made. Leadership of the hospitals' medical staffs should develop and implement methods to assure that members of the medical staffs are familiar with (a) procedures that will be used to identify or screen potential home health patients, (b) the kinds of medical conditions for which home health services are appropriate, and (c) insurance-related restrictions on the provision of home health services. With the initiation of services, physicians should be kept informed of the results of evaluative and/or epidemiological studies of the hospital's home health services program.

3. The Role of Organized Labor

Organized labor in the four county region should consider developing home health services insurance benefits for

their memberships. This recommendation is made because of the demonstrated effectiveness of home health services in reducing the overall costs of hospitalization.

4. The Health Systems Agency

In addition to the health systems agency roles previously mentioned in these recommendations, the agency should also perform other planning assistance activities, such as consultation to hospitals on the development of adequate data systems or support for funding requests, that may be required by the region's hospitals as they develop their home health programs.

5. Planning Coordination

Hospitals, in developing their home care programs, should actively involve other health care providers in developmental activities to assure the future coordination of activities, to improve cooperative efforts among providers, to assure that relevant providers are kept informed of progress made in program development, and to elicit worthwhile suggestions and ideas.

State Level

The findings and recommendations listed in this section have taken from the Health Planning Council's study entitled Home alth Services Under Medicare and Medicaid: A Critical Analysis. reader should consult the study for more detailed descriptions and documentation of the findings that follow.

Findings

Problems in Administration

1. Lack of Policy

   The State of Washington has not developed policies on the relative emphasis to be placed on the development, provision, or use of various kinds of long-term care services through tax-supported health care programs. Likewise, no explicit policy or policies have been developed on the relative societal value or importance of maintaining people, particularly the elderly, at an acceptable level of functional independence in their own homes. The lack of policy interferes with decision-making, problem definition and problem-solving, modifications of programs and spending priorities, and program evaluations.

2. Lack of Planning

   The state has over-emphasized regulatory processes and under-emphasized planning/policy development processes as means by which to improve health and health spending problems. Health planning at the state level has been given such low priority that the state's Comprehensive Health Planning office has been staffed by only three planners the past few years.

3. Lack of Competent Administration

   The State's Medicaid program has not been adequately administered. Needed analytical data are not published or are not available. There appears to be little effort taken to identify Medicaid service delivery problems topically or geographically. The public has not been informed of studies undertaken (if any) of program effectiveness. Although the Medicaid program is characterized by significant levels of spending and spending increases for institutional care, there has been no expansion in the kinds of home health services eligible for reimbursement. Furthermore, no effort has been made to develop home health services in areas deficient in such services, such as this region. Few, if any, experimental projects in the field of long-term care have been designed or implemented by the state despite permissive state and federal law. No systematic procedures have been developed to monitor and analyze problems associated with patient placement - despite the fact that many patients are

placed in inappropriate facilities. Finally, the state continues to pay millions each year for unnecessary and excessive institutional care but only a few thousand for needed but unavailable or under-used home health services.

These problems have existed for roughly five years, despite the responsibility of certain legislative bodies to assure proper administration of the program.

Problems in Resources

1. Gross Under-Spending for Home Health Services

In 1972 the state's Medicaid program should have spent between $1 and $10 million for home health services under Medicaid. Actual spending was less than $200 thousand, about one-fifth the minimum needed. Such under-spending occurred despite the ability of home health services to substitute for inappropriate institutional care at considerable savings to both the state and patients.

2. Reimbursement by Fee Schedule

The state reimburses home health agencies participating in Medicaid via a fee schedule that is not routinely revised (see Attachment 11). The use of such a uniform fee schedule discriminates against home health agencies because payments to hospitals and nursing homes are based on each facility's costs. All home health agencies, however, receive the same amount of money (via the fee schedule) regardless of their individual costs. Although the uniform fee schedule has helped control spending increases for home health services, no attempt has been made to use such a uniform schedule to reimburse hospitals or nursing homes, despite steady annual increases in payments to these types of facilities. The state has not waived or amended the fee schedule method of payment (though it could have done so) in areas of the state, such as Skagit County, where the unrealistic reimbursement level offered by the schedule has been the sole factor preventing the development of home health services for the Medicaid population.

3. No Reimbursement for Needed Services

Very few types of home health services are reimbursed by the state's Medicaid program. No expansion in the kinds of services eligible for reimbursement has occurred despite the amount and rate of increase of spending for institutional care by the program.

4. Payment Keyed to Number of Visits

Health facilities are reimbursed primarily on the basis of a daily service charge. As a result, it is possible to determine

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the cost per day of care. Home health agencies, however, are paid by Medicaid a flat rate per visit. Such a payment method, coupled with Medicaid's failure to collect length-of-stay data, prevents the establishment of cost per day figures that could be used to compare the efficiency of home care relative to other forms of care. As a result of the absence of such data, it is difficult to make needed administrative assessments of efficiencies, trade-offs, opportunity costs, and benefit package adequacy for home care vs. other (institutional) forms of care.

Furthermore, keying payments to visits has a concentration effect on the agency's charge structure with the result that the service appears more expensive than it really is. The concentration effect enables careless or biased individuals to make inaccurate and misleading comparisons of home care charges per visit to institutional charges per day. This type of erroneous comparison is then used to argue that home care is too expensive or too inefficient to be considered as a serious alternative to other modes of care.

Problems in Service Delivery

1. Excess Use of Nursing Homes

Use of nursing homes in this region by Medicaid beneficiaries has been consistently and significantly higher than state averages for at least five years. Use of nursing homes by elderly Medicaid beneficiaries was 20 percent higher than the state average in 1973. Use of nursing homes by all Medicaid beneficiaries was 76 percent higher than the state average in 1973. In addition, rate of use of nursing homes by the state's elderly Medicaid beneficiary population has been increasing. In 1969, 24 percent of the Medicaid elderly were in nursing homes (8,672 patients). Four years later, 34 percent were in nursing homes (10,890 patients).

Recent efforts by the state to reclassify and transfer patients to more appropriate levels of care have often been thwarted by the absence of needed services (see Attachment 15). Locally, there is no evidence that the state has attempted to develop needed home health services.

2. Lack of Home Health Services

Only one of the four counties in this region has a home care program that will serve Medicaid beneficiaries. In light of the problems already described, the absence of services is understandable. The absence of services constitutes de facto discrimination against beneficiaries here and illustrates the inability of current state funding mechanisms to stimulate the development of obviously needed services.

3. Fragmentation of Services

Although professionals in the field of home care refer to the activities performed by homemakers and health aides by the combined title "homemaker/home health aide", the state uses three different personnel classification and payment methods for these personnel. The state pays for home nursing and health aide services via a fee schedule. It provides homemaker services directly. It supplements cash grants of clients to enable the clients themselves to pay for chore (housekeeping) services. This mosaic of payment and service delivery methods fragments demand for and delivery of very similar services. By providing homemaker services directly, for example, the state removes part of the potential market from a non-governmental community agency that might otherwise be able to serve both Medicaid clients and the general community. By removing part of the community agency's market, the state contributes to and participates itself in reduced agency operating efficiency.

Problems in Inter-Coordination

1. Lack of Public Information

The general public receives little information about spending and utilization patterns generated by Medicaid and even less reporting of the few intelligent analyses or studies that have been made of the program. Officials have, furthermore, made little attempt to familiarize the public with important problems and issues surrounding the state's Medicaid program, such as those discussed in this document (see Attachment 16). Denied information about problems and issues, the electorate is unable to assess the quality of program functioning and unable to contribute toward the solution of the problems and issues.

2. Lack of Public Accountability

Hidden behind screens of mis-information and non-information, incompetent appointed and elected officials have been able to let significant, correctable human and economic problems fester and intensify for years with little more than a barely discernible whimper from cheated consumers and taxpayers. The accountability of the program to the public has been and continues to be highly questionable, particularly in view of the size of the program's tax-supported budget and the program's impact on thousands of beneficiaries across the state.

Recommendations: State Level

Recommendations on Administration

1. With the advent of new federal health planning legislation, the State of Washington should develop an integrated health planning/policy development office and provide enough financial resources to enable the office to function effectively. The State should review planning/policy development structure-function models used in other states and utilize policy analysis resources at the University of Washington before establishing its planning/policy development office. These actions should be undertaken by the Executive branch of government with assistance and advice from the Legislative branch.

   Coupled with this activity should be a shift in priorities by both Legislative and Executive branches of government away from regulation toward policy development and implementation as a means of improving the delivery of health services in the state.

2. The state should work in conjunction with health systems agencies to improve the availability of Title XIX data. Data on enrollment, utilization of services, and expenditures for services should be readily available and aggregated by health systems agency planning areas. Annual summaries should also be published.

3. To improve the quality of program administration, the Legislature should require the Department of Social and Health Services to prepare and provide annual reports to relevant Legislative committees on patterns of enrollment, utilization, and expenditures by the State's Title XIX program. These reports should be required to identify areas of the State showing significantly higher per capita services' utilization rates and/or expenditures' rates. In addition, the annual reports should explicitly define problems existing with the Title XIX program and actions the Department intends to take over the year to eliminate the problems. The reports should also review actions taken during the preceding year to correct problems identified in the Department's previous annual report. The Legislature should confer with a variety of consumers, providers, and health planners to help define the kinds of information that should be provided by these annual reports. The reports should, of course, be made available to the public, particularly the press.

4. The Department of Social and Health Services should develop and implement statewide methods to monitor and evaluate statistically the appropriateness with which Title XIX patients are placed into long-term care facilities. The data generated by this monitoring system should be used by DSHS and the Legislature to effect needed changes in Title XIX regulations, benefits, or administration.

Recommendations on Resources

1. Forthcoming budgets for the Title XIX program should reflect shifts needed in the state's currently inappropriate spending patterns. In particular, much more money should be allocated to home health services. These spending shifts should be proposed by the Executive branch.

2. DSHS should largely abolish its fee schedule method of payment of home health services and adopt a prospective payment system similar to that outlined under the Medicare program (see p. 88). Reimbursement for home health services should generally not be linked to the number of visits provided by an agency to a patient.

3. Reimbursement should be extended to additional types of home health services. At a minimum, the same services eligible for reimbursement under Medicare should be eligible for reimbursement under Medicaid. Well-adult services provided by home health agency personnel to beneficiaries living in group quarters or multi-unit housing facilities should also be reimbursed. The Department of Social and Health Services should initiate these modifications.

Recommendations on Service Delivery

1. DSHS should initiate experimental or innovative or research-oriented projects related to the development of needed long-term care services, particularly home care. This region, because of the problems shown in this study, should be given priority for inclusion in such projects.

2. DSHS should continue to pursue and even augment its belated efforts to reduce the unnecessary and inappropriate institutionalization of Medicaid beneficiaries in long-term care facilities. Part of these efforts should be devoted toward the development of additional intermediate care facilities and the reduction of skilled nursing facilities.

3. DSHS should take the initiative to help local areas develop needed home health services. Since additional personnel will be needed for these efforts, the Department's budget should respond to this need. The savings generated by stronger home health programs will help pay for these new personnel.

4. DSHS should cease the provison of homemaker services directly and switch to contractual arrangements with community agencies to provide these and similar services. The funding of homemaker, health aide and chore services should be unified and consolidated. DSHS should revise its homemaker/health aide/chore services personnel classifications and categorizations toward the recognition of a single category of worker, the homemaker/home health aide.

Recommendations on Inter-Coordination

1. The press and the media should expand their coverage of the performance of the Medicaid program in order to improve the public's awareness of Medicaid's benefits and problems. In their reporting, the press and the media should interview consumers, providers, administrators, and planners relative to their viewpoints and concerns about Medicaid. The reporting should, among other things, (1) address the question of whether the program is improving or getting worse, and (2) help define and clarify the problems and issues raised by interviewees.

National Level

The findings and recommendations on Medicare and Medicaid in this section have been taken from the Health Planning Council's study entitled Home Health Services Under Medicare and Medicaid: A Critical Analysis. The reader should consult the study for more detailed descriptions and documentation of the Medicare/Medicaid-related findings that follow.

Findings

A. Medicare

Problems in Administration

1. Inadequate Administrative Data

Data needed for program analysis and program evaluation are not adequately available:

- Data on utilization and expenditures by type of service are not available at the county level after 1969.
- Other county data on enrollment take three years to return to the local level.
- Data appear uncoordinated; it is difficult or impossible to link enrollment, utilization, and expenditures data together at the state or county level, particularly for home health services.

These data problems, in addition to interfering with program evaluation nationally, will also interfere with some of the statutory obligations of health systems agencies under Section 1513 (a) and (b) of Public Law 93-641.

The absence of adequate data raises serious questions about the overall quality of administration of the $10 billion Medicare program.

2. Discriminatory Conditions of Participation

Unlike any other provider participating in Medicare, home health agencies are required to perform an "overall evaluation of the agency's total program at least once a year." This requirement is made of home health agencies despite their receipt of less than 1 percent of Medicare expenditures each year. Institutional providers under Medicare are not required to perform such annual evaluations despite their receipt of over 70 percent of Medicare's expenditures each year. The existence of such program evaluation requirements only for home health agencies clearly discriminates against them.

3. Excessive "Red Tape"

The amount of paperwork required of providers participating in Medicare is frequently criticized in the region. This paperwork confuses both beneficiaries and providers and has led at least one provider in this region to drop out of the program (see Attachment 17).

Problems in Resources

1. Amount and Rate of Spending for Institutional Care

National spending patterns under Medicare have been characterized by (1) large proportions spent for institutional care and (2) steady increases in the amount of money spent for such care. Spending for home health services, however, has not only consistently fallen far short of levels necessary to meet minimum need for services, but has been characterized by virtually no increase in spending between 1968 and 1972, despite a growing elderly population, despite large unmet need for the services, and despite steady annual increases in spending for institutional care.

Coupled with the demonstrated effectiveness of home health services in reducing hospitalization and resultant expenditures, historical Medicare spending patterns imply the existence of considerable over-spending for institutional care, spending that could have been reduced by better use of the home care benefit of the program.

2. Inadequate Spending for Home Health Services

Spending for home health services under Medicare declined from 1.2 percent of total spending in 1968 to 0.8 percent in 1972. Estimates of need for services in combination with estimates of likely spending per home health patient lead to the finding that Medicare should have spent between 2 and 11 percent of its total expenditures for home health services in 1972. Actual spending for the services, 0.8 percent of all spending, was only half the estimated spending needed to meet the minimum need for services among beneficiaries.

3. Payment on the Basis of the "Lesser of Costs or Charges"

Section 233 of Public Law 92-603 amended Medicare law to the effect that reimbursement to hospitals, skilled nursing facilities, and home health agencies would be the lesser of (a) the reasonable cost of the services of (b) the customary charge for the service.

This amendment has several adverse consequences. First, if an agency's charges generate fewer revenues than the

agency's costs, the agency is forced to take a financial loss. Second, to protect against potential financial losses caused by the lesser of costs or charges policy, agencies must charge a fee high enough to compensate for predicted operating expenses as well as to provide a safety factor for inflation. As a result, patients may pay artificially high charges, and Medicare stands to benefit from agency charge structure maladjustments at the expense of the agency providing service. Since the size of the charge definitely decreases the willingness with which physicians will order home care, the lesser of costs or charges policy, but increasing agencies' charges, also serves to reduce the delivery of services to persons who would otherwise need or be able to use home care services. Thus, the policy results in the potential for (a) agency financial difficulty and (b) under-utilization of services by beneficiaries.

4. Payment on the Basis of Fee for Service

Home health services provided under Medicare are generally paid on the basis of fee for service, usually by average cost per visit. This payment method creates no incentives for increased efficiency of operation by providers of service since all reasonable costs are reimbursed (within the constraints of the lesser of costs or charges policy).

5. Payment Keyed to Number of Visits

Health facilities are reimbursed primarily on the basis of a daily service charge. As a result, it is possible to determine cost per day of care. Home health agencies, however, are paid by Medicare on the basis of average cost or charge per visit. Such a payment method, coupled with Medicare's failure to collect length-of-stay data, prevents the establishment of cost per day figures that could be used to compare the efficiency of home care relative to other forms of care. As a result of the absence of such data, it is difficult to make needed administrative assessments of efficiencies, trade-offs, opportunity costs, and benefit package adequacy for home care vs. other (institutional) forms of care.

Furthermore, keying payments to visits has a concentration effect on the agency's charge structure with the result that the service appears more expensive than it really is. The concentration effect enables careless or biased individuals to make inaccurate and misleading comparisons of home care charges per visit to institutional charges per day. This type of erroneous comparison is then used to argue that home care is too expensive or too inefficient to be considered as a serious alternative to other modes of care.

6. Co-Insurance Required for Visits to Skilled Nursing Facility Patients

Under Medicare's Supplementary Medical Insurance program the patient was formerly required to pay a portion of the charges for home health services: "co-insurance." The requirement for co-insurance was eliminated in 1972 for all patients except those SMI beneficiaries who receive home health services as patients in skilled nursing facilities. Requiring the institutional patient to pay co-insurance for services that would be free if provided at home discriminates against the institutional patient, particularly since the receipt of such services is probably necessitated by the absence of the services in the skilled nursing facility itself. Any savings to Medicare as a result of this unique co-insurance requirement are probably largely neutralized by the administrative costs generated by the requirement.

7. No Payment for Assessment Visits

Despite paying for consumer-initiated visits to physicians and hospital outpatient departments for the assessment of possible health problems, consumer-initiated requests for a single assessment visit at home are not reimbursed by Medicare. Confronted by a request for an assessment visit by a homebound beneficiary or the beneficiary's friend or relative, the home health agency must refuse to make the visit, make the visit at its own expense, or charge the person requesting the visit. If the beneficiary were able to visit a physician or outpatient department, however, Medicare would pay for the assessment, regardless of the beneficiary's actual need for care. Thus, Medicare discriminates against home health agencies by paying for all consumer-initiated requests for health assessments except those performed by a home health agency.

Problems in Service Delivery

1. Inappropriate Statutory Orientation Toward Acute Illness

Despite the prevalence of chronic conditions among the elderly, Medicare is oriented primarily toward acute illness or acute episodes associated with chronic illness. This orientation mainly toward acute conditions represents an unbalanced approach toward the health needs of the elderly. The orientation is reflected in a number of ways relative to Medicare's home health benefits.

a. Under Medicare's Health Insurance program beneficiaries must be hospitalized at least three days to establish eligibility for home health services. Thus, home health services are accessible to HI beneficiaries only after an episode of hospitalization.

b. Patients who no longer require the more skilled types of home health services are no longer eligible to receive the less skilled types of home health services even though such services may be needed to consolidate or maintain the patient's revocery from an acute episode. As a result of the failure to receive the less skilled (and less expensive) home health services, many patients regress to various states of incapacity and become patients in hospitals or nursing homes. Purchase of the needed services is out of the question for at least 25 percent of the elderly in this region because of their poverty status.

c. Medicare provides no benefits for homemaker services despite the need for such services among beneficiaries and the ability of the services to prevent or postpone institutionalization. The elderly beneficiary living alone and afflicted by arthritis or other crippling diseases would be the kind of person who would be likely to need homemaker services, particularly during an acute illness, such as influenza.

Medicare's orientation toward acute illness to the exclusion of relatively inexpensive maintenance-of-health services results in unnecessary human misery and unnecessary expenditures for expensive institutional care.

2. Arbitrary Determination of Eligibility

The Medical Malpractice Commission found evidence that fiscal intermediaries frequently make arbitrary findings relative to the beneficiary's eligibility for services. Arbitrariness in decisions involving eligibility, aside from being discriminatory, irritates providers of care, confuses beneficiaries, and creates disincentives for the ordering of services for persons in need.

3. Under-Use of Home Health Services

Analysis of national expenditures patterns reveals that spending for home health services is considerably lower than levels that would be necessary to meet even the most minimum estimates of need for services.

4. Inadequate Mechanisms to Monitor Receipt of Care

Despite spending ever larger amounts of Medicare funds for institutional care each year and despite manifest under-use of home health services by beneficiaries, Medicare administration has developed no method of monitoring the extent to which beneficiaries who need home health services actually receive them. Claims review procedures have been oriented in the past toward preventing over-use of services by beneficiaries receiving services, but no attempts have been made to identify the much

larger number of beneficiaries who needed services but never received them. As a result, the Medicare beneficiary population has been able to remain medically under-served (relative to home care) for years (see pp. 24-26).

5. Reduced Availability of Services

Nationally, the number of home health agencies participating in Medicare has declined from 2,346 in 1970 to 2,217 in 1972.

Problems in Inter-Coordination

1. Lack of Public Information

The public is poorly informed about home health services benefits under Medicare and even less informed about program performance problems.

2. Lack of Responsiveness

Medicare has been characterized in the past by unresponsiveness to large unmet home health services needs among the elderly. Although some minor changes have begun to be made in Medicare's home health services benefits, Medicare must continue to be seen as unresponsive to these needs until significant increases in the availability, use, and funding of home health services occur.

3. Lack of Public Accountability

The existence of such problems as poor administration, unbalanced spending patterns, restrictive benefits for chronic health conditions and subsequent health care needs, lack of public information, and lack of program responsiveness for at least a five year period suggest that both the Department of Health, Education, and Welfare and the Congressional bodies charged with overseeing the performance of the Medicare program have failed to be adequately accountable to the public for their actions.

B. Medicaid

Problems in Administration

1. Lack of Policy

The federal government has failed to develop explicit guiding policies on the relative emphasis to be placed on the development, provision, or use of various kinds of long-term care services through tax-supported programs. Likewise, no policies have been developed on the relative societal value or importance of maintaining people, particularly the elderly, at an acceptable level of independence in their own homes. In addition to the absence of policy, manifest or de facto policies are inappropriate and detrimental to the interests of both taxpayers and health care consumers. Manifest policies, evidenced by national spending patterns, are obviously oriented toward the promotion and support of institutional forms of care at the expense of home health services.

The absence of policy hinders program evaluation and modification, resource allocation and re-allocation, administrative evaluations of trade-off decisions, the definition and solution of problems, and the consistency and rationality of decision-making.

Problems in Resources

1. Gross Under-Spending for Home Health Services

Despite substantial need for home health services among the Medicaid beneficiary population, particularly the elderly, national Medicaid spending patterns indicate that only a small fraction of the need for services is met each year by the program.

Problems in Service Delivery

1. Inadequate Federal Regulations

Existing federal regulations are oriented toward assuring that state Medicaid programs "provide" required home health services "sufficient in amount, duration and scope to reasonably achieve their purposes," but little guidance exists in either the regulations or case law to help define "amount", "duration", "scope", or "purpose". Without definition of these key terms it is virtually impossible to assess the adequacy of home health services "provided" by state programs.

Several federal regulations require state programs to have uniform eligibility standards and service benefits across all categories of beneficiaries, but loopholes in the regulations permit their circumvention. Even though beneficiaries may be entitled to receive home health services, the unavailability of services in many areas of the state and country results in many beneficiaries being deprived of access to the services. By offering to pay for home health services uniformly, state programs technically conform to the regulations even though thousands of beneficiaries may have no access to services.

Other federal regulations require home health agencies to qualify for Medicare certification. While it is laudable to have high standards for providers participating in the Medicaid program, the requirement for qualification as a Medicare provider prevents the reimbursement of small or newly-developed home health agencies that could provide services. As a result, the development of needed services is further hindered.

2. Excess Use of Nursing Homes

Excess use of nursing homes by Medicaid beneficiaries has been repeatedly documented. (See, for example, "Final Report, Survey of Title XIX Long Term Care Facilities and Patients", Social and Rehabilitation Contract 72-68, a study conducted across 15 states.)

Problems in Inter-Coordination

1. Lack of Public Information

One would think that a multi-million dollar, tax-supported, public insurance program such as Medicaid would be subject to considerable review, consideration, and discussion by the people who ultimately have to foot the bill. Such is not the case. The general public receives little information about spending and utilization patterns generated by Medicaid and even less reporting of the few intelligent analyses or studies that have been made of the program. The public is, of course, acutely aware of inflation in health care costs and progressively higher taxes, but their frustration and annoyance are usually directed toward "welfare bums" instead of the policies, procedures, agencies, and officials really responsible for misspending and overspending.

The public's ignorance of the real issues involving Medicaid is all the more remarkable in light of the amount of spending and the human and economic waste that currently characterize the program. Without timely, accurate, and relevant information, the public is prevented from making or influencing

or contributing to the informed decision-making that should characterize our society's democratic processes. Individual curiosity is successfully and easily thwarted by the confusing and increasingly complex bureaucratic machinery surrounding the administration and implementation of the program.

2. Lack of Public Accountability

The existence of the problems identified in this document for at least a five year period suggests that both the Department of Health, Education, and Welfare and the Congressional bodies charged with overseeing the performance of the Medicaid program have failed to be adequately accountable to the public for their actions.

C. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

Problems in Administration

1. Inadequate Administrative Data

Attachment 18 shows correspondence that attempted to elicit basic administrative data from the CHAMPUS program. The correspondence shows that many kinds of data are simply not available from the program, particularly at a sub-national level. National data do show that spending under the program jumped 124 percent from FY 1969 to FY 1973 (about 30 percent per year) despite an increase in the beneficiary population of only 10 percent in the same period.

Problems in Inter-Coordination

1. Lack of Public Accountability

The lack of basic administrative data, coupled with the program's $478 million price tag in FY 1973 and the high rate of spending increase, raises serious questions about the adequacy with which the CHAMPUS program has administered several billions in tax funds over the past few years.

2. Lack of Planning Coordination

The absence of data at sub-national levels interferes with health planning activities in those regions, such as this region, which contain significant numbers of CHAMPUS beneficiaries. CHAMPUS, like most other federal programs, has made no attempt to coordinate its obviously limited data activities with health planning agencies, most of which are also federally funded.

3. Lack of Public Information

The CHAMPUS beneficiary's benefit booklet, confusing and complicated, is mute evidence of the complexity of the CHAMPUS program. The reader is challenged to determine from the booklet the kinds of home health services eligible for reimbursement, the conditions under which the services may be provided, and the extent to which the program will pay for the services. See Attachment 19.

D. Indian Health Service

Problems in Administration

1. Inadequate Administrative Data

An attempt to secure data on the use of home health services (and other services) under the Indian Health Services failed because data are neither adequately nor readily available (see Attachment 20). Only some of the relatively routine data that were requested were provided -- at "the diversion of considerable effort". Are data monitoring activities of the Indian Health Services adequate in light of their $32 million budget in fiscal 1973?

E. Federally-Funded Health and Insurance Programs

The consistent finding of data deficiencies in the Medicare, Medicaid, CHAMPUS, and Indian Health Services programs warrants a short but separate discussion in light of recent Congressional initiatives and data mandates relative to an expanded nationwide program of health planning, the likelihood of passage of national health insurance legislation in the near future, the multi-billion dollar magnitude of federal health spending, and the rapid rate of increase in federal health spending in recent years. The existing deficiencies in rather routine and ordinary administrative data and the lack of congruence and coordination of data collection and distribution activities among federal health spending programs are very serious shortcomings that were uncovered as a by-product of this project.

There are at least three fundamental kinds of data needed for purposes of management and analysis of health programs: the number of people enrolled or eligible or "targeted" for care, the patterns of health services utilization generated by these people, and the expenditures generated by use of the services. The absence of any one of these three fundamental pieces of information will prevent intelligent management and analysis of a program. The availability of these data permits the identification of trends and problems and helps pinpoint the causes of changes in program expenditures.

Since patterns of health care very consideraly from area to area, it is important that enrollment, utilization, and

expenditure data be available for relatively small geo-political areas. In rural areas such as this, data by county are usually sufficient. The availability of enrollment, utilization, and expenditure data by county for various kinds of health care programs enables health planners to identify and analyze patterns and pinpoint problems.

Without these data, planners at the local level are immediately and severaly restricted in their ability to generate accurate analyses and projections. Gaps in data availability also introduce the possibility, if not probability, that incredibly expensive programs are not adequately administered. The public, perforce uninformed of key patterns and trends in tax spending for health, is subsequently prevented from making informed choices.

Thus, data problems serve both internally and externally to prevent intelligent program evaluation and modification. As a result, large programs appear monolithic and, in their inexorable inertia, unresponsive or unaware of real but often inarticulately expressed unment needs. And so in the inflationary present day, 10 years after the beginning of Medicare and Medicaid, it's not too surprising to find that home care is struggling harder than ever simply to survive, let alone flourish, because the program evaluations that would lead to the conclusion that home care must be strengthened have obviously not been done: the data needed for such evaluations are just barely available.

Recommendations: National Level

A. Medicare

Recommendations on Administration

1. Significant efforts should be made by the Social Security Administration to upgrade the quality and timeliness of its planning and administrative data. For example, annual cost reports for home health agencies should require provision of length of stay data. In-the-field health planners should be called upon to assist Social Security in these efforts. See also Recommendation E.1., p. 94 .

2. Discriminatory Conditions of Participation that apply only to home health agencies, i.e., the requirement for annual program evaluation, should be eliminated or else uniformly applied to all providers participating in Medicare. DHEW should initiate this revision.

3. The Social Security Administration should undertake a thorough review of the numerous administrative forms used in the Medicare program with a view toward eliminating unnecessary forms and/or data requirements and simplifying or shortening remaining forms, particularly those forms used by consumers. The advice of consumers and providers outside the Social Security Administration should be used in conducting this review.

4. Because the 1973 "Survey of Title XIX Long-Term Care Facilities and Patients" (SRS Contract 72-68) found that there is virtually no difference between Medicare and Medicaid patients in long-term care facilities, DHEW should perform a study of the feasibility of integrating skilled nursing benefits under either Medicare or Medicaid. Such integration would greatly reduce the red tape and inefficiencies now present in the dual but overlapping benefit structures.

5. The Health Insurance Benefits Advisory Council should monitor indicators of the availability, use, and funding of home health services under Medicare. After a reasonable period of time, the Advisory Council should adopt additional recommendations on home health services benefits under Medicare in the event the indicators reveal that improvements are not occurring.

   The Advisory Council should consider augmenting its September 1974 recommendations on home health services in the event the Council finds the problems discussed in this Guide to be valid, significant, and uncorrected.

6. To improve administrative ability to make appropriate modifications in Medicare, action should be taken by each (multi-state) regional office of the Social Security Administration to publicize the experimental reimbursement and serve delivery projects authorized by Public Law 92-603, particularly in DHEW Region X. If necessary, quotas should be established for each regional office relative to the generation of experimental projects. Increased personnel and financial resources should be allocated to this initiative, particularly for the purpose of provision of technical and financial assistance to potential grantees. Financial assistance could be used by potential grantees to hire grant writers and pay for other project development costs. These projects could provide a wealth of useful information on alternative methods of reimbursing or providing health services under Medicare.

7. Because of the manifest under-utilization of home health services under Medicare at the present time, the Social Security Administration should establish methods of monitoring the adequacy of delivery of home health services. Each multi-state regional Social Security office should file an annual report describing problems identified by the monitoring methods and actions taken to eliminate the problems. These reports will help identify common problems across the nation and thereby serve to improve administrative efforts to modify the program appropriately.

Recommendations on Resources

1. Medicare should change its method of payment of home care services to a prospective system with retrospective, fee for service, payment methods used only as an exception. The prospective system should certify the need for home care for a set minimum period, say 30 days, and pay a flat rate per period of care. The prospective payment system should not be linked to numbers of visits provided to patients. Intermediaries should provide or deny certification of need for care prior to delivery of care. In the event certification is denied, both patients and home health agencies should be furnished with a written justification. The patient's copy should describe actions that can be taken to appeal the decision.

   The payment method should be subject to flexibility from area to area in order to respond to unique characteristics or problems present. For example, if an agency provides a sufficient volume of care such that patients are categorized by level of intensity of care, the payment system should pay different rates according to level of care provided. Such a payment system is routine for the reimbursement of inpatient hospital services.

2. The Health Insurance Benefits Advisory Council should review the impact of Section 233 of Public Law 92-603 on the availability and use of home health services. If the positive impacts of the section appear to be outweighed by the negative impacts, the Advisory Council should make recommendations that will correct the problems identified.

3. Co-insurance requirements for home health agency visits to patients in skilled nursing facilities should be eliminated. The Department of Health, Education, and Welfare should initiate the actions necessary to accomplish this change.

4. Assessment visits by home health agencies should be reimbursable, just as they are reimbursable now for other providers of care. The Department of Health, Education, and Welfare should initiate the actions necessary to accomplish this change.

Recommendations on Service Delivery

1. Under the HI Program, the three-day prior hospital stay required to establish eligibility for home health services should be eliminated or modified in such a way that if prior hospital stay is still required, there is no minimum set on the duration of hospitalization needed for establishment of eligibility for home care. These actions should be taken by Congress.

2. Federal law and relevant regulations should be changed to permit the provision of homemaker/home health aide services to beneficiaries without the requirement that skilled services also be needed on an intermittent basis.

   To rectify the mis-orientation of Medicare toward only the acute recovering patient, home health services, particularly those provided by the homemaker/home health aide, should be made eligible for reimbursement when provided to stabilized patients who need assistance with personal care and the activities of daily living.

   These changes should be initiated by Congress.

3. The Department of Health, Education, and Welfare should continue its recent efforts to assure that beneficiaries will not be subject to arbitrary decisions by fiscal intermediaries relative to their eligibility for home health services.

4. In order to improve the extent to which hospital patients are screened for eligibility for home care services, DHEW should develop regulations as part of the Conditions of Participation for hospitals and skilled nursing facilities to require that:

a. Each participating facility will develop procedures and criteria for the screening of Medicare patients relative to their suitability to receive home health services or care in a skilled nursing facility following discharge. The criteria should be uniform within each PSRO review area or within each area served by a Health Systems Agency. All Medicare patients should be screened.

b. Each participating facility will define in writing the procedures and criteria to be used to screen Medicare patients for their suitability to receive home health services.

c. Each participating facility will use a multi-disciplinary team of health professionals to screen patient need for home health services.

Additional personnel costs incurred by the facility as a result of these requirements should be reimbursable as legitimate Medicare-related costs.

Attachment 13 shows a sample screening protocol developed by the Kaiser-Rermanente program in Portland, Oregon.

6. With the advent of prospective payment methods for home health serivces, mechanisms should be developed by the Social Security Administration to assure that too few services are not provided to beneficiaries who receive services.

Recommendations on Inter-Coordination

1. The Health Insurance Benefits Advisory Council should play more of a watchdog role in monitoring the quality of administration of Medicare. If such a role is not appropriate for the Advisory Council, the Council should review other methods of improving the public accountability of the program and recommend accordingly.

2. The DHEW should make annual, layman-oriented reports on the functioning of the Medicare program. These reports should analyze program performance in terms the general public can understand. The reports should show changes in the use of services, particularly home health services, and spending patterns. The reports should provide some interpretation of the data presented, including a description of manifest problems. These reports should be available, free of charge, at local Social Security offices.

3. The press and the media should expand their coverage of the performance of the Medicare program in order to improve the public's awareness of Medicare's benefits and problems. In their reporting, the press and the media should interview

consumers, providers, administrators, and planners relative to their viewpoints and concerns about Medicare. The reporting should, among other things, (1) address the question of whether the program is improving or getting worse, and (2) help define and clarify the problems and issues raised by interviewees.

B. Medicaid

Recommendations on Administration

1. Because of the manifest under-use of the home health service benefit under Medicaid across the country, the Health Insurance Benefits Advisory Council should monitor indicators of the availability, use, and funding of home health services under Medicaid. After a reasonable length of time, the Advisory Council should adopt additional recommendations on home health services benefits under Medicaid in the event the indicators reveal that improvements are not occurring.

   The Advisory Council should consider augmenting its September 1974 recommendations on home health services in the event the Council finds the problems discussed in this Guide valid, significant, and uncorrected.

2. To improve administrative ability to make appropriate modifications in Medicaid, action should be taken by each (multi-state) regional office of the Social and Rehabilitation Service to publicize the experimental reimbursement and service delivery projects authorized by Public Law 92-603, particularly in DHEW Region X. If necessary, quotas should be established for each regional office relative to the generation of experimental projects. Increased personnel and financial resources should be allocated to this initiative, particularly for the purpose of provision of technical and financial assistance to potential grantees. Financial assistance could be used by potential grantees to hire grant writers and pay for other project development costs. These projects could provide a wealth of useful information on alternative methods of reimbursing or providing health services under Medicaid.

3. Because of the manifest under-utilization of home health services under Medicaid at the present time, the Social and Rehabilitation Service should establish methods of monitoring the adequacy of delivery of home health services. Each multi-state regional SRS office should file an annual report describing problems identified by the monitoring methods and actions taken to eliminate the problems. These reports will help identify common problems across the nation and thereby serve to improve administrative efforts to modify the program appropriately.

Recommendations on Resources

1. In light of national spending patterns under Medicaid, federal regulations should be amended to require states to reimburse a broader range of home health services under Medicaid. At a minimum, states should reimburse the same kinds of home health services under Medicaid as Medicare. These modifications should be initiated by the Congress.

Recommendations on Service Delivery

1. Federal regulations and associated deficiencies discussed in this Guide (pp. 82-83) should be reviewed and amended, to the extent possible, to eliminate the deficiencies. This review and modification should be initiated by DHEW. Regulations which require home health agencies to qualify for Medicare certification in order to participate in Medicaid should be eliminated. This modification should also be proposed by DHEW.

2. In order to improve the extent to which hospital patients are screened for eligibility for home care services, DHEW should develop regulations for hospitals and skilled nursing facilities to require that:

   a. Each participating facility will develop procedures and criteria for the screening of Medicaid patients relative to their suitability to receive home health services or care in a skilled nursing facility following discharge. The criteria should be uniform within each PSRO review area or within each area served by a Health Systems Agency. All Medicaid patient should be screened.

   b. Each participating facility will define in writing the procedures and criteria to be used to screen Medicaid patients for their suitability to receive home health services.

   c. Each participating facility will use a multi-disciplinary team of health professionals to screen patient need for home health services.

   Additional personnel costs incurred by the hospital as a result of these requirements should be reimbursable as legitimate Medicaid-related costs.

   Attachment 13 shows a sample screening protocol developed by the Kaiser-Permanente program in Portland, Oregon.

Recommendations on Inter-Coordination

1. The Health Insurance Benefits Advisory Council should play more of a watchdog role in monitoring the quality of

administration of Medicaid. If such a role is not appropriate for the Advisory Council, the Council should review other methods of improving the public accountability of the program and recommend accordingly.

2. The DHEW should make annual, layman-oriented reports on the functioning of the Medicaid program. These reports should analyze program performance in terms the general public can understand. The reports should show changes in the use of services, particularly home health services, and spending patterns. The reports should provide some interpretation of the data presented, including a description of manifest problems. These reports should be available, free of charge, at local Social Security offices.

C. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

Recommendations on Administration

1. See Recommendations E.1., p. 94.

2. An independent consultant should be hired by a federal contractor other than the Department of Defense to evaluate the CHAMPUS program and recommend changes that should be made in the program over the next 10 years. The consultant should review relevant laws and administrative practices, payment methods and resource constraints, serve benefits and eligibility requirements, and inter-coordination activities currently in effect with a view toward identifying changes needed to modernize and simplify the program in ways appropriate to characteristics of the projected beneficiary population of the future. Appropriate Congressional bodies should review the findings of the study and assure that necessary and appropriate program changes are made.

Recommendations on Inter-Coordination

1. Congressional bodies charged with overseeing the performance of the CHAMPUS program should require the Department of Defense to prepare annual reports on CHAMPUS program performance similar to the reports discussed under Recommendation 2 on p. 90. These reports should be available to the public on request.

2. The beneficiary booklet distributed by the Washington Physicians Service should be reviewed by a panel composed in part of CHAMPUS beneficiaries with a view toward clarifying and simplifying the booklet's descriptions of benefits. Since problems of clarity and intelligibility that currently

detract from the effectiveness of the booklet are largely due to structural/functional problems of the CHAMPUS program itself, the review panel should also identify the most troublesome structure/fuction program problems that prevent needed simplification and clarification of descriptions of benefits and provedures in the booklet. Having identified the most salient such problems, the review panel should make recommendations on the program changes that should be made to reduce the problems. This type of review should be funded in this state and several other states by the Department of Defense. The results of such reviews will provide grassroots-based information that should be used to supplement the findings of the national study recommended on p. 93.

D. Indian Health Service

Recommendations on Administration

1. See Recommendation E.1. below.

E. Federally-Funded Health and Insurance Programs

Recommendations on Administration

1. The Department of Health, Education, and Welfare should organize a task force to review national data systems of Medicare, Medicaid, CHAMPUS, the Indian Health Service, and other relevant programs. The review should focus on identifying the actions needed to develop adequate, appropriate, uniform, and coordinated data systems among the programs. In light of the data and analytical requirements of P.L. 93-641 and the obvious impact federal health and insurance programs have on eligible populations at the regional health planning level, the advice, assistance, and participation of professional health planners should be solicited by the task force in its review.

2. The Cooperative Health Statistics System should add a new component on health expenditures. The continued absence of this component from the currently proposed set of seven components will seriously interfere with administrative assessments of cost-effectiveness, benefit-cost ratios, patterns of spending, and program efficiencies. Such an expenditure component would not only assist future health planning activities under Public Law 93-641 but also promote the public accountability of federal programs.

F. Political Parties and Candidates for Elective Office

Because of the magnitude, diversity, and national prevalence of the problems identifed in this Guide, political parties and candidates for elective office should consider making the improvement of home health services a priority health-related campaign issue.

ATTACHMENT 1

DANIEL J. EVANS
GOVERNOR

RICHARD W. HEMSTAD
DIRECTOR

EMPLOYMENT DEVELOPMENT
SERVICES COUNCIL
ROBERT L. BAILEY, CHAIRMAN
LYLE M. TINKER, EXECUTIVE DIRECTOR
GENERAL ADMINISTRATION BUILDING
OLYMPIA, WASHINGTON 98504

STATE OF WASHINGTON
Office of the Governor
OFFICE OF COMMUNITY DEVELOPMENT
OLYMPIA, WASHINGTON 98504
206/753-2200

July 7, 1975

Ms. Sara F. Hackler, Coordinator
Home Health Aide Program
315 Halleck Street
Bellingham, Washington 98225

Dear Ms. Hackler:

Thank you for your letter and the information describing the Home Health Aide Program. It is a program which is serving individuals who otherwise might be forgotten.

One of our original goals when establishing CETA positions was to place them in programs which would help individuals stay at home rather than having to be placed in nursing facilities. Sadly, this objective has been met in only a few areas of the state. The Home Health Aide Program is one that is working toward this goal.

As you know, most Title II CETA positions have had to be either phased out or moved to Title VI. The Home Health Aide Program positions have been moved to Title VI. This should not make any difference in your operation of the program. You have undoubtedly been informed by now that your positions will be maintained until at least September 30. However, because of the need that your program fills in the community and because of the quality of the service provided, I can assure you that your positions will be funded through CETA until the end of our grant, June 30, 1976. I hope that through this you can continue to provide the service to the many persons in need of it.

Sincerely,

Lyle M. Tinker

Lyle M. Tinker
Administrator

LMT/bjb

cc: Eudora Peters
Dwight Wood
Cloyd Campbell

May 5, 1975

CETA Program

Dear Mrs. Hackler:

This Program is a Godsend to the elderly. It supplies a great need. It looked as if Mrs. B. W. who is just home from the hospital and Mrs. M. H. who is blind might have to go to a rest home. Mrs. W's savings were simply eaten up by her stay in the hospital.

Neither of these people could live alone but together with a little help they can manage.

If possible it is far better for the elderly to remain in their own homes where they are much happier. I think it is also much less expensive and better management for the government than for paying for two in a rest home.

With this girl coming twice a week and also being able to get a meal three times a week from Lincoln Square, their need will be met. They are two very happy people.

When I see the good that this Program is accomplishing I am very grateful for it. It's one Government Program that I can whole heartedly support and I fervently hope it will be continued.

These people are thrify and independent and wouldn't ask for help unless it was vitally necessary.

Thank you with all my heart.

Sincerely,

/s/

Mrs. Phoebe B. Townley

ATTACHMENT 1

Bellingham, Washington
June 2, 1975

Dear Mrs. Hackler,

I just want you to know what it has meant to us that you were able to send us help when you did through CETA.

I had been trying for over a year to hire a responsible person, housekeeper or nurse, to help me care for my husband who has been bedfast for over a year, but no help was to be had.

I was getting so tired I was afraid I'd be unable to continue the rigid routine and that he'd have to be placed in a nursing home.

Since Cheryl has been coming I've been able to do necessary shopping, get jobs done that wouldn't wait any longer and most of all I'm getting some rest.

I was scheduled for a series of x-rays when my husband became ill. Now I hope to get these x-rays taken.

We both want you to know we are very pleased with Cheryl. Her attitude and her work is most commendable.

Sincerely,

/s/

Judith Christofferson

GERALD R. FORD LIBRARY

ATTACHMENT 1

June 24, 1975

Dear Sara,

The Home Health Care Aide Program has truly been a blessing for all involved. Already there have been many lives deeply touched in the short two months that the program has existed.

There is a family in which the husband, who is 91 years old, has been bedridden with heart congestion for the past year. His wife is totally devoted to him and answers his every need. But after a year of caring for him, she is worn out. Before this program started, she had fears that she might have to send him to a nursing home. Now, with help two times a week, she can leave the home and her husband in the hands of another - she can relax and be with other people. And she certainly does look and feel better now. She has said many times that the program has been a real lifesaver for her and her husband.

There is another family in which the wife is a paraplegic. She has been bedridden for the past 18 years, and it had been several years since she had seen a doctor. Since the program started, a doctor has been to see her, she has been given a bed bath twice a week, her pressure sores (one covered her entire left buttock) are starting to heal, her hair has been shampooed weekly. She is now given the personal care her husband is not able to give her. And they both enjoy an evening meal which offers a change from the husband's quick, but not so nutritious cooking.

There are two ladies who have lived together for the past 18 years. One has been blind the last 20 years and the other is now suffering from terminal cancer. The lady who is blind is 85 years old and a very proud and determined woman. She loves her home and moving to a nursing home would be detrimental to her fine spirit. The other lady is 83 years old and is very much at peace when she's in her home. This is where she wants to be during the last few months of her life. These ladies are able to remain in their home with the help of a Home Care Aide. Because of this program they can stay at home and yet be assured of a clean home, clean clothes, clean hair and bodies, groceries in their cupboards, food cooked up for their dinner - all the chores they have done for years and years but now must rely on others to do for them. How joyous it is that there is a program that gives them that help.

And there is a lady who is an alcoholic. She is divorced and somewhat abandoned from her family. She is a very lonely woman. Because of this program, she is given at least two good meals a week, her laundry is done, and her hair and body washed. In her case, maybe the most important thing of all is that there is now someone she can play the piano for. And how she does play!

There are many others who have been helped. Sometimes older folks are forgotten about in these times. No longer do they move in with their children and become a part of their children's family. And even though the children may visit and keep in touch, they are oftentimes too busy with their own lives to care for their folks. So where do the elderly turn when they find they can no longer do the chores that need be done - to a nursing home - where everything is new, strange and oddly institutionalized. At an older age, that is quite an adjustment to make. An adjustment that might take a lot of life out of them. With the Home Health Care Aide Program, they can remain in their familiar setting, enjoying the peace and tranquility that only their home can offer.

Sincerely,

/s/

Cheryl Kellerman

Home Health Aide Program
Whatcom County Opportunity Council
Senior Citizens
Bellingham, WA 98225

I have been asked to record some of the experiences which I have had, as well as some of the cases I have covered during the past two months of this program. First of all, I would like to introduce myself. I am one of four women working as an aide in this program, along with our supervisor, Ms. Sara Hackler. I am the only one without some previous medical training or experience. My training is in education and particularly working with handicapped children.

We work with several families who have a handicapped child, cerebral palsy being the main affliction. All of these families have other children besides, and we were called in to give the mothers in these situations a time to be away from the home and pursue business and social matters with the peace of mind in knowing they had left their children in the care of a trained professional. These mothers have been under particular strain in their various family situations, and could be placed in the situation of venting their anger and frustrations upon their children. By coming into the home and giving them some time to themselves, helping with some household chores, and running errands for them, we have taken much pressure from their shoulders and allowed them a breathing space and some rejuvenation.

Specific situations include a woman with two children, one with cerebral palsy, whose husband has left her with total responsibility for the children as well as the property. She is scheduled for uterine surgery soon and is trying to find foster care for her son (with cerebral palsy) during her surgery and recuperation time. She is under much pressure at this time and vitally needs some time to herself to take care of the many business matters facing her right now. I visit her two afternoons a week for four hours each, and during this time she has taken care of personal and business matters. I take her son to therapy sessions and have been taught some exercises to do with him by the therapist.

Another mother has a one and a half year old son with cerebral palsy as well as two older sons. She is with the children constantly and greatly needs some time to herself. I also visit her two afternoons a week for four hours each, giving her some time to run errands and take care of family business. I do some simple household chores for her also, which gives her some respite from the daily grind. There are other families in similar situations where the mother is given some respite from family obligations. I have worked with the Occupational Therapist with these children and do some therapy exercises with them at home when I am there.

Besides the children I take care of, I also visit several senior citizens in the community. One woman has bone cancer and has been taken care of by her husband for about a year. They are both in their seventies and he was getting tired and somewhat bitter in his position as full-time partner and nurse. I visit them two mornings a week and help her with her bath and personal care, something her husband would be very uncomfortable doing.

I see two different households where the residents are 90 years old (and above) and still trying to maintain their own homes. They have done (in both cases I'm connected with) very nice jobs of maintaining their own apartments, but they are expending a maximum of energy merely providing for their living necessities. With our visits, we are able to help them do a more thorough job of keeping their living quarters up to sanitary standards, and also take them out of the house for errands and social calls. Our visits are keeping many of these people out of costly nursing homes as well as preserving some sense of dignity and self-sufficiency for our elderly citizens.

All four of us have been visiting one elderly lady who was seriously ill but refused to stay in the hospital. We helped her through some very critical stages and she is now recovering somewhat and becoming self-sufficient again. If she had been forced to go to a nursing home, she quite possibly may have given up and died, but she remained in her own home and fought back to continue living.

One particular case bears mentioning here to point out the help we can give persons who are temporarily afflicted with some disability. This man had been injured in a ski accident and had broken both arms. He was sent home from the hospital with both arms in a cast which covered the entire trunk and made movement of arms and hands impossible. We went in every morning and bathed him, fed him breakfast, and did his immediate cleaning chores. He was quite helpless for three weeks and would not have been able to afford private help. In fact, our services are provided free-of-charge to all of our patients, who are from low-income situations where private help is an impossibility. Without our help, these people would have had to change their situations drastically.

A Home Health Aide Program can do these things I have mentioned and much more. All of our patients were found in the community in only two months of service of the program. There are most certainly many more cases like them who have yet to be discovered or recommended to the program. These people will suffer without the home health aide service, but certainly not as much as those who have already been initiated into our service and have now come to depend on us for help and relief.

A program such as this is a vital community service that Whatcom County can be proud of. That it is possible that it will be discontinued is almost unspeakable, but yet exists. I hope that this brief report gives some idea of the type of thing we are doing for people in the community and points out the basic service such a program can provide to all kinds of people.

/s/

Diana L. Gay

ATTACHMENT 2

REPORTED SAVINGS ON HOSPITAL COSTS THROUGH HOME CARE

Selected Studies

This paper summarizes data on savings in hospital costs resulting from early discharge to home health care as reported in selected studies in New York State and elsewhere. Various other reports now available could have been included, but the number has been restricted in the interests of brevity.

Studies selected represent programs at three levels -- statewide, metropolitan area, a single community hospital. Also included are two studies related to a single disability -- 1) care at home of patients in traction, and 2) home care of children with hemophilia.

Figures are given below which summarize savings in hospital days and hospital costs reported in these studies. Later tables give source references and additional breakdown data.

REPORTED HOME CARE SAVINGS

Study Report	Hospital Days Saved Per Patient	Net Savings Per Patient[1]
Visiting Nursing Service, Denver, 1971	15.6	$1,170
Hemophiliac Children, McGill Univ, 1972	70.2	4,477
Blue Cross, Philadelphia, 1963-71	12.9	330
St. Luke's Hospital, Denver, 1970	14.0	850
Blue Cross, Connecticut, 1970-72	21.6	2,175
Patients in Traction, Rochester, 1973	49.8	4,590
Blue Cross, Michigan, 1961-70	14.7	562

1) Figures are net savings -- costs of home care deducted from estimated savings in hospital costs.

A number of comments are in order with reference to the above figures

First, reported hospital days saved in the Philadelphia, Connecticut, Denver VNA, and Michigan studies are based on estimates made by attending physicians. Figures in 4 of the 5 studies fall within a relatively narrow range of 12.9 to 15.6 days saved. Such a result involving hundreds of physicians and thousands of patients in so many parts of the country

Prepared by Edward G. Lindsey, Director of Health Services, State Communities Aid Association, New York, New York.

strongly supports the validity of the data even though an element of subjective judgment is involved. (See Table V for explanatory comment on the higher Connecticut figures).

Second, data in the St. Luke's and McGill University reports are based on carefully designed control studies. Savings reported are based on objective data comparing selected groups receiving hospital care only, and groups receiving hospital plus home health services.

Third, the substantial reductions in hospital stays reported in the hemophiliac and traction case studies add an important dimension to the cost effectiveness potential of home care. The number of such patients in the population, of course, is relatively small. However, in view of the very high dollar savings, there is strong indication that earlier discharge to home care for these and other special disability groups -- post-surgical, pediatric, coronary, pulmonary, to name a few -- could add up to an impressive cost reduction.

Fourth, taken together these studies present a strong weight of evidence that home care can make significant savings in hospital days. Admittedly, there are limitations in the studies. But it would seem imprudent to ignore the evidence of these reports while awaiting some more comprehensive research project for which there is presently no visible sponsor or source of funding.

Meanwhile, the explosion in health costs continues. Careful clinical studies consistently report unnecessary hospital and nursing home use, a portion of which could be reduced by home care. Over 42% of Medicaid expenditures in the state in 1970 were for hospital care, and more than 24% for nursing home care. Only a fraction goes for low-cost care in the home.

The cost situation and the data in this report strongly suggest the timeliness for action on home care.

For breakdown data on studies cited, see pages 3 through 9.

ADDITIONAL DATA ON STUDIES

Tables I through VII which follow present additional data on the home care studies cited on page 1. In some instances for convenience, figures have rounded to the nearest dollar.

A. Denver Early Discharge Program

Table I below summarizes data reported by the Denver Visiting Nurse Service on the 1971 Early Discharge Program. The study involves 620 patients referred to home care by 10 voluntary hospitals.

TABLE I

DENVER EARLY DISCHARGE PROGRAM - HOSPITAL DAYS SAVED[1)]

Year 1971

Hospital Days Saved Per Patient[2)]	Hospital Savings Per Patient[2)]	Home Care Cost Per Patient[2)]	Net Savings
15.6	$1,472	$302	$1,172

1) "Report of Early Discharge Program," Visiting Nurse Association, Denver, Colorado, 1972.

2) Based on average hospital per diem of $95.

An additional 768 patients were referred to home care, but not designated as "early discharge." Data on these patients is not included in Table II.

B. Home Care of Hemophiliac Children

Table II below reports on a controlled study of 40 bleeding hemophiliac children carried out by McGill University and Montreal Children's Hospital over a period of two years. One group of 20 children received care at home and limited hospital care. The control group received care for each bleeding episode only in the hospital.

TABLE II

HOME CARE VS. HOSPITAL CARE OF 40 HEMOPHILIAC CHILDREN[1)]

Years 1970-72

	Group A Hospital Care[2)]		Group B Home Care[2)]		
	Days Care	Cost	Days Care	Cost	Total
Hospital Group	1,644	$164,400	-	-	$164,400
Home Care Group	241	24,100	2,030	$50,750	74,850
				Net Savings	$ 89,550
				Savings Per Patient	$ 4,477

1) "Delivery of Care to Hemophiliac Children: Home Care Versus Hospitalization," Dr. Hanna Strawczyski, McGill University, Department of Pediatrics, and Children's Hospital, Montreal, Canada, November 1972.

2) Hospital costs estimated at $100 per day; home care costs averaged approximately $25 per day during bleeding episodes.

Control Group B, through the addition of home care, used 85% fewer hospital days than Group A. "School attendance in the home care program was significantly better with an average of 2.5 school days missed per bleeding episode, as compared to 6.2 days in the hospital program."

C. Philadelphia Blue Cross Study

Table III below summarizes data on hospital days saved as reported in a home care study by Blue Cross of Greater Philadelphia. The study covered a ten (10) year period -- 1961-70, and provides figures on 3,940 patients discharged to home care by four (4) hospitals during that time.

TABLE III

HOSPITAL DAYS SAVED - PHILADELPHIA BLUE CROSS[1)]

Years 1961 - 1970

Hospital Days Saved Per Patient	Hospital Savings Per Patient	Home Care Cost Per Patient	Net Savings Per Patient
12.9	$634	$304	$330[2)]

1) "Coordinated Home Care: An Effective Alternative," Blue Cross of Greater Philadelphia, February 1972.

2) A net savings of $473 per patient was later reported for the year ending June 30, 1970.

Estimated hospital days saved on 3,940 cases totaled 50,800 days valued at $2,495,267. Net savings after deducting costs of home health services and related administrative costs were estimated at $1,298,381.

D. St. Luke's Hospital Study, Denver

Table IV below summarizes data on hospital days saved as reported in a controlled study by J. W. White at St. Luke's Hospital, Denver, Colorado in 1970. The study involved one sample of 100 patients referred by the Hospital Nurse Coordinator's Office to home care, and a second sample of 100 patients selected on admission until "the same number of cases for each diagnostic category was reached" as in the home care sample.

TABLE IV

STUDY OF HOSPITAL DAYS SAVED THROUGH REFERRAL TO HOME CARE[1)]

St. Luke's Hospital - 1969

	Hospital Days	Hospital Cost[2)]	Home Care Cost	Total Cost
Hospital Group	2,554	$196,504	-	$196,504
Home Care Group	1,155	88,935	$22,534	111,469
			Net Savings	$ 85,035

1) "A Comparison of Referred and Non-Referred Cases to Home Nursing Care," unpublished Masters Thesis, J. W. White, M.A. Hospital Administration, 1970.

2) Average per diem (St. Luke's, 1969) . . . $77.

Hospital days saved averaged 14.0 days per patient. Hospital costs saved averaged $1,076 per patient. Home health services averaged 36.4 days per patient. Net savings were $850 per patient, a cost reduction of over 43%.

E. Connecticut Blue Cross Study

Table V below summarizes data on hospital days saved as reported by Connecticut Blue Cross in a study of statewide home care coverage which began in April 970 with one hospital participating. During the two-year period the number participating hospitals increased to 16.

TABLE V

STUDY OF HOSPITAL DAYS SAVED - CONNECTICUT BLUE CROSS[1)]

August 1970 - September 1972

Hospital Days Saved Per Patient	Average Hospital Savings Per Case[2)]	Home Care Costs Per Case	Net Savings Per Case
21.6	$2,528	$353	$2,175

1) "Coordinated Home Care - The Facts Speak for Themselves," Blue Cross of Connecticut, May 1972.

2) Total in-patient dollars saved were reported as $1,329,588, based on "physician estimates of days saved multiplied by an average per diem weighted cost of 16 hospitals."

A total of 526 patients were covered in the study. Blue Cross reported in May 1973, eight months after completion of the study, that there had been an increase of 100% over the total for the first two years of coverage.

In reviewing the long-range Michigan and Philadelphia studies, it is interesting to note that estimates of hospital days saved were substantially higher in the early years of the program than in the later years. This experience may relate to the relatively high estimates in this study which covers a new program.

F. Home Care of Patients in Traction

Table VI below summarizes data reported by the Home Care Association of Rochester on care at home of six (6) patients in traction. Diagnoses included: broken femur - 4; bilateral femoral fracture - 2. The data assumes that without home care these patients would have continued to be hospitalized for the full period in traction -- an average of 49.8 days per patient.

TABLE VI

COSTS OF CARE AT HOME OF SIX (6) PATIENTS IN TRACTION[1)]

Compared to Hospital Costs

	Days at Home In Traction	Cost Per Day	Cost Per Patient	Total Cost
HOSPITAL CARE	49.8	$110.00	$5,965	$35,794
HOME CARE	49.8	27.60	1,375	8,250
Home Care Savings		$ 92.40	$4,590	$27,544

1) "Home Care Tractions Cases - Six Patients," Home Care Association of Rochester, November 15, 1973.

Ages of patients in the study were 8, 15, 16, 17, 19, and 61 years. Some patients required limited home care services after removal from traction, but this is not involved in the above data.

G. Michigan Blue Cross Study

Table VII below summarizes hospital savings estimated in the Michigan Blue Cross home care program for the year 1967. Included are 1,157 discharges from coordinated home care. The data covers the last year of a seven (7) year period of home care coverage -- 1960 through 1967.

TABLE VII

HOSPITAL DAYS SAVED - MICHIGAN BLUE CROSS[1)]

Year 1967

Hospital Days Saved Per Patient[2)]	Average Hospital Savings Per Patient[2)]	Home Care Average Costs Per Patient[3)]	Net Savings Per Patient
14.7	$755	$193	$562

1) "Blue Cross Home Care Benefits: The Michigan Experience," Krause and Harmon, Michigan Hospital Service, 1969.

2) With estimated hospital savings of 17,008 patient days. Average home care costs were $51.34 per diem.

3) Average home care days per case were 48.8 in 1967, and totaled 52.8 over the 1960-67 period.

Estimates of hospital days saved averaged 17.9 days per patient over the 1960-67 period: approximately 20 days for 1960-63; 17.2 for 1964-66, and 14.7 days for 1967.

SUMMARY

This report has presented only a portion of available studies on home care cost-effectiveness. Further, data presented has related only to those hospital savings which result from early discharge to health carein the home.

Additional hospital savings through home care could be documented:

. . . the effectiveness of home health services in preventing unnecessary or premature return to the hospital which can occur for lack of proper follow-up care after discharge;

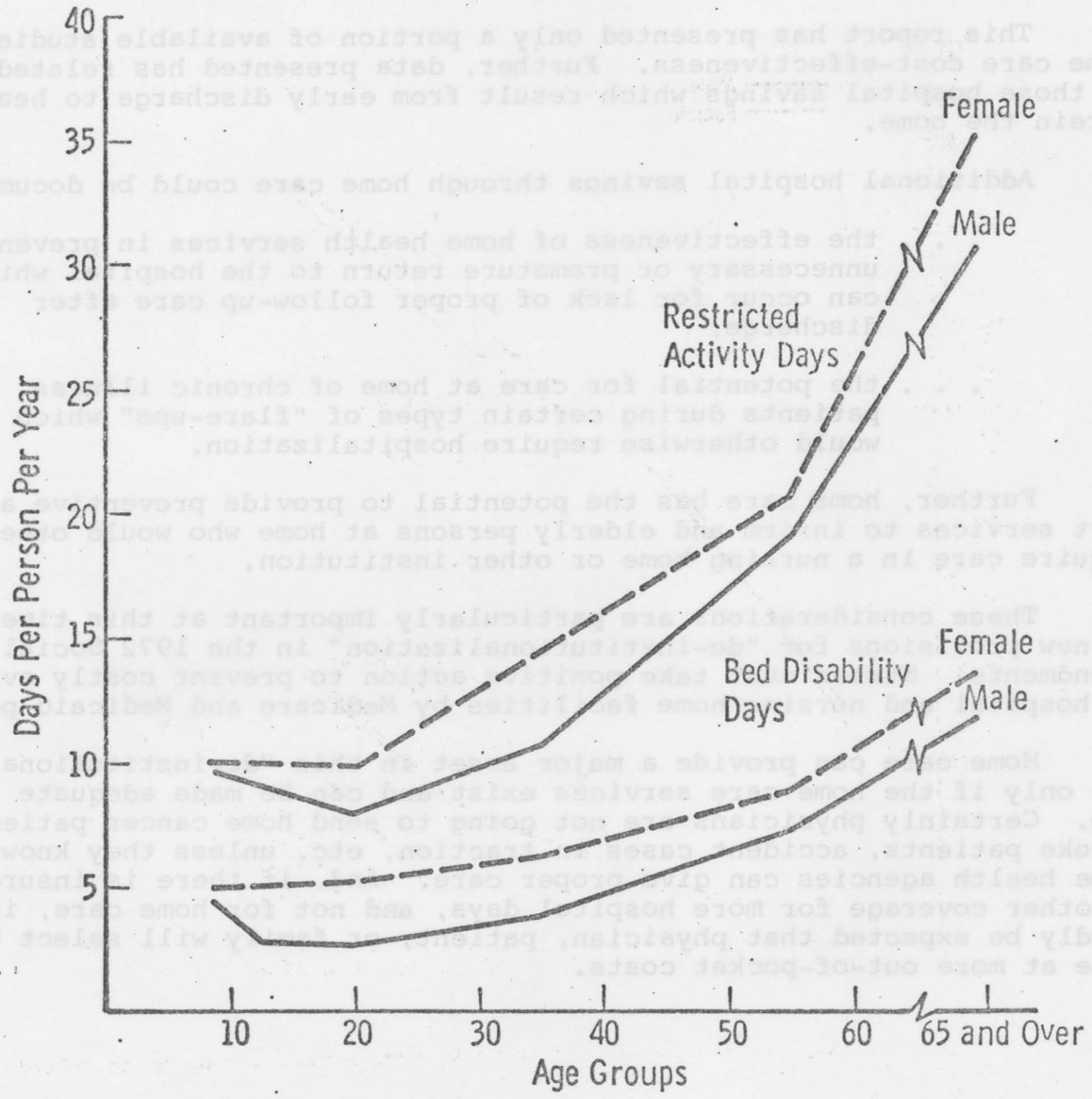
. . . the potential for care at home of chronic illness patients during certain types of "flare-ups" which would otherwise require hospitalization.

Further, home care has the potential to provide preventive and support services to infirm and elderly persons at home who would otherwise require care in a nursing home or other institution.

These considerations are particularly important at this time in v of new provisions for "de-institutionalization" in the 1972 Social Sec -y Amendments. States must take positive action to prevent costly over-use of hospital and nursing home facilities by Medicare and Medicaid patients.

Home care can provide a major asset in this "de-institutionalization," but only if the home care services exist and can be made adequate for the job. Certainly physicians are not going to send home cancer patients, stroke patients, accident cases in traction, etc. unless they know that home health agencies can give proper care. And, if there is insurance or other coverage for more hospital days, and not for home care, it can hardly be expected that physician, patient, or family will select home care at more out-of-pocket costs.

Chart B-15. Days of Restricted Activity and Disability Per Person Per Year, by Age and Sex* (U.S.A., 1969).

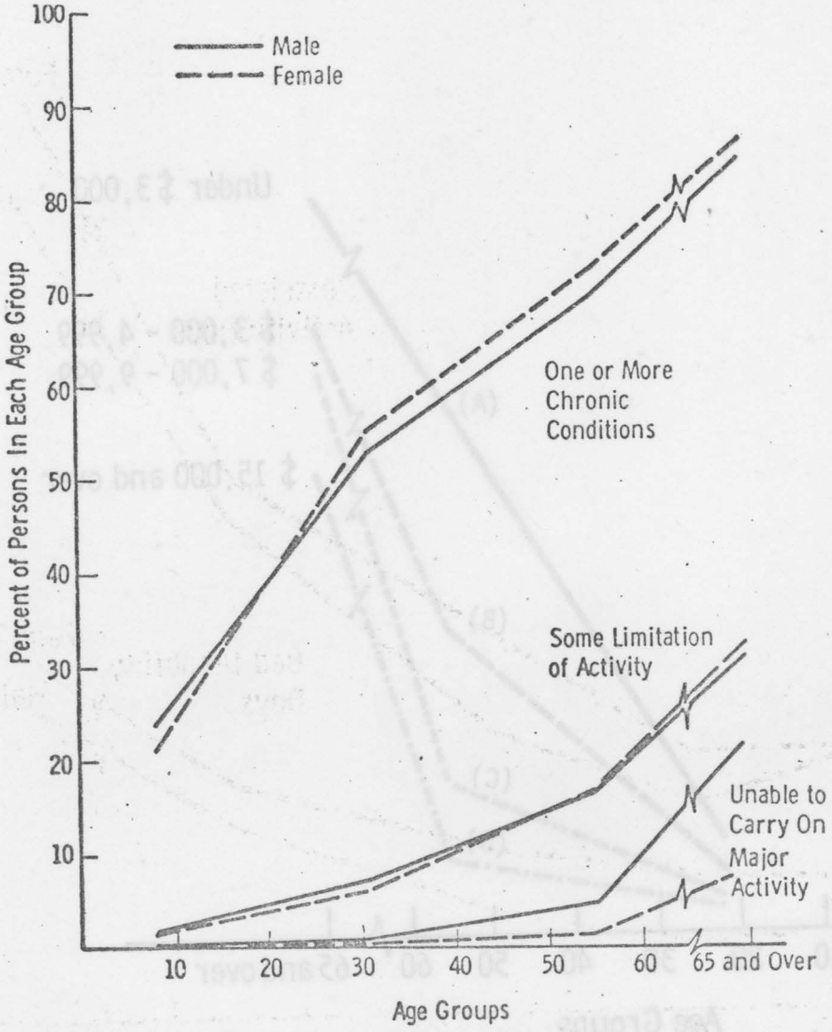


*Civilian, non-institutionalized population.

Source: U.S. National Center for Health Statistics, Current Estimates from the Health Interview Survey: United States, 1969, Public Health Service Pub. No. 1000, Series 10, No. 63 (Rockville, Maryland, June, 1971), Table 16, p. 20.

Chart taken from Medical Care Chart Book Fifth Edition, the University of Michigan School of Public Health, 1972.

Chart B-14. Percent of Persons with a Chronic Condition and with Specified Limitations, by Sex and Age* (U.S.A., July 1965-June 1967).



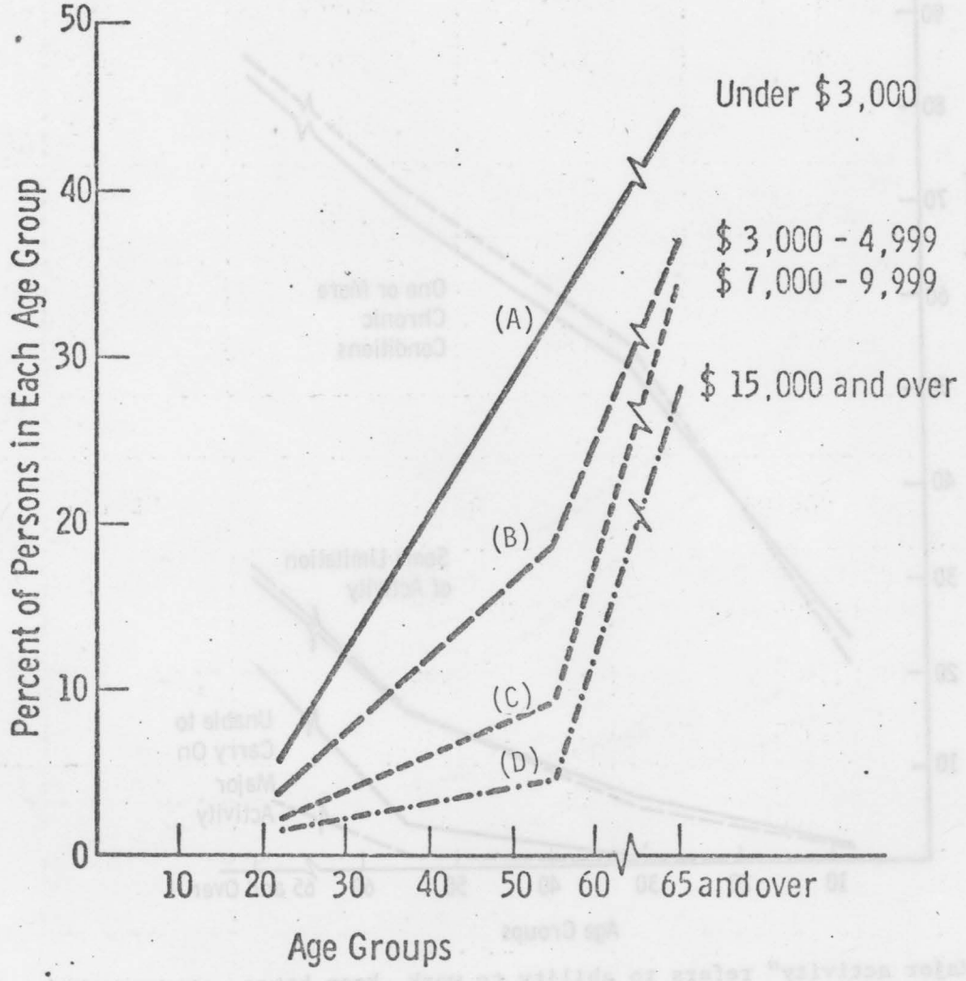
NOTE: "Major activity" refers to ability to work, keep house, or engage in school or pre-school activity.

*Civilian, non-institutionalized population.

Source: U.S. National Center for Health Statistics, Chronic Conditions and Limitations of Activity or Mobility: United States, July 1965-June 1967, Public Health Service Pub. No. 1000, Series 10, No. 61 (Rockville, Maryland, January, 1971), Table 1, p. 19.

Chart taken from Medical Care Chart Book Fifth Edition, the University of Michigan School of Public Health, 1972.

Chart B-17. Percent of Persons with Chronic Conditions Causing Limitation in or Inability to Carry on Major Activity, by Family Income and Age* (U.S.A., July 1965-June 1967).



*Civilian, non-institutionalized population.

Source: U.S. National Center for Health Statistics, Chronic Conditions and Limitations of Activity and Mobility: United States, July 1965-June 1967, Public Health Service Pub. No. 1000, Series 10, No. 61 (Rockville, Maryland, January, 1971), Table 15, p. 33.

Chart taken from Medical Care Chart Book Fifth Edition, The University of Michigan School of Public Health, 1972.

ATTACHMENT 6

Population Age 65 and Over, Four County Region and State of Washington, 1970-1975

Year	Whatcom	Skagit	Island	San Juan
1970	9,564	6,469	2,465	767
1971	9,490	6,670	2,580	800
1972	9,610	6,670	2,810	830
1973	9,850	6,810	3,010	870
1974	10,090	6,980	3,070	890
1975	10,360	7,170	3,130	910

Year	Region	State	Nation
1970	19,265	320,712	
1971	19,490	327,690	
1972	19,920	334,840	
1973	20,540	342,920	
1974	21,030	351,480	
1975	21,570	360,870	

Source: State of Washington, Office of Program Planning and Fiscal Management, Population Studies Division, State of Washington Population Trends 1975, July 1975, Table 9

Projecting the Aged[1] Population to 1980, Four County Region and State of Washington

	1980 Total Pop. Est.		Growth of Aged Pop. Method			Percent of State Aged Pop. Method			Range of 2 Methods	
	low	high[3]	% factor[5]	low	high	% factor[6]	low	high	low	high
State	3,672,100[2]	4,015,630[4]	10.8	397,492	434,678					
Region	179,849	194,585	13.1	23,524	25,547	6.00	23,860	26,092	23,524 -	26,092
Whatcom	90,110[2]	94,100[3]	13.1	11,802	12,324	2.98%	11,853	12,962	11,802 -	12,962
Skagit	53,746[2]	58,526[3]	13.8	7,396	8,054	2.01	8,006	8,755	7,396 -	8,755
Island	29,800[2]	35,000[3]	10.6	3,139	3,687	0.768	3,052	3,338	3,052 -	3,687
San Juan	6,193[3]	6,959[3]	21.3	1,319	1,482	0.238	(948)[7]	(1,036)[7]	1,319 -	1,482

1. Over 65 years.
2. State of Washington, Office of Program Planning and Fiscal Management, 1972.
3. Whatcom County: Northwest Regional Council. Other Counties: County Planning Departments.
4. Obtained from summation of county projections to obtain regional projection. State projection obtained by assuming region would retain the same fraction of state population as in the low projection.
5. The state's aged population (65+) is forecast by OPPFM as increasing from 9.4 percent of the total in 1970 to 10.8 percent of the total in 1980. The regional and county fractions of aged population have been estimated for 1980 to increase by the same 1.4 percent over the 1970 fraction shown in Table 13. The 1.4 percent additional growth in aged population is based on the OPPFM projections of total population for 1980.
6. Assumes the elderly constitute the same fraction of county and regional population in 1980 as they did in 1970. Factor is that fraction.
7. Projections made in 1970 are already lower than current population due to unanticipated migration to the San Juan Islands.

Part A Medicare Enrollment, Four County Region, State of Washington, and U.S., 1968-1973

Year	Whatcom	Skagit	Island	San Juan
1968	6,095	6,225	1,657	658
1969	9,581	6,351	1,758	680
1970	9,650	6,505	1,894	723
1971	9,563	6,640	2,003	751
1972	9,724	6,656	2,267	785

Year	Region	State	Nation
1968	14,635	313,002	19,457,518
1969	18,370	316,991	19,683,691
1970	18,772	322,986	20,014,667
1971	18,957	329,706	20,375,400
1972	19,432	336,379	20,731,382
1973		345,000	

Data sources:

1968-1972 D.H.E.W., Social Security Administration, Office of Research and Statistics, Medicare: Health Insurance for the Aged, 19--, Section 2: Persons Enrolled in the Health Insurance Program. 1968 through 1972.

1973 Social Security Administration, Social Security Bulletin, Annual Statistical Supplement, 1973. U.S. Government Printing Office, Washington, D.C., 1973. Table 131.

Population Under Age 65, Four County Region and State of Washington, 1970-1975

Year	Whatcom	Skagit	Island	San Juan
1970	72,419	45,912	24,546	3,089
1971	74,310	46,080	25,120	3,100
1972	75,390	46,230	25,090	3,070
1973	75,150	46,190	25,190	3,130
1974	75,110	46,020	25,530	3,110
1975	75,840	46,230	26,870	3,590

Year	Region	State	Nation
1970	145,966	3,092,538	
1971	148,610	3,102,410	
1972	149,780	3,083,960	
1973	149,660	3,081,380	
1974	149,770	3,096,620	
1975	152,530	3,133,254	

Source: State of Washington, Office of Program Planning and Fiscal Management, Population Studies Division, State of Washington Population Trends 1975, July 1975, Tables 1 and 9.

Population Estimates, Four County Region and State of Washington, 1980

All Persons

	Whatcom	Skagit	Island	San Juan	Region	State
1980 low	90,110[1]	53,746[2]	29,800[3]	6,193[4]	179,849	3,672,100[5]
1980 high	94,100[6]	58,526[7]	35,000[8]	6,959[9]	194,585	4,015,630[10]

Persons Under Age 65[11]

	Whatcom	Skagit	Island	San Juan	Region	State[12]
1980 low	78,308	46,350	26,748	4,874	156,325	3,274,608
1980 high	81,138	49,771	31,313	5,477	168,493	3,618,138

Notes

1. Source: Office of Program Planning and Fiscal Management, State of Washington, "Interim Population Projections to Year 2000 by County," (mimeo), October 2, 1972.
2. Ibid.
3. Ibid.
4. Ibid.
5. Ibid.
6. Source: Whatcom County Council of Governments.
7. Estimates assumes 1.0 percent growth rate per year from 1973. Estimate includes anticipated 1,134 person population increase because of Skagit Nuclear Project.
8. Source: Island County Planning Department.
9. Estimate assumes 4.0 percent annual gorwth rate per year from 1974.
10. Source: Attachment 7.
11. Figures for region and counties obtained by subtracting population figures shown in Attachment 7 from overall population figures shown in Attachment 10.
12. Figures obtained by subtracting estimate of over-65 population in 1980 (397,492) from overall population figures shown in Attachment 10 Source of 1980 over-65 estimate: Office of Program Planning and Fiscal Management, State of Washington, "Preliminary Population by Sex and Age Groups, 1960-1980," (mimeo), 1972.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

121

J. EVANS
VERNON

HEALTH SERVICES DIVISION
P. O. BOX 1788, OLYMPIA, WASHINGTON 98504

JOHN A. BEARE, M.D.
ASSISTANT SECRETARY

December 11, 1973

ATTACHMENT 11

Robert M. Eastman, Assistant Director
Comprehensive Health Planning Council
of Whatcom, Skagit, Island & San Juan Counties
102 South Barker Street
Mount Vernon, Washington 98273

Dear Mr. Eastman:

Your letter dated November 26, 1973 to Doctor Robert Atwood was referred to this office for review and response. The interest expressed by the Task Force in the development of home health services should result in some improvement as well as in more coordination of community service.

The following is an attempt to respond to the questions you presented which are identified by the numbers used in your communication.

1. Home health nursing service provided through Medical Assistance funds for the years requested is as follows:

1967	$60,394.36
1968	95,302.87
1969	64,817.30
1970	169,087.85
1971	176,423.39
1972	173,603.00

The figure for 1972 is approximated because the accounting source of the previous five years is not available at this time.

2. The budgetary process in the Department is on a biennial basis. In preparation the past history is reviewed and the projection is developed, incorporating increments as legislative action permits.

3. The present fee schedule is $13.55 reimbursement for home health nursing visit, and $5.65 per hour for home health aide service. Payment for these services is subject to approval by Nursing Care Consultants assigned to local areas and directed from this office.

4. The cost of care experience of certified home health agencies is reviewed and verified by the Office of Standards within the Department prior to submission to the Governor's committee on vendor rates. This committee is charged with the function of recommending fees for provider service to the Governor's office.

5. The present fees were implemented in early 1973. There has not been a routine revision of the fee schedule.

6. The fees are paid on the basis of fee-for-service. At the present time other methods of reimbursement are not utilized, and there are no WAC's concerned with alternative methods.

7. A home health nursing visit for Medical Assistance purposes is a professional public health nursing service provided to a Medical Assistance client eligible for the service which has been determined to be appropriate in meeting his health needs. Such nursing service may be extended by home health aide service on an hourly basis under the supervision of the certified home health agency nursing personnel.

8. Recommendations from your Task Force related to home health nursing service for Medical Assistance clients may be sent to this office. Should you wish to discuss such recommendations, a conference for that purpose could be readily arranged.

   If the recommended changes refer to the availability of home health nursing services to the total population, they should be addressed to Doctor Robert Atwood, Supervisor, Office of Community Support, Department of Social and Health Services, P.O. Box 1788, Olympia, Washington, 98504, Mail Stop 1-2.

9. Chore services are provided eligible recipients through the direction of the Office of Social Services, Department of Social and Health Services, Capitol Center Building, Olympia, Washington, 98504, Mail Stop 27-1, which is headed by William B. Pope.

If you desire an elaboration of any of the responses to the questions, this office will attempt to secure as much information as is available.

Sincerely,

R.P. Hall M.D.

Robert P. Hall, M.D., Chief
Office of Personal Health Services

RPH:MAR:nh

cc: Robert Atwood, M.D., Supervisor,
Office of Community Support MS 1-2

SKAGIT COUNTY MEDICAL BUREAU

A Member of Blue Shield

Second and Milwaukee
P. O. Box 699
Mount Vernon, Wash. 98273
Telephone 336-3101

February 21, 1974

Mr. Robert M. Eastman
Assistant Director
COMPREHENSIVE HEALTH
PLANNING COUNCIL
102 So. Baker Street
Mount Vernon, Wa 98273

Dear Mr. Eastman:

Thank you for your letter of February 5th, extending an invitation to a representative of the Medical Bureau to speak at your meeting of fiscal intermediaries and the Council's Task Forces on Long-Term Care and Home Health Services on Thursday, February 21st. I am also responding in this letter to the questions that were posed, and I think you will see from the replies that the Bureau is really not in a position to speak with expertise on the subject matter, therefore, our attendance at the meeting would be as a listener, not as a speaker, and if this would be of benefit to your organization please advise me so that arrangements can be made for a representative to attend.

Our answers to your six questions follow:

1. and 2. The Medical Bureau contracts have historically provided its subscribers service benefits of member physicians and have, in general, excluded custodial or convalsecent care. None of our contracts provide coverage of non-physician home care services.

3. All of the Medical Bureau's contracts provide a core of benefits which include physicians services, inpatient hospital care, and ambulance service. These contracts incorporate optional provisions to include prescription drugs, appliances, etc. Non-physician home care benefits are not a part of our benefit core.

4. Individual and group policies provide the same benefit structure, and as stated above,

our contracts do not provide the option for purchase of non-physician home care benefits.

5. To date, the Medical Bureau has not developed experimental reimbursement methods for hospital services. The Bureau would be willing to participate in the development of such experiments if the facts available gave indication of sound fiscal management.

6. We do not have an opinion on how non-physician home care services should be financed.

Should you wish further information concerning these answers please advise.

Yours very truly,

Wm. Y. Duncan, M.D.
President
SKAGIT COUNTY
MEDICAL BUREAU

ww

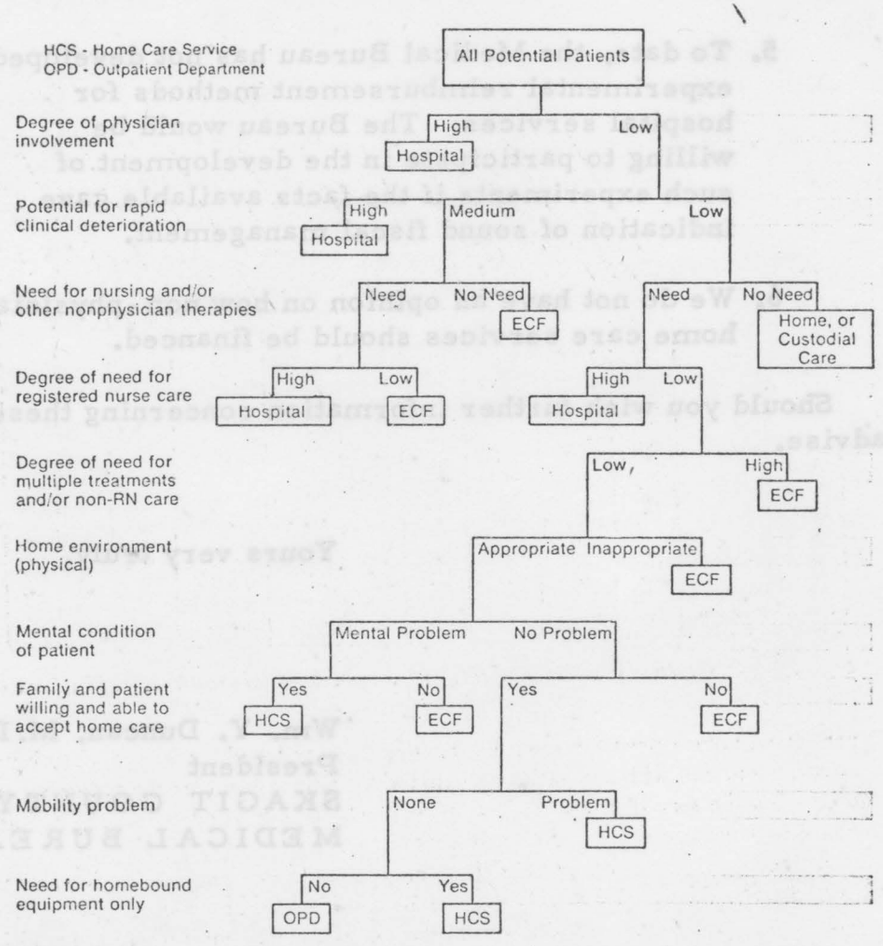


Figure 3. *Decision Grid for Evaluation of Need for Care in Home Care Service and Extended Care Facility*

8. Willingness and ability of patient and/or patient's family to accept home care
9. Mobility of patient
10. Special equipment needed

This system was designed to provide independent sequential evaluations to place the patient in the appropriate mode of care. Figure 4 (next page) shows how this can be done. It illustrates, for example, that a patient with no need for high physician involvement, with a medium potential for rapid clinical deterioration, and with a need for nursing and/or other nonphysician therapies and for intensive care from a registered nurse, might be best cared for in a hospital. On the other hand, a

Source: Hurtado, Arnold V; Greenlick, Merwyn R.; Saward, Ernest W., Home Care and Extended Care in a Comprehensive Prepayment Plan. Hospital Research and Educational Trust, Chicago, Illinois, 1972, pp. 14-15.

Appropriate Site for Care	Degree of Physician Involvement	Potential for Rapid Clinical Deterioration	Need for Nursing and or Other Non-Physician Therapies	Degree of Need for IV Care	Degree of Need for Medical Treatment Not IV Care	Home Environment (Inapp, Approp)	Mental Condition of Patient	Family and Patient Willing and Able to Accept Home Care	Mobility Problem	Need for Homebound Equipment Only
Hospital	High	High								
	Low	Medium	Need	High						
	Low	Low	Need	High						
Home, or Custodial Care	Low	Low	No Need							
	Low	Medium	No Need							
	Low	Medium	Need	Low						
Extended Care Facility	Low	Low	Need	Low	High					
	Low	Low	Need	Low	Low	Inapp				
	Low	Low	Need	Low	Low	Approp	Problem	No		
	Low	Low	Need	Low	Low	Approp	No Problem	No		
	Low	Low	Need	Low	Low	Approp	Problem	Yes		
Home Care Service	Low	Low	Need	Low	Low	Approp	No Problem	Yes	Yes	
	Low	Low	Need	Low	Low	Approp	No Problem	Yes	No	Yes
Outpatient Department	Low	Low	Need	Low	Low	Approp	No Problem	Yes	No	No

Figure 4. *Specification of Decision Grid for Determination of Appropriate Site for Care*

patient without a need for intensive nursing care and with an appropriate home environment, but with a negative patient and/or family attitude toward home care, might best be served in an ECF. A patient whose only need is nursing therapy might best be served by a home care service.

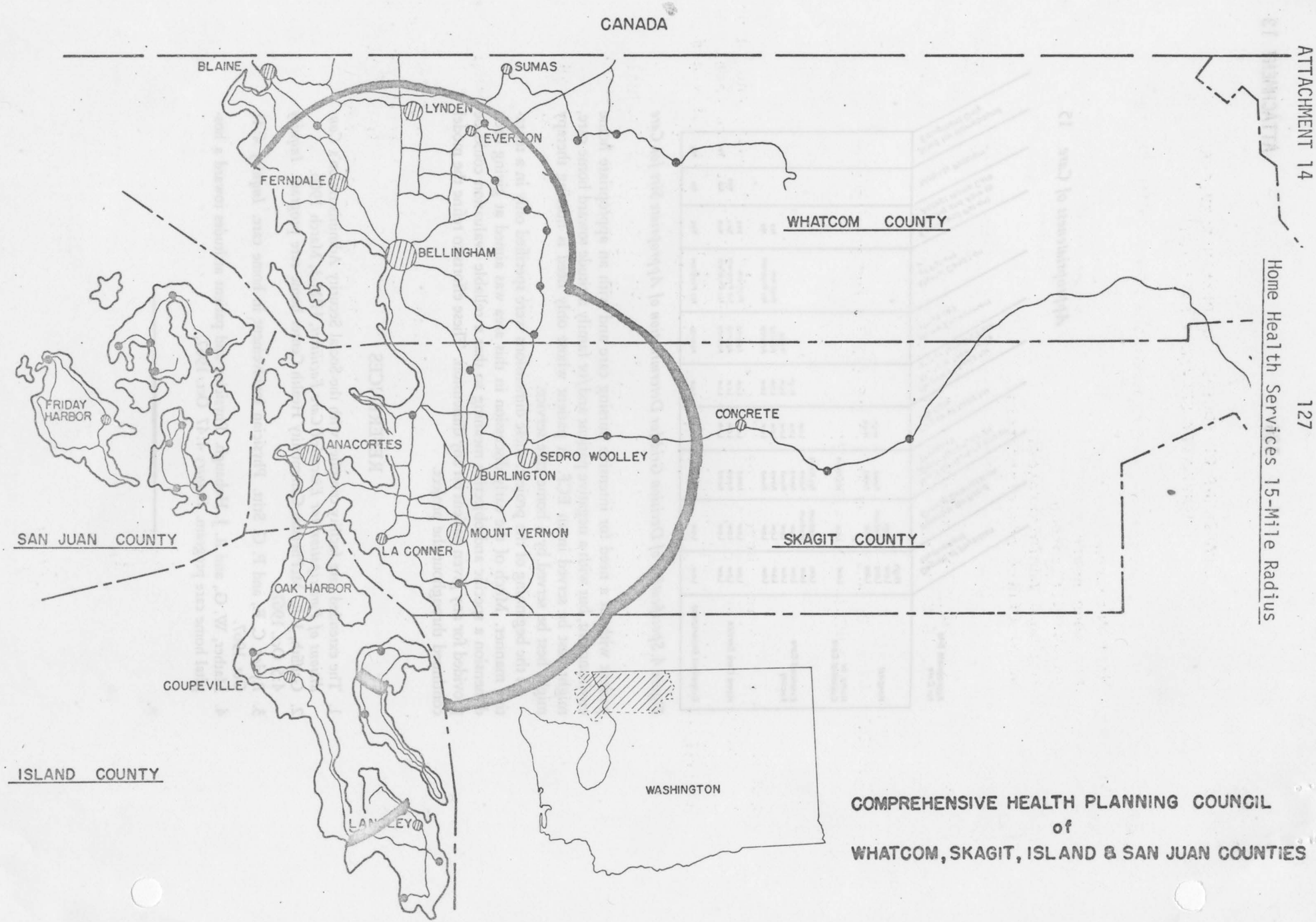
At the beginning of the project, these dimensions were specified only in a tentative manner. Much of the early discussion in this area was aimed at giving each dimension a specific and objective meaning so that a reliable evaluation could be provided for any given patient on any dimension. These efforts to refine the model continued throughout the project.

REFERENCES

1. The extended care facility complies with the Social Security Administration's *Conditions of Participation for Extended Care Facilities*, HIM-3, March 1966.
2. Griffith, J. R. McPherson Community Health Center home care program. *Inquiry* 4:5 Oct. 1967.
3. Ryder, C. F., and P. G. Stitt. Physician involvement in home care. *Inquiry* 4:41 Oct. 1967.
4. Mather, W. G., and R. J. Hobaugh. Physician and patient attitudes toward a hospital home care program. *Inquiry* 4:47 Oct. 1967.

ATTACHMENT 14

127



ATTACHMENT 15

EPARTMENT OF SOCIAL AND HEALTH SERVICES
COMMUNITY SERVICES DIVISION

TO: Neil Peterson
Dr. John Beare
Ralph Littlestone
Regional Administrators
Local Office Administrators

FROM: Community Services Division
Gerald E. Thomas, Deputy Director

SUBJECT: DELAY OF ACTION ON RECLASSIFICATION AND TRANSFER OF NURSING HOME PATIENTS

Due to the continuing shortage of ICF care on a statewide basis, and in order to avoid hardship as a result of the geographic location of such care, effective immediately and pending further study of the availability and distribution of ICF beds, the following policy is to be observed:

It will not be necessary to attempt to transfer individuals classified as not needing skilled care from SNF's to ICF's.

Any notices already sent to patients advising them that they may be moving to another facility due to reclassification downward shall be immediately retracted.

Any fair hearings on the issue of movement of patients will be resolved in the patient's favor.

Voluntary relocations requested by patients and new admissions shall be made to ICF care where such care is most appropriate and where ICF resources are available. Good placement practices shall be followed in all instances, which include pre-planning with the patient, family and facilities.

Inflation may force welfare cuts to hospital, nurse home patients

OLYMPIA (AP) – Reeling under the pressure of inflation, the Department of Social and Health Services will have to cut back its aid to welfare patients in nursing homes and hospitals or ask the legislature for more money, says the agency director.

Were the state's largest department to finance fully all programs already budgeted, it would have a deficit of between $30 million and $35 million by next June, Secretary Charles Morris revealed in an interview Thursday.

"We are being able to cover some of that by internal economy measures," he said. "But it is hard to cover Medicaid costs by economy measures."

If the department continues spending at its present rate – after the initial cuts are counted – it will more than about $27.4 million in the hole by the end of the biennium, he said. Of that total, roughly $12.3 million would have to come from state funds, with the rest paid by the federal government, he added.

"We are now meeting with the governor and his budget experts to decide which route to take," Morris said. "The choice is simple – ask for more funds or cut services."

With nearly all of the predicted deficit due to soaring costs in nursing home and hospital care, some cutbacks in state aid might have to be considered, he said grimly.

"It is always possible to cut," he said. "No cuts are easy...."

Morris quickly added that "if we do ask the legislature for more money, we can show reasonable grounds."

Inflation rates in the medical aid field are running between 10 and 11 per cent, whereas the agency had only counted on a rate of about 8 per cent, he said.

Morris said the department pays or helps pay for 15,000 nursing home patients and that about 50,000 welfare recipients get short-term hospital aid each year.

Although expressing concern for the deficit, he said the overrun, if it comes about, will be only one per cent of the agency's total budget.

Earlier this week, House Appropriations Chairman A.N. Shinpoch, D-Renton, accused the superagency of mismanagement and told agency brass they should have a better reading on where their money is going.

At the time, a department official said the latest computer read-out on actual nursing home costs was for the month of May.

Source: Bellingham Herald, Bellingham, Washington, November 22, 1974

Too much red tape

Medicare patients turned away

By BETH ERICKSON
Herald Staff Writer

Charging that he can no longer contend with time-consuming Health, Education and Welfare requirements and "still make a buck," Gordon Den Adel will no longer admit Medicare patients to his nursing home.

Den Adel, Schome Convalescent and Retirement Center administrator, has not admitted a Medicare patient since Feb. 7.

A skilled nursing home is a facility which has registered nurses on its staff capable of offering extended care services to convalescing patients.

"I have worked with Medicare the last five years and the rules and regulations are becoming more and more complex," Den Adel said.

"I can no longer cope with (Medicare's) bureaucratic way of doing business and not make a buck doing it. My staff works too hard at too little pay to keep within its system."

Medicare's interpretations of eligible patient care during 1973 resulted in Schome's having to repay $3,327 to the Social Security health insurance agency.

Wound up in red

The nursing home ended up the year $41 in the red.

Den Adel was especially angry at unspecified HEW rules and regulations which went into effect last June but which have only really been applied the last two months or so.

Asked what these new regulations are, Social Security's Russ Weller said there were none specifically. Federal regulations tend to change gradually, he explained.

"There are now more rigid requirements for admission to nursing homes," Weller said, and closer monitoring of treatment before payment to nursing homes is made.

"There are more requirements for documentation that medical treatment is actually necessary," he added.

One problem in the past has been that nursing homes have accepted patients in good faith on a doctor's recommendation only to find that the care they require is not covered under Medicare.

Den Adel contends that persons are given a "song and dance" concerning Medicare, that they believe it is all-inclusive when they learn that Medicare will no longer pay the bills.

He says Medicare has turned his registered nurses into paper shufflers who are kept busy filling out forms instead of caring for patients.

The rest of his staff also spends what Den Adel believes is an inordinate amount of time keeping up with the bookkeeping and paperwork generated by Medicare regulations.

Way out of line

Diane Robertson, Den Adel's secretary, said the time she spends on Medicare paperwork is "way out of line compared with that spent for other patients."

Den Adel estimates it may run as high as 50 per cent. "It's not worth the effort to continue in the program," he said.

Medicare will pay for all covered services in a skilled nursing home facility the first 20 days a person needs them "in each benefit period," according to a Medicare handbook, and nearly all for 80 days after that — only if all of the following are true.

—Medical care needs require daily skilled nursing care or skilled rehabilitation services.

—A doctor determines that a patient needs skilled nursing or rehabilitation care and orders such care.

—A patient has been in a participating or otherwise qualified hospital for a least three days in a row before admission to the nursing home.

—A patient is admitted for further treatment of a condition for which he was treated in the hospital.

It helps pay for regular nursing services, drugs furnished by the skilled nursing facility, physical occupational and speech therapy, medical supplies such as splints and casts, use of appliances and equipment furnished by the facility such as a wheelchair, crutches and braces, and medical social services.

No private duty nurse

It does not pay for private duty nurses, doctor's services, person comfort items such as television sets or telephones, or "noncovered level of care."

This means, the Medicare booklet explains, that persons cannot be paid for seeking help with personal, daily needs such as eating, getting about "and similar things one ordinarily does for himself, or that can be done for him by people without professional skills or training," even if a person is in a nursing home.

Den Adel believes this is wrong. He cites the example of an elderly woman who fell down a flight of steps, breaking an arm and a leg.

"She was as hopelessly immobilized as anybody could be," he said, yet Medicare would not pay for her nursing home stay because she does not require skilled nursing care.

Russ Weller admits this is a weak point in Medicare coverage, and says nothing, unfortunately, is being done at the federal level to remedy the problem.

The fact that Schome will no longer accept its average of three Medicare patients a month does not mean an added burden will be placed on the remaining extended care facilities in Bellingham.

Medicare patients may choose between St. Luke's Hospital, Highland Convalescent Center, Alderwood, Shuksan and Bellingham Villa Care.

Den Adel is the first nursing home administrator in Whatcom County to stop accepting Medicare patients. He appears relieved its paperwork is behind him.

"We just couldn't continue under a system where we do not get paid. I told them to take the whole system and stick it in their ear," he added.

130

ATTACHMENT 17

Source: Bellingham Herald, Bellingham, Washington, April 4, 1974

P.O. Box 39

May 31, 1974

Lt. John G. Meyer, M.D., M.P.H.
Special Assistant to the Medical Advisor
Office for the Civilian Health and Medical
Program of the Uniformed Services
Department of Defense
Denver, CO 80240

Dear Lt. Meyer:

The Council is in the process of completing an inventory of hospital and other health-related facilities prior to the development and publication of a regional hospital plan by December. Concurrently, we are also developing plans for nursing homes and home health services (see your previous correspondence with Mrs. Mary Lou Shadle, Washington Physicians' Service, Seattle, No. CHO2), and assembling a "health indicators" report.

One section of the health indicators report will deal with medical care utilization and expenditures. Combined with enrollment figures, the utilization and expenditures data, when analyzed, will permit identification of patterns and trends across various insured groups. In one county in our region, for example, Medicaid patients are hospitalized more than twice as often as persons insured by the Blue Shield program. Analyses and comparisons enabled by enrollment, utilization, and expenditure data will also be used, of course, to improve our planning for hospitals, nursing homes, and home care services.

The complexity of planning for the health services mentioned is compounded in this region by the existence of Whidbey Island Naval Air Station in Island County and the presence there of a naval hospital. There may be as many as 10,000 people in this region, about 6 percent of the population, eligible for C.H.A.M.P.U.S. coverage. I really don't know. Things are complicated even more by the rumored eventual closure, or at least curtailment, of the naval hospital. Clearly, our planning efforts for the western fringe of this region are and will be effectively hampered without at least ballpark-level data on the C.H.A.M.P.U.S. population here. With these thoughts in mind, and with fears that I already know what your replies will be, I have several questions for the C.H.A.M.P.U.S. program.

1. Approximately how many people are now eligible for C.H.A.M.P.U.S. benefits or "enrolled" in the program in the following areas: Whatcom, Skagit, Island, and San Juan Counties; the four-county region; the state? How many people were eligible each calendar year between 1968 and 1973 (same areas)? The easiest way of expressing eligibility might be "persons eligible per month."

ATTACHMENT 18

2. For the same areas and calendar years in question 1, what were the hospital and nursing home admission or discharge rates (admissions or discharges per 1,000 enrollees) for the C.H.A.M.P.U.S. enrollees? What were the home care utilization rates (home care starts per 1,000 enrollees) for the same areas and years?

3. For the same areas and years in question 1, how much hospital and nursing home care was provided (days of care per 1,000 enrollees)? How much home care was provided (either visits per 1,000 enrollees or days of home care per 1,000 enrollees)?

4. For the same areas and years in question 1, how much money did the C.H.A.M.P.U.S. program spend on hospital care? Nursing home care? Home care? How much money did the program spend for physician services? Dental services? How much money did the program spend for all types of medical care for the areas and years in question 1?

5. Are figures on costs and utilization based on place of residence of the enrollee regardless of the geographic site of care or on geographic site of care regardless of place of residence of the enrollee?

The enrollment, utilization, and expenditure data I have requested are readily available for the state's federally-supported Medicaid program. The data are also available, to a lesser extent, for the Medicare program. I point out this federal insurance program data availability because I wish to prevent the impression that the C.H.A.M.P.U.S. program is being singled out for unreasonable requests. If it's any consolation, the Indian Health Service is being asked the same questions.

Finally, I'd like to point out that this agency was established under Public Law 89-749 and currently receives over $70,000 in federal funds annually to conduct health planning activities. Please contact me if the data requests are at all unclear.

Sincerely,

Robert M. Eastman, M.P.H.
Assistant Director

RME/cjs

ATTACHMENT 18

DEPARTMENT OF DEFENSE
OFFICE FOR THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
DENVER, COLORADO 80240

14 June 1974

IN REPLY REFER TO:
CH.02

CIVILIAN PROGRAM FOR:
ARMY
NAVY
MARINE CORPS
AIR FORCE
COAST GUARD
U.S. PUBLIC HEALTH SERVICE
N.O.A.A.

Robert M. Eastman, M.P.H.
Assistant Director
Comprehensive Health Planning Council
102 South Baker Street
Mount Vernon, WA 98273

Dear Mr. Eastman:

Thank you for your very interesting and clearly written correspondence of May 31, 1974. I readily appreciate what you are attempting to do, and fully understand its implications. Unfortunately, I am afraid I will have to confirm your fears by stating that no demographic statistics are available for the CHAMPUS population. While this may seem incomprehensible to you (as it was to me), let me assure you that multiple people have encouraged the development of such statistics, but with no success to date. However, there is a very good chance that such data will be available within the next couple of years. Unfortunately, that would be a little late for your needs.

Inasmuch as the demographic data is unavailable, any of the "per thousand enrollees" questions which you addressed are at this time unable to be answered. Question four could be answered; however, it would require a computer run, and such computer runs must be requested from the Assistant Secretary of Defense (H&E), The Pentagon, Washington, D.C. Regarding question five, what data is available is based on the cost and utilization of care reported by the Fiscal Administrator or Hospital Contractor located in the sponsor's geographic area. In other words, the sponsor's residence is the geographic area where cost and utilization rates are based.

I am sorry I cannot help you more at this time. I strongly support the work that Comprehensive Health Planning Councils are doing across the country, and have numerous friends in the various CHP agencies.

One last thought. It has been my experience through the research I have been conducting here, that the cost for acute medical and surgical services are within the usual and customary in a given state. While I do not have the utilization figures, I can assure you that if the State of Washington is looked at out of the top ten diagnoses, five of them will encompass psychiatric diagnoses. Might I also suggest that you contact the CHAMPUS office at Washington Physicians' Service inasmuch as the individuals there have a good understanding of costs for various services in the various

CH.02
Robert M. Eastman, M.P.H.

geographical areas in Washington. In addition, you might be able to get ballpark figures on how many claims come out of that area without going through the Department of Defense.

Best regards,

JOHN G. MEYER, M.D., M.P.H.
LCDR, MC, USN
Assistant to Medical Advisor

NUMBER OF ADMISSIONS TO CIVILIAN HOSPITALS PER 1,000 POTENTIAL CHAMPUS BENEFICIARIES CY 1968 THROUGH CY 1973

Dependents of Active Duty Personnel

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	3,719,000	3,573,000	3,462,000	3,415,000	2,996,000	3,136,000
Total Admissions	262,400	281,816	276,230	273,821	255,121	244,058
No. Adm Per 1,000 Benef.	70.6	78.9	79.8	80.2	85.2	77.8

Retired Personnel

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	668,000	736,000	800,000	859,000	929,000	977,000
Total Admissions	16,700	21,951	27,825	36,230	43,657	48,404
No. Adm Per 1,000 Benef.	25.0	29.8	34.8	42.2	47.0	49.5

Dependents of Retired or Deceased Personnel

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	1,163,000	1,325,000	1,476,000	1,608,000	1,953,000	2,062,000
Total Admissions	55,200	71,731	87,407	108,638	126,764	137,948
No. Adm Per 1,000 Benef.	47.5	54.1	59.2	67.6	64.9	66.9

Total - All Eligible Beneficiaries

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	5,550,000	5,634,000	5,738,000	5,882,000	5,878,000	6,175,000
Total Admissions	334,300	375,498	391,462	418,689	425,542	430,410
No. Adm Per 1,000 Benef.	60.2	66.6	68.2	71.2	72.4	69.7

NOTE: Total beneficiaries shown for Dependents of Active Duty Personnel represent an estimate of the number residing in the United States, Canada, Mexico and Puerto Rico. Total beneficiaries shown for Retirees and Dependents of Retired or Deceased Personnel represent estimates of the number of beneficiaries worldwide.

Total admissions represent admissions under CHAMPUS in the United States, Puerto Rico, Canada and Mexico. Due to the lag in the submission of claims, total admissions shown for CY 1973 are estimated to be approximately 96% complete.

ESTIMATED NUMBER OF POTENTIAL CHAMPUS BENEFICIARIES
CY 1968 THROUGH CY 1973

Category of Beneficiary	CY 1968	CY 1969	CY 1970	CY 1971	CY 1972	CY 1973
Dependents of Active Duty Personnel	3,719,000	3,573,000	3,462,000	3,415,000	2,996,000	3,136,000
Retired Personnel	668,000	736,000	800,000	859,000	929,000	977,000
Dependents of Retired or Deceased Personnel	1,163,000	1,325,000	1,476,000	1,608,000	1,953,000	2,062,000
TOTAL - ALL Categories of Beneficiaries	5,550,000	5,634,000	5,738,000	5,882,000	5,878,000	6,175,000

NOTE: Dependents of Active Duty Personnel include only those dependents residing in the United States, Canada, Mexico, and Puerto Rico. Source for this data was Directorate of Information Operations, OSD, Report P14, as of 31 March for each year.

Retired Personnel and Dependents of Retired or Deceased Personnel include beneficiaries residing Worldwide since there are no data available which show the number of these beneficiaries who reside only in the United States, Canada, Mexico or Puerto Rico. Totals shown are based on estimates provided by each uniformed service in its annual budget estimate.

ATTACHMENT 18

ATTACHMENT 18 137

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AND
ENVIRONMENT

17 JUL 1974

Honorable F. Edward Hebert
Chairman, Committee on Armed Services
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in further reply to your letter of June 11, 1974 enclosing correspondence from Mr. Robert M. Eastman, Assistant Director of the Comprehensive Health Planning Council, Mount Vernon, Washington.

The ability to answer Mr. Eastman's questions is greatly hampered by the nonavailability of demographic statistics on CHAMPUS beneficiaries. Enclosed is a table which gives the estimated number of potential CHAMPUS beneficiaries. These same individuals are eligible to use military medical facilities as well. Therefore, while we have included a chart which shows the number of admissions and hospital days/thousand potential CHAMPUS beneficiaries, these numbers represent the demand seen by CHAMPUS only, and are not a reflection of the demand these people place on the total Department of Defense Health System. The per thousand potential CHAMPUS beneficiary figure would vary greatly if broken out by geographical area, and would depend to a great extent on the availability of military facilities.

The CHAMPUS Data System records only inpatient care and does not isolate nursing home care from hospital care. Home care is likewise not isolated. The number of admissions and hospital days/thousand potential CHAMPUS beneficiaries in the hospital setting are the only data we can present in answering questions two and three of Mr. Eastman's letter at present.

The Total CHAMPUS Program Cost chart was prepared within the constraints listed in the prior two paragraphs. An additional note regarding the costs under professional services. These figures represent all professional services (psychologists, speech therapists, physical therapists, etc.) and not just physician (M.D. and D.O.) services.

I trust that this information will be helpful in replying to Mr. Eastman.

Sincerely,

Vernon McKenzie
Deputy Assistant Secretary of Defense
(Health Resources & Programs)

Enclosures

TOTAL CHAMPUS PROGRAM COSTS*
CY 1968 THROUGH CY 1973
(Government Cost Only)

Type of Service	CALENDAR YEAR					
	1968	1969	1970	1971	1972	1973
Hospital Services	$110,383,568	$142,347,736	$170,507,574	$202,841,161	$227,174,625	$242,259,035
Professional Services Inpatient & Outpatient) Excluding Dental	$ 70,895,348	$ 89,367,428	$105,565,607	$126,224,680	$141,823,539	$152,767,512
Dental Professional Services (Inpatient & Outpatient) Excluding Dental Handicapped	$ 220,784	$ 440,748	$ 734,812	$ 1,728,107	$ 4,372,608	$ 5,289,807
Outpatient Prescription Drugs	$ 1,263,923	$ 2,605,245	$ 3,057,840	$ 3,927,547	$ 5,090,445	$ 5,898,581
Program for Handicapped (Includes Physically Handicapped, Mentally Retarded and Dental Handicapped)	$ 4,426,502	$ 8,654,929	$ 12,434,391	$ 20,983,980	$ 29,249,067	$ 23,437,655
TOTAL	$187,190,125	$243,416,086	$292,300,224	$355,705,475	$407,710,284	$429,652,590

* Excludes Administrative Costs. Based on all claims processed through 31 May 1974. Total costs for CY 1973 are estimated to be approximately 96% complete.

Directorate of Management Services
3 July 1974

NUMBER OF HOSPITAL DAYS IN CIVILIAN HOSPITALS PER 1,000 POTENTIAL CHAMPUS BENEFICIARIES CY 1968 THROUGH CY 1973

Dependents of Active Duty Personnel

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	3,719,000	3,573,000	3,462,000	3,415,000	2,996,000	3,136,000
Total Hospital Days	1,633,958	1,819,952	1,855,966	1,886,550	1,909,388	1,828,466
No. Days Per 1,000 Benef.	439.4	509.4	536.1	552.4	637.3	583.1

Retired Personnel

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	668,000	736,000	800,000	859,000	929,000	977,000
Total Hospital Days	166,351	215,630	276,803	337,999	393,147	414,617
No. Days Per 1,000 Benef.	249.0	293.0	346.0	393.5	423.2	424.4

Dependents of Retired or Deceased Personnel

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	1,163,000	1,325,000	1,476,000	1,608,000	1,953,000	2,062,000
Total Hospital Days	548,528	762,349	937,319	1,199,145	1,455,151	1,500,311
No. Days Per 1,000 Benef.	471.6	575.4	635.0	745.7	745.1	727.6

Total - All Eligible Beneficiaries

	CY 68	CY 69	CY 70	CY 71	CY 72	CY 73
Total Beneficiaries	5,550,000	5,634,000	5,738,000	5,882,000	5,878,000	6,175,000
Total Hospital Days	2,348,837	2,797,931	3,070,088	3,423,694	3,757,686	3,743,394
No. Days Per 1,000 Benef.	423.2	496.6	535.0	582.1	639.3	606.2

NOTE: Total beneficiaries shown for Dependents of Active Duty Personnel represent an estimate of the number residing in the United States, Canada, Mexico and Puerto Rico. Total beneficiaries shown for Retirees and Dependents of Retired or Deceased Personnel represent estimates of the number of beneficiaries worldwide.

Total Hospital Days represent days under CHAMPUS in the United States, Puerto Rico, Canada and Mexico. Due to the lag in the submission of claims, total hospital days for CY 1973 are estimated to be approximately 96% complete.

COMPONENT COUNTY MEDICAL BUREAUS

Benton Franklin Counties Medical Service Division of Medical Service Corp of Spokane County Kennewick

Chelan County Medical Service Corp Wenatchee

Clallam County Physicians Service Inc Port Angeles

Clark County Physicians Service Inc Vancouver

Columbia Basin Physicians Service Corp Moses Lake

Cowlitz County Medical Service Corp Longview

Grays Harbor County Medical Service Corp Aberdeen

Jefferson County Medical Service Bureau Port Townsend

King County Medical Blue Shield Seattle

Kitsap Physicians Service Bremerton

Kittitas County Medical Service Corp Ellensburg

Lewis County Medical Service Corp Chehalis

Okanogan County Medical Service Division of Medical Service Corp of Spokane County Spokane

Pacific County Medical Service Corp Raymond

Pierce County Medical Bureau Inc Tacoma

Skagit County Medical Bureau Mount Vernon

Snohomish County Physicians Corp Everett

Medical Service Corp of Spokane County Spokane

Thurston County Medical Bureau Olympia

Walla Walla Valley Medical Service Corp Walla Walla

Whatcom County Physicians Service Bellingham

Yakima Medical Service Association Yakima

WASHINGTON PHYSICIANS SERVICE

SPONSORED BY THE WASHINGTON STATE MEDICAL ASSOCIATION

220 WEST HARRISON • SEATTLE, WASHINGTON 98119 281-3422 / AREA CODE 206

To CHAMPUS and CHAMPVA Beneficiaries:

As the Fiscal Administrator for the State of Washington we wish to serve the members of the CHAMPUS and CHAMPVA programs efficiently and expediently. In order to do this we will need your utmost cooperation. The following information will serve that purpose.

Very truly yours,

WASHINGTON PHYSICIANS SERVICE

Claims for services and supplies provided after January 1, 1974 must be filed by the last day of the calendar year following the calendar year in which the services and supplies were provided. EXAMPLE: Services provided in January, 1974, must be submitted no later than December 31, 1975. Claims for services and supplies provided before January 1, 1974 will be processed according to past policies and regulations.

TABLE OF CONTENTS

Washington Physicians Service is the CHAMPUS and CHAMPVA fiscal administrator for the State of Washington; however, because of the volume of claims and in order to continually improve the relationship between providers of care, beneficiaries and CHAMPUS, we are sub-contracting to three additional medical bureaus, bringing the total to six. In most instances the division is geographical which allows for closer contact between the aforementioned three parties. This change in procedure is effective January 1, 1975. If your health services are provided in:

KING or YAKIMA COUNTIES - claims should be submitted to:
King County Medical Blue Shield
1800 Terry Avenue, Seattle, Washington 98101 464-3773
Attn: CHAMPUS Department, Telephone Number: (206) ~~624-4171~~

PIERCE, THURSTON, GRAYS HARBOR or LEWIS COUNTIES - claims should be submitted to:
Pierce County Medical Bureau
1114 Broadway, Tacoma, Washington 98402
Attn: CHAMPUS Department, Telephone Number: (206) 627-7121

SPOKANE COUNTY (including Benton, Franklin, Okanogan, Ferry, Lincoln, Pend Oreille, Whitman, Stevens, Asotin and Garfield), CHELAN and DOUGLAS COUNTIES, COLUMBIA BASIN (including Grant and Adams), KITTITAS COUNTY and WALLA WALLA - claims should be submitted to:
Medical Service Corporation of Spokane County
Terminal Annex Box 3048, Spokane, Washington 99220
Attn: CHAMPUS Department, Telephone Number: (509) 455-5400

*CLARK, COWLITZ and PACIFIC COUNTIES - claims should be submitted to:
Clark County Physicians Service
3305 Main, Vancouver, Washington 99663
Attn: CHAMPUS Department, Telephone Number: (206) 693-2526

*KITSAP, MASON, CLALLAM and JEFFERSON COUNTIES - claims should be submitted to:
Kitsap Physicians Service
820 Pacific, Bremerton, Washington 98310
Attn: CHAMPUS Department, Telephone Number: (206) 377-5576

*SNOHOMISH, SKAGIT and WHATCOM COUNTIES - claims should be submitted to:
Snohomish County Physicians Corporation
2520 Colby Avenue, Everett, Washington 98201
Attn: CHAMPUS Department, Telephone Number: (206) 259-8181

*New Claims processing locations

The Civilian Health and Medical Program of the Uniformed Services, better known as CHAMPUS, applies to all of the United States Uniformed Services; The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the United States Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.

WHO IS ELIGIBLE FOR CHAMPUS?

1. The spouse and children of active duty members, as long as the member is on active duty for a period of 30 days or more.
   NOTE: Dependents residing with their sponsor are required to obtain INPATIENT treatment in military facilities when such facilities are within 30 miles from their residence and are capable of providing the needed care, except:

A. When care is not available from the military facility and a Statement of Non-Availability (DD Form 1251) is issued by the military.
B. In an emergency, when certified as such by the attending physician.
C. When the status of the dependent is changed from "residing apart from sponsor" to "residing with sponsor" while he is hospitalized in a civilian facility; or while a spouse is obtaining maternity care and does not desire to change physicians.
D. During a period of absence from the area of the sponsor's household.

2. Retired members who are entitled to retired[1], retainer, or equivalent[2] pay and their spouse and children.
NOTE: The retirees and/or spouse lose eligibility for CHAMPUS upon reaching age 65 if they become eligible for hospital insurance benefits (Part A) under the Social Security Medicare Program.* They are still eligible for care in military facilities, however.
3. The unremarried widow and children of deceased members who, at the time of sponsor's death, were active duty or retired members.
NOTE: The beneficiary's eligibility is terminated on the 65th birthday if he becomes eligible for hospital insurance benefits (Part A) under the Social Security Medicare program.* They are still eligible for care in military facilities, however.
4. The spouse and children of North Atlantic Treaty Organization Military Personnel who are on duty in, or traveling in, the United States in connection with official orders.
NOTE: Parents and parents-in-law are not eligible for care in Civilian facilities under the CHAMPUS.
5. Eligible dependents of active duty, retired, and deceased personnel are:
A. Wife
B. Unremarried widow
C. Husband, if dependent on service wife for more than one-half of his support.
D. Unremarried widower, if he was dependent on service wife at the time of her death for more than one-half of his support because of a mental or physical incapacity.
E. Unmarried legitimate child, including an adopted child or stepchild, in one of the following categories:
(1) Under 21 years of age, regardless of whether or not dependent on the active duty or retired member.
(2) Twenty-one or over, but incapable of self-support because of a mental or physical incapacity that existed before the age of 21, and is (or was at the time of the member's death) dependent on the member for more than one-half of his support.
(3) Under 23, enrolled in a full-time course of study in an approved institution of higher learning, and is (or was at the time of the member's death) dependent on the member for more than one-half of his support.

1 "Retired pay" is pay from a uniformed service which the member was entitled to at the time of retirement.
2 "Equivalent pay" is pay which the member elects to receive from the Veterans Administration in lieu of retired pay from the uniformed service concerned at the time of retirement.
* If not entitled to Part A (hospital portion) of Medicare, a copy of the disallowance letter from Social Security must be submitted with the first claim to CHAMPUS.

F. Unmarried illegitimate child or illegitimate stepchild who is, or was at the time of death of the active duty or retired member, dependent on the member for more than one-half of his support; residing in the member's household or in a dwelling place provided or maintained by the member and –
(1) Under 21 years of age.
(2) and (3) – same as #2 and #3 listed for unmarried legitimate child.

WHO IS ELIGIBLE FOR CHAMPVA?

The effective date for CHAMPVA is September 1, 1973.

Section 613 of the Veteran's Health Care Expansion Act of 1973 (PL93-82) authorizes a CHAMPUS–like program for the spouse or child of a veteran with a total permanent service–connected disability or the surviving spouse or child of a veteran who dies from a service–connected disability. People entitled to CHAMPUS benefits are excluded.

ELIGIBILITY DETERMINATION

Eligibility determination is the responsibility of the VA. Prospective beneficiaries will make application to the nearest VA hospital or clinic for their ID card. A list of VA issuing stations is provided.

Washington
American Lake, Tacoma 98403
Seattle 98108 (4435 Beacon Ave., South)
Spokane 99208 (North 4815 Assembly St.)
Vancouver 98661
Walla Walla 99362 (77 Wainwright Drive)

1. The issuing station S number will appear on the ID card to identify the "home station" where that beneficiary S case file will be kept. Once eligibility has been determined and an appropriate VA identification issued, these beneficiaries have complete freedom of choice in electing their civilian health care providers. CHAMPUS non-availability statement requirements do not apply to CHAMPVA beneficiaries.
   The ID cards, when available, are the authority for providers to deliver authorized services to these beneficiaries and bill for their services through the CHAMPUS system using CHAMPUS contractor and CHAMPUS deductible and cost sharing formulas. CHAMPVA beneficiaries may pay for their care and seek reimbursement from fiscal administrators and hopsital contractors.
2. CHAMPVA beneficiaries eligible for Part A Medicare at age 65 lose their entitlement to CHAMPVA the same as CHAMPUS people. The CHAMPUS relationship with Medicare, Medicaid, and FEHBP benefits apply to CHAMPVA.

AUTHORIZED PROVIDERS OF CARE (CHAMPUS–CHAMPVA)

1. Doctors of medicine and osteopathy.
2. Doctors of dental surgery and dental medicine.
3. Optometrists, psychologists, podiatrists and pharmacists.
4. Specialists in sciences allied to the practice of medicine *when ordered by a physician*. Such specialists include physical therapists, audiologists, speech therapists, social workers, (MSW), pastoral counselors, consultants and similar personnel.
5. Private duty nurses when ordered by a physician. (Check with fiscal agent.)
6. Christian Science practitioners and nurses.
7. Civilian Hospitals.
8. Extended care facilities.
9. Ambulatory Surgical Centers.
10. Equipment rental agencies.
11. Medical and Surgical Supply Houses.
12. Civilian pharmacies.

AUTHORIZED BENEFITS UNDER THE BASIC PROGRAM

Authorized benefits under CHAMPUS or CHAMPVA generally include medical care and surgical treatment including maternity, nervous, mental and emotional disorders; chronic conditions; and contagious diseases. As a rule, care which is furnished on either an inpatient or outpatient basis which is generally accepted as good medical practice will be authorized as a CHAMPUS or CHAMPVA benefit – except for certain benefits specifically excluded by law. Benefits may not ordinarily be provided, however, in facilities which discriminate on the basis of race, color or national origin. The following are authorized:

1. Professional services of all eligible practitioners providing authorized treatment necessary to treat the patient's condition.
2. Semi-private hospital accommodation and all necessary services and supplies furnished by the hospital. The charge for a private room is allowable only when medically indicated, or when it is the only kind of room available.
3. Drugs obtainable only by prescription and insulin.
4. Ambulance service when medically indicated.
5. Rental of durable equipment such as wheel chairs, respirators and hospital beds. (These are not to be purchased under the basic program.)
6. Diagnostic examinations.
7. Dental care required as a direct result of injury or secondary to the treatment of another medical or surgical condition or its aftermath.
8. Anesthetics and oxygen.
9. Blood transfusions, including the cost of blood and blood plasma, except when donated or replaced.
10. Radiation therapy and physical therapy.
11. Orthopedic braces (except orthopedic shoes) and crutches.
12. Artificial limbs and eyes.
13. Immunizations when required as part of medical treatment. (Not routine flu, DPT shots, etc.)
14. Family planning services including marital counseling (medically necessary—referred by M.D.), vasectomies, tubaligations, and abortions if legal in the state where you reside.
15. Home calls when medically indicated.

BENEFITS NOT AUTHORIZED (CHAMPUS–CHAMPVA)

1. Routine physical examination and immunizations (except when required because of overseas orders).
2. Outpatient routine well-baby care.
3. Routine eye examinations or glasses.
4. Prosthetic devices other than artificial limbs and eyes.
5. Routine dental care.
6. Domicillary or custodial care.
7. Chiropractic treatment.
8. Acupunture.
9. Human Chorionic Gonadotropin (HCG) injections.

HOW DOES ONE OBTAIN CARE UNDER CHAMPUS OR CHAMPVA?

CHAMPUS or CHAMPVA IS A *voluntary* program. The patient and the provider of care enter into a private contract. The contract states that the provider of care will perform a service and the patient will provide payment for that service.

Under CHAMPUS or CHAMPVA the patient is responsible for finding a provider of care who *participates* in the program. A participating provider of care agrees that in addition to the *cost share** (20%/25% plus *deductible,*** if

* Cost share later defined.
** Deductible later defined.

applicable) the provider will accept the *usual, customary,* and *prevailing fee* as full payment for his services. Thus, when the provider signs the certification (Block 20 of Form 1863-2) and receives an amount allowable which is less than the charges he submitted, the patient has no moral obligation to pay the difference. However, should the provider bill the patient for the difference, the patient should *furnish a copy of the additional billing* to the fiscal agent so that the agent can remind the provider of care of his agreement. If the provider of care does not participate, the patient may still go to the non-participating provider of care, but the patient or sponsor is *responsible for any difference between the provider's charges and the amount allowed by CHAMPUS or CHAMPVA as a reimbursement to the beneficiary.*

WHAT IS INPATIENT CARE AND OUTPATIENT CARE?

A. *Inpatient care* is treatment in a medical facility with formal admission to the institution or to a bed in the institution. The 30-120 day inpatient ruling *no longer applies* for any services after *August 1, 1974.* The care is either inpatient (care provided on date of admission until date of discharge) or the services are outpatient. At this time the two exceptions are maternity and certain emergency room services.

B. *Outpatient care* is medical services performed by a provider of care which do not involve admittance to a bed in a hospital and is not related to hospitalization. Outpatient care is subject to the applicable *deductible* and *20%* or *25% cost share. Drugs* obtained in civilian pharmacies are always considered *outpatient.*

C. *Emergency room treatment* may be considered *outpatient* or *inpatient* care depending on the following: The claim can be paid as *inpatient* care if a *surgical procedure* is performed and/or if *anesthesia* is used. If there is *no* surgical procedure or no anesthetic, it is considered an *outpatient* benefit. This is important to remember since emergency room charges are paid in whatever way is most advantageous to the beneficiary. For example, if we pay a claim as inpatient care and the sponsor is *active duty,* the beneficiary would be responsible for up to $25.00 of the emergency room charge. The physician and other providers of care would be paid at 100% of allowable charges for services provided in the emergency room or related care *on that date only.* Follow-up care is outpatient. In this case the beneficiary could not use the money paid to the hospital as part of the outpatient deductible. Consequently, you as the beneficiary must help us decide whether you want the charges to be paid on an inpatient or outpatient basis. Retired personnel would pay 25% of all related claims for services provided in the emergency room or related care *on that date only.* Follow-up care is outpatient.

NOTE: Exception: Maternity care and treatment for conditions related to or caused by the pregnancy are considered inpatient throughout the entire pregnancy.

Emergency room charges could be paid either inpatient or outpatient if no formal admission occurs. The following examples show how a claim submitted for the *dependent of an active duty serviceman* could be processed:

ACTIVE DUTY

Inpatient:

Total charges submitted	$65.00 – Emergency Room & Supplies
Inpatient Admission Responsibility	–25.00 – Patient Pays
Total Payable	$40.00 – CHAMPUS Pays

Outpatient: (No deductible satisfied)

Total charges submitted	$65.00 – Emergency Room & Supplies
Deductible	–50.00 – Deductible
Co-Insurance	– 3.00 – Co-insurance – 20%
Total Payable	$12.00 – CHAMPUS Pays

Outpatient: (Deductible met)

Total charges submitted	$65.00 – Emergency Room & Supplies
Co-Insurance	–13.00 – Co-insurance – 20%
Total Payable	$52.00 – CHAMPUS Pays

The following examples show how it could be processed for *retired personnel and dependents, eligible unremarried widows and dependents, and CHAMPVA dependents.*

Inpatient or Outpatient if deductible has been satisfied:

Total charges submitted	$65.00 – Emergency Room & Supplies
Co-Insurance	–16.25 – Co-insurance – 25%
Total Payable	$48.75 – CHAMPUS Pays

Outpatient – No Deductible satisfied

Total charges submitted	$65.00 – Emergency Room & Supplies
Deductible	–50.00 – Deductible
Co-Insurance	– 3.75 – Co-insurance – 25%
Total Payable	$11.25 – CHAMPUS Pays

HOW DOES THE BENEFICIARY ESTABLISH THE DEDUCTIBLE?

In the past, as the CHAMPUS Administrator for Washington, we have processed claims toward the OUTPATIENT DEDUCTIBLE even though the claims submitted did not total $50.00 on one person or $100.00 per family. This policy has changed as of April 1, 1974. Any *outpatient* claims submitted which are to establish the deductible must total $50.00 or more on one person, or collectively, $100.00 per family. The *maximum* deductible taken for one person is $50.00 per fiscal year.

Claims are being returned because the outpatient deductible has not been established for the fiscal year. Providers of care who do not come into direct contact with the patient and are therefore, unaware of the deductible status may still submit their claims. However, if the deductible has not been met, the claim will be returned and it will be the beneficiary's responsibility to pay the charges.

The *deductible* applies only to the *outpatient* program. The beneficiary is responsible for satisfying the deductible each fiscal year (July 1 to June 30), based on services provided during that fiscal year. He pays the provider of care for the authorized services he receives and obtains an *itemized statement.* An itemized statement includes the patient's name, each date of care, the amount charged, and the type of care, [i.e., office call or lab work], and diagnosis (a complaint, symptom or reason for care). Itemizations from out of state providers may also be used toward establishing the deductible.

As soon as the beneficiary accumulates itemized statements and/or drugs* which total $50.00 on one person or $100.00 per family, he completes items 1-13 on the claim form (1863-2) for *each* member of his family who has received care and submits this form and itemized statements to the Fiscal Administrator. The Fiscal Administrator then processes the claims and establishes the deductible for the individual or family. The beneficiary will receive from the Fiscal Administrator a deductible certificate showing that either the $50.00 or the $100.00 deductible has been satisfied. The beneficiary *should carry* this certificate and *show* it to all providers of care. This tells the provider of care that the individual or family has established the deductible and that CHAMPUS will pay *80%* of the allowable charges for *active duty dependents* or *75%* for *retirees, their dependents, eligible dependents of deceased personnel and CHAMPVA dependents* for the remainder of that fiscal year.**

If the charges submitted for establishing the deductible exceed the required amount, the fiscal administrator will reimburse the beneficiary the appropriate amount over the deductible and co-insurance (20% or 25%). Remember, if any information is missing from the claim, the itemized statement, or

the drug reimbursement form, payment will be delayed until the information is furnished by the sponsor, patient, or provider of care. Children under 10 years use either parent's I.D. card, preferably the mother's. Be sure to use effective date located in block 15b on the back of the card. Retirees be sure to give the name, address, group # and effective date of your insurance through employment. CHAMPUS co-ordinates with group insurance coverage.

*List prescription drugs on a drug reimbursement form (198). This allows you to keep the receipts for your records.

**If the deductible has been established in another state, be sure to send a copy of the out-of-state deductible certificate with the first claim you submit in Washington.

PSYCHOTHERAPEUTIC/PSYCHIATRIC CARE

Effective 6 September 1974, the 120 inpatient day and 60 outpatient visits/days constraints on psychotherapeutic/psychiatric care under CHAMPUS were removed and a review system initiated based on medical necessity. Continued coverage and extent of care after the 120th day/60th visit will be determined by this review process. Questions should be referred to our office at the address below as this benefit and its regulations are subject to change.

Washington Physicians Service
220 W. Harrison
Seattle, WA 98119
Area Code (206) 281-3422

COST SHARE – ACTIVE DUTY

A. *Inpatient Care*
The beneficiary pays the initial $25.00 or $3.70 per day, whichever is greater, to the hospital. CHAMPUS will pay 100% of the balance of the allowable charges to authorized providers of care or as a reimbursement to the beneficiary. There is *no deductible* requirement for inpatient care.

B. *Outpatient Care*
There is the deductible of $50.00 for one person or $100.00 per family each fiscal year, which runs from July 1 to June 30. Once the deductible has been established, CHAMPUS will pay 80% of the allowable charges and the beneficiary pays his deductible and 20% *directly* to the providers of care – not to the fiscal administrator.

COST SHARE – RETIRED

Retired members, their dependents and dependents of deceased members who were on active duty or retired at the time of their death and CHAMPVA dependents:

A. *Inpatient Care*
The beneficiary is responsible for 25% to *all* authorized providers of care and CHAMPUS will pay 75% of the allowable charges to all authorized providers of care or as reimbursement to the beneficiary.

B. *Outpatient Care*
The annual deductible of $50.00 on one person or $100.00 per family each fiscal year (July 1 to June 30) plus a cost share of 25% is to be paid to the providers of care. CHAMPUS will pay 75% of the allowable charges to authorized providers of care once the deductible has been established or as reimbursement to the beneficiary.

CERTIFICATION

Certification (block 13) is to determine whether or not you have other insurance coverage. If you are *retired, the dependent of a retiree, the unremarried widow of a deceased member who died while on active duty,* or *during retirement, or CHAMPVA dependents, the following applies to you:*

A. *Individual* (Personal Health Care Plan)
If you have individual coverage, (insurance not offered by employment) you should check the first square in block 13 of the certification section on the 1863-1 and/or 1863-2 form. CHAMPUS pays as the primary

carrier when you have individual insurance coverage. We do not coordinate unless the private insurance company will pay only the provider of care. In this instance CHAMPUS will not duplicate payments to the providers of care.

B. *Insurance through employment*

If you have insurance through employment (group coverage), it should be established whether that plan or CHAMPUS is your primary carrier.* It is considered group coverage if the employer contributes 10% or more of the annual premium for coverage provided to the employee and/or his family. If the employer contributes more than 10% of the premium and if the insurance contract does not contain an exclusionary clause, your group coverage is the primary carrier.

Basically, the exclusionary clause means that if you were entitled to CHAMPUS benefits and had insurance through your employment prior to October 1, 1966, CHAMPUS is considered the primary carrier (first-pay) and your group coverage is the secondary carrier (last-pay). However, if you obtain your insurance through employment or operation of law after October 1, 1966, the exclusionary clause no longer applies and your group coverage is the primary carrier and CHAMPUS is the secondary carrier. This October 1, 1966, rule does not apply in the case of retirees, their dependents and dependents of deceased personnel enrolled in a health plan under the *Federal Employees Health Benefits Program (FEHBP);* in all such instances, such a plan is "first-pay" and CHAMPUS is "last-pay". The other insurance provisions of CHAMPUS also apply to CHAMPVA beneficiaries except the exclusionary clause effective date is 1 September 1973 instead of 1 October 1966.

If you are in doubt as to which coverage is primary, you should furnish CHAMPUS with the information requested below in Step 1, and we will assist you in the determination. Once you have determined that your group plan is the primary carrier, you should follow these four steps:

1. Furnish the CHAMPUS fiscal agent and/or CHAMPUS hospital contractor with the name of the insurance company, the address of the insurance company, the group or policy number, the subscriber's Social Security number, and if possible, the effective date of the policy or the date of your employment.
2. Send all claims to the primary carrier first, and not to CHAMPUS.
3. When you receive either worksheets, payments, or disallowances from your primary carrier, attach them to a completed DA 1863-2 form with an itemized statement showing dates of service, amount charged and diagnosis and submit them to our office. If the provider is to be paid directly, please be sure he has completed Items 14 through 20, indicating the amount (to be) paid by other insurance, and that he has signed the claim form. We will then process and pay the balance as the secondary carrier, if the deductible for outpatient care has been satisfied, and if the primary plan has paid an amount equal to or greater than the amount that would normally have to be paid by the beneficiary.
4. The payment procedure is the same for inpatient related charges except there is no deductible taken, and the hospital room and board charges are submitted to the hospital contractor (Blue Cross) on the completed 1863-1 form.

Please follow the above steps. It will expedite the processing of your claims. If these steps are not followed, we will be unable to process your claims because we lack necessary information.

MEDICARE – DISABILITY (UNDER AGE 65)

You can use either Medicare, CHAMPUS, or CHAMPVA. CHAMPUS and CHAMPVA suggest that you submit your claims to Medicare first; then, as with other insurance, submit an 1863-2 form, itemization and the Medicare explanation of benefits to CHAMPUS. Medicare would become a first payor and CHAMPUS or CHAMPVA would pay secondary and pay the balance

* The primary carrier is the company which receives and processes all claims first.

whenever possible. This offers more coverage than if you sumbit to either CHAMPUS or CHAMPVA or Medicare.

Insurance Available to Supplement CHAMPUS

As the cost of medical care continues to rise, the 25 per cent share that many beneficiaries have to pay takes a bigger and bigger chunk out of the family budget. As a result, numerous organizations are now offering private health insurance to cover the costs not covered by CHAMPUS.

Although the plans differ in detail, in general they offer similar coverage. As a rule, the plans pay the 25 per cent that CHAMPUS does not cover for inpatient and outpatient care. Some of the plans also cover the deductible.

There are, however, certain limitations in comparison with CHAMPUS. The plans, for example, do not cover any injury or sickness resulting from an act of war, or treatment for prevention or cure of alcoholism or drug addiction. They also usually exclude coverage for pre-existing conditions during the initial months the policy is in effect.

In addition to the CHAMPUS supplement, there are plans to supplement Medicare coverage for members over 65 and their spouse, plus hospital income plans which provide a cash income whenever the insured is hospitalized.

Here is a listing of some organizations offering this type of insurance:

ASSOCIATION	ADDRESS
Air Force Sergeants Association	P.O. Box 9081 Washington, D. C. 20003
Association of the United States Army	1529 18th Street, NW Washington, D. C. 20036
Defense Supply Association	1026 17th Street, NW Washington, D. C. 20036
Fleet Reserve Association	1303 New Hampshire Ave., NW Washington, D. C. 20036
National Association for Uniformed Services	956 North Monroe Street Arlington, Virginia 22201
Navy League of the United States	2100 M Street, NW Washington, D. C. 20037
Reserve Officers Association of the U.S.	1 Constitution Avenue, NE Washington, D. C. 20002
The Retired Officers Association	1625 Eye Street, NW Washington, D. C. 20006
North Carolina Blue Cross and Blue Shield, Inc.	P.O. Box 2291 Durham, North Carolina 27702
Mutual of Omaha Insurance Company	Joseph E. Jones 1666 Connecticut Avenue Washington, D. C. 20009

DENTAL

I. GENERAL
   A. Dental care under the CHAMPVA or CHAMPUS Basic program is available on a limited basis to eligible beneficiaries.

II. DENTAL CARE AUTHORIZED UNDER THE CHAMPUS BASIC PROGRAM
   A. Eligibility – All categories of beneficiaries.
   B. Dental care authorized.
      1. Dental care required as the direct result of an accident.
      2. Adjunctive dental care.
         For dental care to be determined adjunctive, the patient must have been under the care of a physician for a medical or surgical

condition, OTHER THAN DENTAL, where proper treatment required that the dental care given was necessary for the proper treatment of that medical or surgical condition or its aftermath. The primary diagnosis must be specific so that the relationship between the primary condition and the requirement for dental care in the treatment of the primary condition is clearly shown. Treatment intended merely to improve the general health of the patient is insufficient basis to support payment for dental care under the CHAMPUS. Claims for adjunctive dental care must be accompanied by a statement from the patient's physician giving the medical diagnosis and attesting to the necessity for dental care in the treatment of the primary medical condition.

3. Certain surgical procedures that come within the scope of the dentist's license, such as reduction of fractures, removal of cysts and tumors, the repair of clefts, etc. The surgical removal of teeth is NOT an authorized program benefit unless said removal falls under paragraph II B, 1 or 2.
4. Limited orthodontic care.
   a. Orthodontics required in connection with the treatment of a cleft palate.
   b. Orthodontics required in connection with the treatment of Scoliosis (wherein the wearing of a Milwaukee Brace is required).
   c. Orthodontics required following extensive surgery, such as a bilateral sliding osteotomy of the mandible.

C. The beneficiary is also permitted to obtain a pre-authorization for dental care. Obtaining a pre-authorization is recommended if it appears the dental care is a questionable benefit. This will enable both the beneficiary and the dentist to know whether or not it is an authorized benefit before the work begins. Dentists should submit requests for pre-authorization for the Basic Program to Colorado Dental Service with a description of the work to be performed accompanying x-rays and an estimate of the charges.

D. Submission of Claims

1. Claims for authorized dental care provided under the Basic Program must be submitted on a copy of DA form 1863-2. Section I of this claim must be completed by the patient (or sponsor); Section II by the dentist if he wishes direct payment. If you wish reimbursement for authorized services, the beneficiary should complete Section I and attach an itemized statement which shows the patient's name, dates of care, the exact nature of the services provided and the cost. You must also submit documentation verifying the adjunctive nature of the claims or give the date and type of accident.

   Dental claims under the *Basic Program* should be submitted directly to:

   Colorado Dental Service
   1600 Downing Street
   Denver, Colorado 80218
   ATTN: CHAMPUS Dept.

   Inquiries on claims previously submitted should also be directed to Colorado Dental Service – CHAMPUS Department.
2. Claims for related hospital care should be completed in the same manner as in D1., on a DA form 1863-1, and submitted directly to the appropriate hospital contractor in the state where the services were provided.
3. Claims for care other than the dental care should be submitted on a copy of DA form 1863-2 directly to the appropriate fiscal administrator for the state in which the services were provided.

E. Be sure to submit a copy of your deductible certificate with your dental claim (if you have a certificate) to Colorado Dental Service. If

your deductible is established by your dental claim, send a copy of the deductible certificate to the fiscal administrator in the state where you reside.

F. Exceptions, Outpatient Care
When outpatient care is DIRECTLY RELATED TO THE MEDICAL CONDITION FOR WHICH A PATIENT IS HOSPITALIZED, it is considered INPATIENT care in computing the patient's share of charges in the following instances:
1. Pregnancy. That dental care required during a woman's pregnancy, prescribed by her physician as being necessary to protect the health of the mother and/or unborn child.

III. DENTAL CARE AUTHORIZED UNDER THE CHAMPUS PROGRAM FOR THE HANDICAPPED.

A. Eligibility – LIMITED TO DEPENDENTS OF ACTIVE DUTY MEMBERS ONLY.

B. Termination of Eligibility – A patient's eligibility for treatment under the Program for the Handicapped ceases as of midnight of the date of separation, retirement or death of the sponsor.

C. Effective Date of Program – 1 January 1967.

D. Dental Care Authorized – CHAMPUS is authorized to share in the cost of treatment of certain ORTHODONTIC conditions under the CHAMPUS Program for the Handicapped which was established by Public Law 89-164. Under this program, CHAMPUS may share in the cost of orthodontic treatment which is needed to correct, overcome or aid in adjustment to a handicapping condition. However, the condition must be classified as a SERIOUS physical handicap.

E. For the purpose of determining the severity of the malocclusion – CHAMPUS Form 161 (Handicapping Labio-Lingual Deviations) has been developed for the use of the orthodontist. CHAMPUS Form 161, which may be obtained from the fiscal administrator or the address indicated below, must be completed by the orthodontist and forwarded to:

Executive Director
OCHAMPUS
ATTN: MEDDC-D
Denver, Colorado 80240

All authorization for dental care under the *Program for the Handicapped* must go through Colorado Dental Service.

Upon receipt of CHAMPUS Form 161 by OCHAMPUS, the orthodontist will be informed whether or not the case qualifies as a serious physical handicapping condition for financial assistance under the CHAMPUS Program for the Handicapped. If the case does qualify, the doctor will also be provided with the applicable claim form (DA Form 1863-3) and instructions for its use.

Only spouses and children of ACTIVE DUTY MEMBERS are eligible for orthodontic care under the Program for the Handicapped. The service member pays an initial share of the monthly cost of orthodontic care according to his pay grade, as set forth below. CHAMPUS pays the balance of the authorized charges up to a maximum of $350 per month. A different payment procedure is used where the orthodontist bills on a quarterly basis. (See Note on Quarterly Billings.)

MINIMUM MONTHLY COST

Pay Grade	Amount Per Month
E-1 through E-5	$25
E-6	30
E-7 and O-1	35
E-8 and O-2	40
E-9, O-3, W-1 and W-2	45
W-3, W-4, and O-4	50
O-5	65
O-6	75
O-7	100
O-8	150
O-9	200
O-10	250

The sponsor of a patient receiving orthodontic care under the Program for the Handicapped has a monthly liability based on grade as reflected above.

Therefore, if the orthodontist bills a CHAMPUS beneficiary on a monthly basis, CHAMPUS will generally only make a one-time payment for orthodontic care, during the month in which the initial or banding services are provided, as the subsequent monthly charges usually fall within the cost-sharing liability of the sponsor. Payment for care cannot be made prior to the time care was provided.

When claims for orthodontic care provided under the Program for the Handicapped are submitted on DA Form 1863-3, the patient, sponsor or other responsible family member completes Section I, Items 1 through 11. The source of care completes Section II, Items 12 through 16, and submits the completed claim forms to:

Colorado Dental Service
1600 Downing Street
Denver, Colorado 80218

IV. FOR FURTHER INFORMATION CONCERNING DENTAL CARE UNDER THE CHAMPUS

Inquiries pertaining to dental care under the Civilian Health and Medical Program of the Uniformed Services should be directed to:

Colorado Dental Service
CHAMPUS Division
1600 Downing Street
Denver, Colorado 80218

Phone: (Area Code 303) 832-1111

NURSING CARE

Before placing an eligible CHAMPUS beneficiary in a nursing home or obtaining a private duty nurse, contact the fiscal agent in your state. This benefit is provided only under certain conditions and only in nursing homes accredited by CHAMPUS or Medicare. Be sure to notify the CHAMPUS fiscal agent before beginning care.

Claims for services and supplies provided after January 1, 1974 must be filed by the last day of the calendar year following the calendar year in which the services and supplies were provided. EXAMPLE: Services provided in January, 1974, must be submitted no later than December 31, 1975. Claims for services and supplies provided before January 1, 1974 will be processed according to current policies and regulations.

HANDICAPPED PROGRAM

The CHAMPUS Program for the *Handicapped* provides benefits for the wife and the children of *Active Duty Members* of the uniformed services and for the dependents of military personnel of the NATO Nations.

To be eligible for care, the wife or child must. . .
*Have a *serious physical handicap*. . .or,
*Must be *moderately* or *severely mentally retarded.*

The authorized benefits include, but are not limited to. . .
*Diagnosis
*Inpatient Treatment
*Outpatient Treatment
*Home Treatment
*Training and Special Education
*Institutional Care
*Dental Care, Including Orthodontics
*Prosthetic Devices
*Orthopedic Appliances
*Special Optical Devices
*Purchase of Durable Equipment
*Rental of Durable Equipment
*Drugs and Medicine Obtainable *only* by Prescription
*Supplies Ordered by the Attending Practitioner
*Transportation
*Professional Services

Benefits are obtained by submission of an *Application for Benefits* and *A Plan for Management of the Handicapping Condition* to:

The Executive Director
OCHAMPUS (Attn: MEDDC-PS)
Denver, CO 80240

who will review the plan and approve the plan. He may also suggest an alternative method of obtaining the required care under the *Basic Program* which would be more beneficial, from a financial standpoint, to the beneficiary or his sponsor.

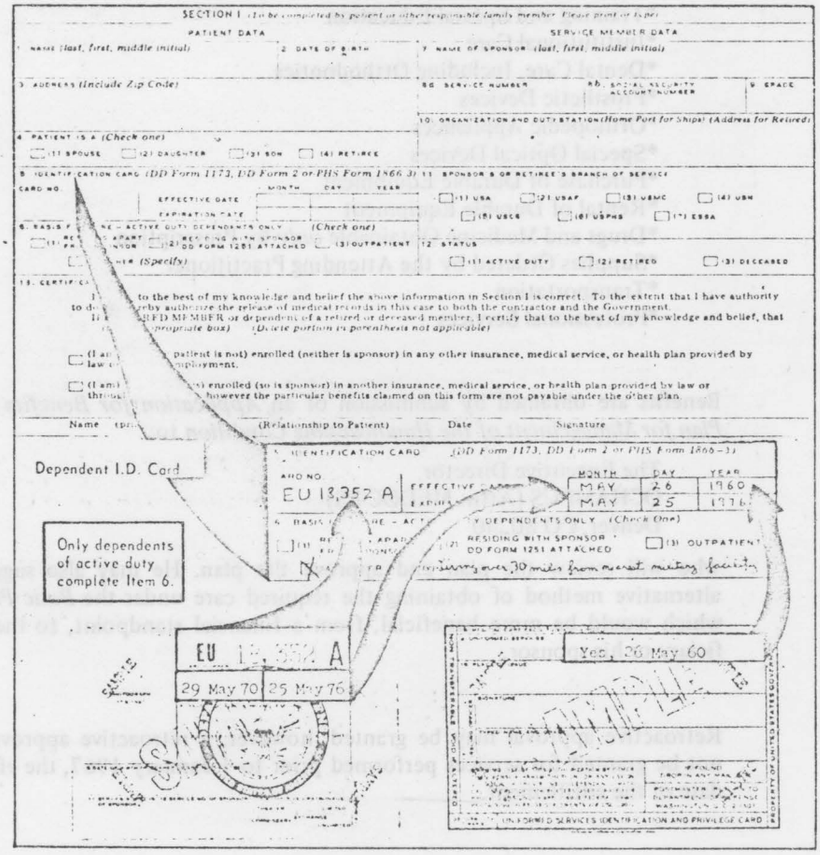
Retroactive approval may be granted; however, a retroactive approval may not be granted for services performed prior to 1 January 1967, the effective date of the entitlement.

If you are active duty and are in need of this type of assistance, please contact Washington Physician Service.

HOW TO COMPLETE DA 1863-2 CLAIM FORMS FOR DIRECT PAYMENT TO SOURCE OF CARE – CHAMPUS Beneficiaries only

a) PATIENT'S PORTION

Submit DA 1863-2 (yellow) claim form completed one through 13 for patient, one for each member of the family. Indicate necessary identification card numbers, effective and expiration dates for eligibility. Children under ten may use their mother's or father's identification card. Children ten years and over are required to have an identification card of their own. A dependent child is not eligible after age 21 unless a fulltime student; then they are eligible until their 23rd birthday. Also indicate the sponsor's Social Security number, Grade, Status, Branch of Service, Insurance Status if retired, etc., on all claims. Each form must be signed by the patient, sponsor, spouse, or guardian.



b) SOURCE OF CARE PORTION (MD, Ambulance, etc.)

The source of care for CHAMPUS or CHAMPVA must complete 14 through 20 of the DA 1863-2 claim form indicating the diagnosis, the dates of service, services provided, and the charges. Please indicate in Block 18 (dates) if the care is related to hospitalization. Block 20 should be signed by the provider of service if direct payment is to be made.

SECTION II *(To be completed by Source of Care)*

14. NAME AND ADDRESS OF SOURCE OF CARE *(Include Zip Code)*

a. SOURCE OF CARE LOCATION CODE

b. PROVIDER OF SERVICES
☐ (1) ATTENDING PHYSICIAN
☐ (2) OTHER *(Specify)*

c. PATIENT STATUS
☐ (1) INPATIENT
☐ (2) OUTPATIENT

15. NAME AND TITLE OF INDIVIDUAL ORDERING CARE

16. INCLUSIVE DATES OF CARE
FROM MONTH DAY YEAR TO MONTH DAY YEAR

17. DIAGNOSIS *(Use standard nomenclature)*

g. INTL STAT CODE

(Check when applicable) ☐ *services were necessary for treatment of a bonafide medical emergency*

h. 12 BREAK CODE

18. RELATED HOSPITALIZATION *(If applicable)*
FROM TO

19. ENTER ESTIMATED OR ACTUAL DATE OF DELIVERY IN MATERNITY CASES. LIST BY DATE SURGICAL OPERATIONS AND/OR CARE FURNISHED INCLUDING VISITS FOR WHICH SEPARATE CHARGES ARE CLAIMED. *(Type or print)* *(Attach additional sheets if required)*

a. DATE(S) OF SERVICE	g. ITEM OR DESCRIPTION OF SERVICE	b. CHARGES	c. PROCEDURE CODE
		$	
d. TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED		$	
e. (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*		$	
f. DUE FROM GOVERNMENT TO SOURCE OF CARE		$	
g. DUE PATIENT OR SPONSOR, REIMBURSEMENT		$	

20. CERTIFICATION BY SOURCE OF CARE

I certify that the services and / or supplies listed hereon were performed or authorized by the attending physician, dentist or other professional personnel in charge, that payment due from the Government has not been received, and that, except for the amount payable by the patient in accordance with the terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and / or supplies listed hereon.

I further certify that I am not an intern, resident or otherwise in training status for which I am receiving compensation for services listed on this claim.

Name (print or type) Title Date Signature

The persons signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws.

DA FORM 1 JUN 67 1863-2 (Civilian Sources) REPLACES DA FORM 1863-2, 1 SEP 61, WHICH IS OBSOLETE Form Approved Comptroller General, U.S., 22 Sep 67

ATTACHMENT 19

HOW TO COMPLETE DA 1863-2 CLAIM FORMS FOR REIMBURSEMENT

a) PATIENT'S PORTION

A DA 1863-2 claim form should be completed for each member of the family. Please refer to Section I 'DIRECT PAYMENT–PATIENT'S PORTION' for further instructions.

b) Submit itemized statements showing the name of the patient, dates of service, services provided, amount, and the diagnosis and attach to the DA 1863-2 claim forms. If any of this information is missing, payment of your claim will be delayed.

THE ABC CLINIC

STATEMENT OF ACCOUNT

L John Doe
PATIENT

CLINIC NO

6 01 72
STATEMENT DATE

Diagnosis: Diabetes

BILL TO
Doe, John
1234 6th St.
Anywhere, Washington

PLEASE RETAIN THIS STATEMENT FOR INCOME TAX PURPOSES. A CHARGE WILL BE MADE FOR ADDITIONAL COPIES

CERTAIN PROFESSIONAL FEES AND OTHER CHARGES MAY NOT BE BILLED UNTIL THE CONCLUSION OF TREATMENT OR EXAMINATION

HOSPITAL CHARGES ARE NOT INCLUDED IN THIS STATEMENT AND WILL BE BILLED SEPARATELY

PAYMENTS RECEIVED AFTER STATEMENT DATE DO NOT APPEAR ON THIS STATEMENT

DATE	PHYSICIAN/DEPT	DESCRIPTION & CODE	AMOUNT
5-04-72	1 LAB	URINALYSIS-ROUTINE	2.50
5-04-72	1 LEONARD, J	DIAGNOSTIC HISTORY-PHYSICAL	42.00
5-04-72	1 LAB	COMPLETE BLOOD COUNT	7.50
5-04-72	1 LAB	KETO ACID - URINE	1.00
5-04-72	1 LAB	CHEM SCREEN BATTERY	17.50
5-04-72	1 LAB	BLOOD SUGAR	4.50
5-04-72		ICDA 250.	
5-08-72		REG DF DIABETES 05-08/05-12	
5-08-72	1	14 DIABETIC MEALS	34.00
5-08-72	1	DAILY PHYS VISITS FOR	60.00
5-08-72	1 LAB	BLOOD SUGAR	4.50
5-10-72	1 LAB	KETO ACID - URINE	N/C
5-10-72	1 LAB	BLOOD SUGAR	4.50
5-10-72	1 LAB	SUGAR BY DIP STICK	N/C

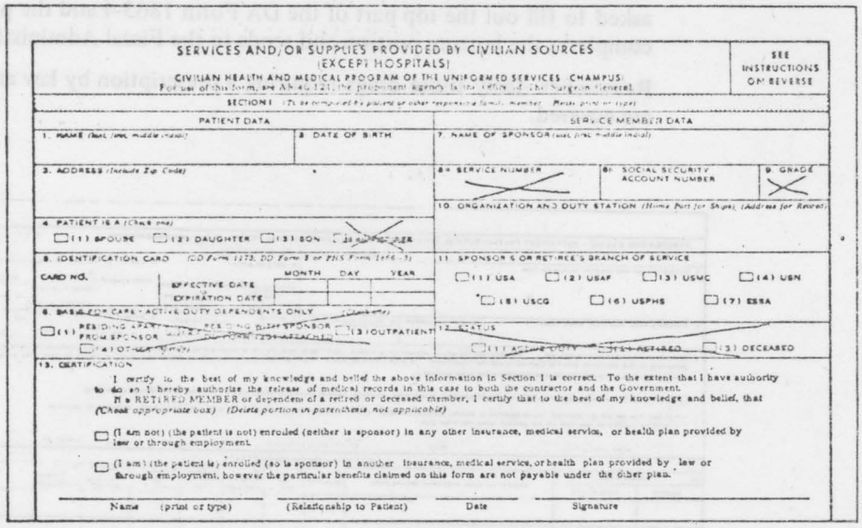
PLACE OF SERVICE
1. OFFICE
2. IN HOSPITAL
3. EXT. CARE FACILITY

PLEASE PAY THIS AMOUNT $ 178.00

CHAMPVA BENEFICIARIES

HOW TO COMPLETE 1-13 OF THE 1863-2 FORM FOR DIRECT PAYMENT AND REIMBURSEMENT.

If direct payment, beneficiary completes 1-13 of an 1863-2 form and the source of care completes 14-20 of the form and signs the bottom (example, p. 18). If for reimbursement, beneficiary completes 1-13 of 1863-2 form and attaches an itemized statement (example, p. 19). Please read carefully. Any omission delays payment.



SERVICES AND/OR SUPPLIES PROVIDED BY CIVILIAN SOURCES (EXCEPT HOSPITALS)

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

SEE INSTRUCTIONS ON REVERSE

SECTION I

PATIENT DATA

1. NAME
2. DATE OF BIRTH
3. ADDRESS
4. PATIENT IS A (Check one)
☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) OTHER
5. IDENTIFICATION CARD
CARD NO.
EFFECTIVE DATE MONTH DAY YEAR
EXPIRATION DATE
6. BASIS FOR CARE - ACTIVE DUTY DEPENDENTS ONLY
☐ (1) PENDING APPLY FROM SPONSOR ☐ (2) PENDING DIRECT SPONSOR ☐ (3) OUTPATIENT
☐ (4) OTHER

SERVICE MEMBER DATA

7. NAME OF SPONSOR
8A. SERVICE NUMBER
8B. SOCIAL SECURITY ACCOUNT NUMBER
9. GRADE
10. ORGANIZATION AND DUTY STATION
11. SPONSOR'S OR RET-REE'S BRANCH OF SERVICE
☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN
☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA
12. STATUS
☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

13. CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. To the extent that I have authority to do so, I hereby authorize the release of medical records in this case to both the contractor and the Government.
If a RETIRED MEMBER or dependent of a retired or deceased member, I certify that to the best of my knowledge and belief, that
(Check appropriate box) (Delete portion in parenthesis not applicable)

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service, or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service, or health plan provided by law or through employment, however the particular benefits claimed on this form are not payable under the other plan.

Name (print or type) (Relationship to Patient) Date Signature

CHAMPVA claims will be submitted to CHAMPUS contractors on forms 1863-1 (hospital) and 1863-2 (except hospital). The following information is required:

Block 1: Patient name.
Block 2: Patient date of birth.
Block 3: Patient address.
Block 4: Check 1, 2, or 3 (4 does not apply, since sponsor is not eligible).
Block 5: ID data will consist of the ID card number and the effective and expiration dates shown on the ID card. The ID card number will be the veteran S VA file number with an alpha suffix. The suffix will be different for each beneficiary of a sponsor.
Block 6: Not applicable.
Block 7: Veteran's name.
Block 8A: Leave blank.
Block 8B: Veteran's VA file number (omit prefix or suffix). Do not use any other former service numbers.
Block 9: Not applicable.
Block 10: Show the three-digit number of the VA station that issued the ID card.
Block 11: Print VA in the Block.
Block 12: Not applicable.
Block 13: Other insurance blocks must be checked (see p. 8-9) and the claim form signed. The same categories of people may sign CHAMPVA claims as sign for CHAMPUS. The remainder of each form applies as for CHAMPUS except the emergency item (Block 33A of 1863-1) is not necessary for CHAMPVA.

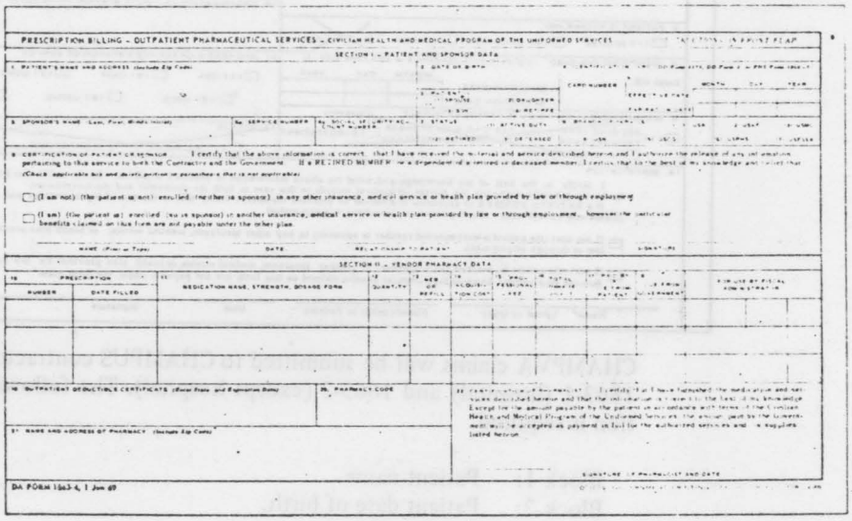
GERALD R. FORD LIBRARY

HOW TO COMPLETE A DA 1863-4 FORM FOR DIRECT PAYMENT OF DRUGS TO THE PHARMACIST.

Be sure to show your deductible certificate when requesting service. If your pharmacy does not have the prescription Billing Forms DA Form 1863-4, they are available from the CHAMPUS Fiscal Administrator.

Pharmacies participating in the CHAMPUS or CHAMPVA Drug Program will collect 20% or 25% directly from you. They in turn will submit a claim to the CHAMPUS Fiscal Administrator for the remainder. You are asked to fill out the top part of the DA Form 1863-4 and the pharmacist completes the bottom portion and sends to the Fiscal Administrator.

Remember–Only those drugs requiring a prescription by law and Insulin are covered.



PRESCRIPTION BILLING – OUTPATIENT PHARMACEUTICAL SERVICES – CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

SECTION I – PATIENT AND SPONSOR DATA

1. PATIENT'S NAME AND ADDRESS (Include Zip Code)

2. DATE OF BIRTH

3. PATIENT STATUS: SPOUSE, SON, DAUGHTER, STEPCHILD

4. CARD NUMBER

5. SPONSOR'S NAME (Last, First, Middle Initial)

6a. SERVICE NUMBER

6b. SOCIAL SECURITY ACCOUNT NUMBER

7. STATUS: ACTIVE DUTY, RETIRED, E OF CASED, OTHER

8. BRANCH: ARMY, NAVY, AIR FORCE, MARINES, USPHS, NOAA

9. CERTIFICATION OF PATIENT OR SPONSOR. I certify that the above information is correct, that I have received the materials and service described herein and I authorize the release of any information pertaining to this service to both the Contractor and the Government. If a RETIRED MEMBER or a dependent of a retired or deceased member, I certify that to the best of my knowledge and belief that (Check applicable box and delete portion in parenthesis that is not applicable)

☐ (I am not) (The patient is not) enrolled (neither is sponsor) in any other insurance, medical service or health plan provided by law or through employment

☐ (I am) (The patient is) enrolled (as a sponsor) in another insurance, medical service or health plan provided by law or through employment, however the particular benefits claimed on this form are not payable under the other plan

NAME (Please Type) DATE RELATIONSHIP TO PATIENT SIGNATURE

SECTION II – VENDOR PHARMACY DATA

10. PRESCRIPTION NUMBER	DATE FILLED	11. MEDICATION NAME, STRENGTH, DOSAGE FORM	12. QUANTITY	13. NEW OR REFILL	14. ALLOWABLE CHARGE PER UNIT	15. PHARMACY'S USUAL CHARGE PER UNIT	16. TOTAL CHARGE	17. PAID BY PATIENT	18. AMOUNT PAID BY OTHER INSURANCE	FOR USE BY FISCAL INTERMEDIARY

19. OUTPATIENT DEDUCTIBLE CERTIFICATE (Enter Date and Expiration Date)

20. PHARMACY CODE

21. NAME AND ADDRESS OF PHARMACY (Include Zip Code)

22. I certify that I have furnished the medication and services described herein and that the information is correct to the best of my knowledge. Except for the amount payable by the patient in accordance with terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and supplies listed herein.

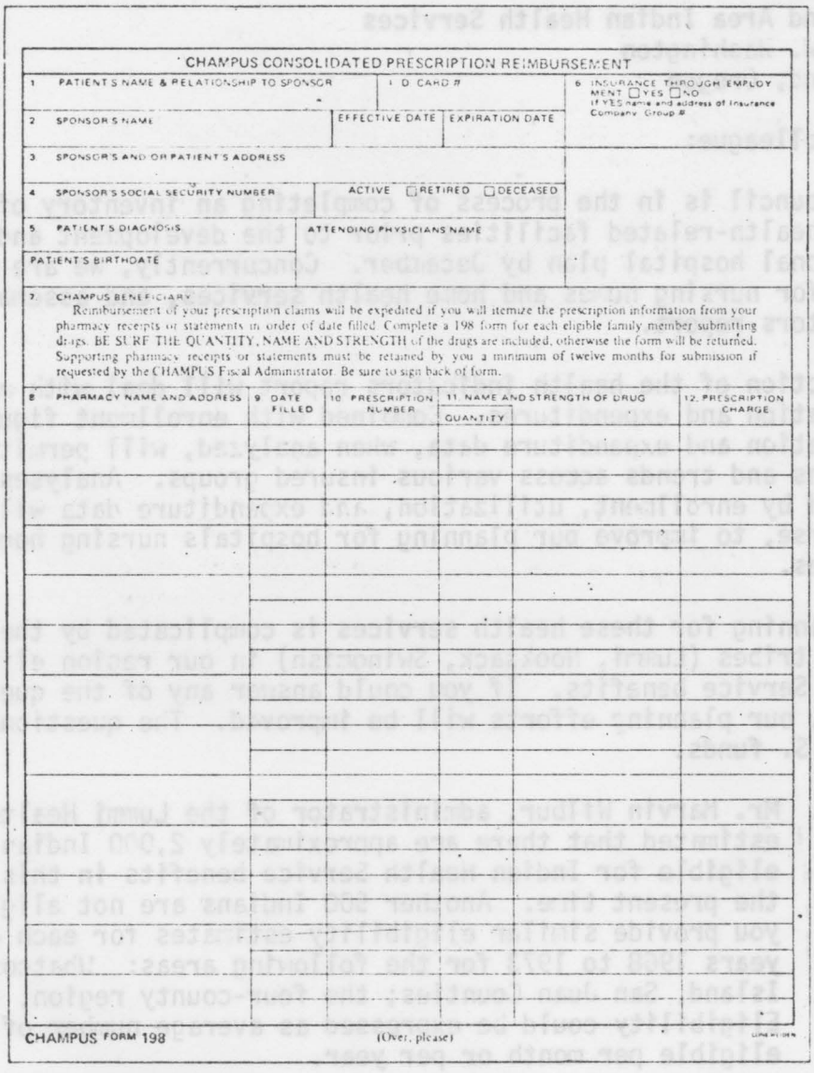
SIGNATURE OF PHARMACIST AND DATE

DA FORM 1863-4, 1 Jun 69

HOW TO SUBMIT CHAMPUS OR CHAMPVA CONSOLIDATED PRESCRIPTION REIMBURSEMENT (FORM 198) –

Complete blocks 1 through 8. Please list your drug charges according to date of purchase including state tax on the Form 198. You must also include the strength and quantity of the drug. Be sure to read item number seven on the Form. Sign back of form.

Keep the drug receipts for your records and send only the completed 198 form. Complete one form for each member of the family and be sure to sign the back of the claim form. If any information is missing the form will be returned.



CHAMPUS CONSOLIDATED PRESCRIPTION REIMBURSEMENT

1 PATIENT'S NAME & RELATIONSHIP TO SPONSOR | I. D. CARD # | 6 INSURANCE THROUGH EMPLOYMENT ☐YES ☐NO If YES name and address of Insurance Company Group #

2 SPONSOR'S NAME | EFFECTIVE DATE | EXPIRATION DATE

3 SPONSOR'S AND OR PATIENT'S ADDRESS

4 SPONSOR'S SOCIAL SECURITY NUMBER | ACTIVE ☐RETIRED ☐DECEASED

5 PATIENT'S DIAGNOSIS | ATTENDING PHYSICIANS NAME

PATIENT'S BIRTHDATE

7 CHAMPUS BENEFICIARY

Reimbursement of your prescription claims will be expedited if you will itemize the prescription information from your pharmacy receipts or statements in order of date filled. Complete a 198 form for each eligible family member submitting drugs. BE SURE THE QUANTITY, NAME AND STRENGTH of the drugs are included, otherwise the form will be returned. Supporting pharmacy receipts or statements must be retained by you a minimum of twelve months for submission if requested by the CHAMPUS Fiscal Administrator. Be sure to sign back of form.

8 PHARMACY NAME AND ADDRESS	9 DATE FILLED	10 PRESCRIPTION NUMBER	11 NAME AND STRENGTH OF DRUG / QUANTITY	12 PRESCRIPTION CHARGE

CHAMPUS FORM 198 (Over, please)

P.O. Box 39

June 4, 1974

Director
Portland Area Indian Health Services
921 S.W. Washington
Portland, Oregon

Dear Colleague:

This Council is in the process of completing an inventory of hospital and other health-related facilities prior to the development and publication of a regional hospital plan by December. Concurrently, we are also developing plans for nursing homes and home health services, and assembling a health indicators report.

One section of the health indicators report will deal with medical care utilization and expenditures. Combined with enrollment figures, the utilization and expenditure data, when analyzed, will permit identification of patterns and trends across various insured groups. Analyses and comparisons enabled by enrollment, utilization, and expenditure data will also be used, of course, to improve our planning for hospitals nursing homes, and home care services.

The planning for these health services is complicated by the presence of three Indian tribes (Lummi, Nooksack, Swinomish) in our region eligible for Indian Health Service benefits. If you could answer any of the questions that follow, our planning efforts will be improved. The questions refer strictly to I.H.S. funds.

1. Mr. Marvin Wilbur, administrator of the Lummi Health Center, has estimated that there are approximately 2,000 Indian people eligible for Indian Health Service benefits in this region at the present time. Another 500 Indians are not eligible. Could you provide similar eligibility estimates for each of the calendar years 1968 to 1973 for the following areas: Whatcom, Skagit, Island, San Juan Counties; the four-county region; the state? Eligibility could be expressed as average number of persons eligible per month or per year.

2. For the same areas and calendar years in question 1, what were the hospital and nursing home admission or discharge rates (admissions or discharges per 1,000 persons eligible) for Indians eligible for I.H.S. benefits? What were the home care utilization rates (home care starts per 1,000 enrollees)?

3. For the same areas and years in question 1, how much hospital and nursing home care was provided (days of care per 1,000 beneficiaries)? How much home care (either visits per 1,000 beneficiaries or days of home care per 1,000 beneficiaries)?

4. For the same areas and years in question 1, how much money did the I.H.S. spend for hospital care? Nursing home care? Home care? How much money for physician services? Dental services? How much for all types of medical care?

5. Are figures on costs and utilization based on place of residence of the beneficiary regardless of the geographic site of care or on geographic site of care regardless of place of residence of the beneficiary?

The enrollment, utilization, and expenditure data I have requested are readily available for the state's federally-supported Medicaid program. The data are also available, to a lesser extent, for the Medicare program. I point out this federal insurance data availability because I wish to prevent the impression that the I.H.S. is being singled out for unreasonable requests. If it's any consolation, the C.H.A.M.P.U.S. program is being asked the same questions.

Please contact me if these data requests are at all unclear.

Sincerely yours,

Robert M. Eastman, M.P.H.
Assistant Director

RME:afj

Ref: DPPaS

14 June 1974

Robert M. Eastman, M.P.H.
Assistant Director
Comprehensive Health Planning Council
P.O.Box 39
Mount Vernon, Washington 98273

Dear Mr. Eastman:

This is in reply to your letter of the 4th of June. We have assembled the information you requested insofar as we have been able to do so.

The Northwest Washington Service Unit (Lummi) has been in existence as a separate entity only since FY1971 and in many cases it is quite impossible to separate the information for that area from other parts of Western Washington. Our own reporting system has undergone extensive change since its inception. To retrieve information from 1968 would require, at this time, more time and manpower than is presently available and, in addition, we still could not obtain all the information in the form you desire.

You will appreciate that this retrieval required the diversion of considerable effort. We hope that the information provided to you is sufficiently useful as to have warranted the effort. In addition, we would like to request a copy of your health indicators report as well as your regional hospital plans when they are ready.

Very sincerely yours,

C.S.Stitt, Jr., D.D.S.
Director, Portland Area
Indian Health Service

AMBULATORY PATIENT CARE	F. Y. 71	F. Y. 72	F. Y. 73	F.
No. of visits to Lummi Health Center	8,257	7,292	8,687	4,

CONTRACT HEALTH SERVICES		F. Y. 71	F. Y. 72	F. Y. 73	F. Y. 74*
Outpatient Visits (MD Only)		1,417	1,559	2,508	1,347
Total Cost**		$ 24,826	$ 19,051	$ 33,599	$ 20,022
Average Cost Per Visit		$ 18	$ 12	$ 13	$ 15
GM&S Hospitalization					
Discharges		134	95	299	108
Days		4,647	977	1,503	478
Total Cost**		$ 34,522	$ 24,568	$ 87,985	$ 33,077
Average Cost Per:	Discharge	$ 258	$ 259	$ 294	$ 306
	Day	$ 7	$ 25	$ 59	$ 69
Nursing Home Care					
Discharges		-	14	10	8
Days		-	269	233	136
Total Cost**		-	$ 3,918	$ 3,523	$ 2,336
Average Cost Per:	Discharge	-	$ 280	$ 352	$ 292
	Day	-	$ 15	$ 15	$ 17

AMBULATORY PATIENT CARE	F. Y. 71	F. Y. 72	F. Y. 73	F. Y. 74*
No. of visits to all IHS Clinics in Washington State	58,365	61,651	70,785	23,417

CONTRACT HEALTH SERVICES (Wash. State)		F. Y. 71	F. Y. 72	F. Y. 73	F. Y. 74*
Outpatient Visits (M.D. & Optometrist)					
No. of Visits		17,962	20,033	23,953	12,033
Total Cost**		$233,050	$258,260	$307,749	$170,862
Average Cost per Visit		$ 13	$ 13	$ 13	$ 14
GM&S Hospitalization					
Discharges		2,212	2,168	3,683	994
Days		12,094	13,806	21,534	5,081
Total Cost**		$575,943	$820,577	$1221,219	$369,777
Average Cost per:	Discharge	$ 260	$ 378	$ 332	$ 372
	Day	$ 48	$ 59	$ 57	$ 73
Nursing Home Care					
Discharges		15	88	116	27
Days		247	1,948	2,650	564
Total Cost**		$ 3,453	$ 27,960	$ 39,290	$ 8,151
Average Cost per:	Discharge	$ 230	$ 318	$ 339	$ 302
	Day	$ 14	$ 14	$ 15	$ 14

* First six (6) months of FY 74.
** Includes partial pay on some documents
SOURCE: APC & CHS Tabulations

BRIEFING INFORMATION ESPECIALLY PREPARED
FOR MR. SPENCER JOHNSON, THE DOMESTIC
COUNCIL February 10, 1976 1:45 p.m.
Old Executive Office Building
Washington, D.C.

CONTENTS

APPENDIX

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HOME HEALTH CARE

UNDER

THE MEDICAID PROGRAM

-

National Association of Home Health Agencies

February 10, 1976

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STATEMENT

The National Association of Home Health Agencies, comprising a membership of approximatley 500 providers of home care in the United States is deeply concerned with proposed regulations related to provision of services under the Medicaid program now under consideration by the Department of Health, Education and Welfare.

In concert with other organizations that have an interest in home care such as the National League for Nursing, National Council for Homemakers-Home Health Aide Services, Inc., and the American Hospital Association, N.A.H.H.A. is prepared to commit its resources to constructive action which would assure the highest quality in service to patients who receive home care and, expand the availability of service to all those for whom it would be appropriate.

To achieve such action, N.A.H.H.A. herein submits a recapitulation of analyses of the regulations and specific recommendations related to the provision of home health care under Medicare and Medicaid.

I. Facts

In the Federal Register of August 21, 1975, the Administrator of the Social and Rehabilitation Service, with the approval of the Secretary of Health, Education and Welfare, set forth tentative regulations with respect to Home Health Services provided in State Medicaid programs (Title XIX, Social Security Act). The purpose, according to S.R.S., "is to remove certain restrictions and ambiguities in current regulations which have prevented full realization of the benefits of home health services..."

The revisions, said S.R.S., were proposed "in light of the statutory requirement under Title XIX to provide home health services, to all individuals entitled to skilled nursing facility service under a State's Medicaid Plan, the Department's efforts to develop alternatives to institutional care, and Congressional interest in expanding the use of home health care..."

The revisions would permit certain types of qualified health service agencies (those offering nursing or home health aide services), in addition to those which meet Medicare standards, to provide services under State Medicaid programs.

" " " prescribe standards...which parallel those for Medicare but are appropriately adjusted for differing needs under Medicaid.

" " " permit proprietary agencies to participate if they meet standards whether or not the State has a licensing law.

The revisions would clarify that States must make available...three main types of services...nursing, home health aide, and supplies and equipment, and also, permit them to provide various therapies...

" " " clarify Medicaid recipients to whom...services must be available, specify requirements for a physicians determination of medical needs in a plan of care... and clarify that Medicare requirements relating to need for 'skilled' care on to post-hospitalization do not apply under Medicaid.

In the 30 day period (extended to 47) allowed for comment, S.R.S. received over 1,000 responses. On October 28, 1975, hearings on the proposed regulations were held by the Subcommittee on Long-Term Care, Special Committee on Aging of the U.S. Senate and the Subcommittee on Health and Long-Term Care, Select Committee on Aging of the House of Representatives.

In a letter on December 12, 1975, the chairmen of these committees, the Honorable Frank E. Moss and the Honorable Claude Pepper wrote to Secretary David Mathews, stating in part:

"...the regulations as proposed...are not in concert with Congressional intent and would clearly have a deleterious effect on the quality of home health care in the United States.

"...we ask that you intervene personally and examine the proposed regulations and their likely effects. We ask that you eliminate language facilitating the entry of for-profit agencies in the home health field. We believe this to be critical. The result of this decision, we believe, will determine whether home health care will continue at a high level or whether a few years from now, we will be confronted with the problems all too familiar from our nursing home experience."

Final action on the proposed regulations has not been taken by the Secretary of H.E.W. as of this date.

II. Analysis of Proposed Regulations

The following is a summary of comments from a variety of responsible leaders engaged in or thoroughly familiar with the home care field.

Herbert Semmel, Center for Law and Social Policy (in behalf of National Council of Senior Citizens and the Department of Public Advocate, New Jersey)

"1. The regulations will deprive the states of the power to control the provision of home health care services by mandating the certification by the states of unlicensed commercial enterprises as Medicaid home health care providers. Such an imposition on the states is contrary to congressional action in four major legislative acts.
2. The regulations would undermine the development of

comprehensive home health service centers by requiring the states to certify single service agencies as Medicaid home health care providers.

3. The regulations will foster the same kind of uncontrolled financial abuses in the delivery of home health services as has occurred in the nursing home industry and will result in higher costs without substantial improvement in the quality of care being provided those in need."

Abraham Ribicoff, Chairman, Committee on Government Operations, U.S. Senate

"...I must question whether policy to expand such services necessitates the weakening of performance standards for the providers...

"...agencies which qualify under the proposed Medicaid only option would not have to prepare an overall plan and budget, providing for an annual operating budget and a capital expenditure plan, nor comply with existing requirements for certificate of need through designated planning agencies. Neither would they have to comply with existing requirements for coordination with related federal programs."

Ellen Winston, National Council of Homemaker-Home Health Aide Services

"...regulations need to be held in abeyance until careful study of their impact not only in quantity but in quality of homemaker-home health service has been made."

Senator Charles Percy

"I am not certain that the real problem is the shortage of home health agencies. The problem may be more one of the availability of home health benefits for the elderly. Perhaps we should be focusing our attention on ways to commit more dollars to home health programs."

Honorable John B. Martin, American Association of Retired Persons

"Preliminary evidence evaluating proprietary home health agencies indicates that profit may interfere with the provision of quality care."

Eva Reese, Visiting Nurse Service of New York

"By definition, profit-making health care agencies do not make quality patient care their primary concern. This point has been made over and over again in the nursing home situation in New York. Millions of tax dollars have been siphoned off for marginal or non-existent services. Under these circumstances, enabling profit-making enterprises to provide home health services under tax-supported programs invites similar abuse."

Representative Claude Pepper

"...I am concerned that these regulations will deprive the States

of the power to control the provision of home health care services by mandating the certification by the States of unlicensed commercial enterprises..."

Representative Edward I. Koch

"...regulations establish a dangerous precedent whereby, regardless of whether a state has stricter legal requirements than federal standards, the state cannot stop what are in its judgment potentially abusive agencies from operating in the state."

Congressional Research Service

"The proposed regulations do not require Medicaid agencies to have written policies. It is unclear as to how an agency's unwritten policy would be evaluated. In addition, no mechanisms are required to be established to collect data pertinent to evaluation (also a Medicare requirement)."

Homemakers-UpJohn

"The way to ensure quality of service is to establish a set of workable controls for standards, accountability, organization, and incentives for efficiency. These should then be applied across the board to all providers with exclusions not based on whether the providers are profit or not-profit organizations, but whether they can live up to the standards. Participation should be based on quality of service, availability, and reasonable cost.

"We believe that all providers of home health care must be subject to thoughtful and productive government regulations, and we welcome any effort to establish such uniform standards."

Nancy Tigar, National League for Nursing

"Currently, the standards by which home health agencies are certified to participate in the Medicare program are acknowledged to be minimum, basic standards. The regulations, as set forth in Section 249.150 of the Medical Assistance Program, will lower even those minimum standards and set up a 'separate but not equal' system of home health care for the Medicaid population. Home health service needs of patients reimbursed under the Medicaid program are not different from the needs of patients reimbursed under Medicare. Agency standards cannot be lessened for this group unless a two-class system of care, qualitatively speaking, is acceptable as national policy.

"We have long believed that home health services must be made available to all segments of the population and at the same time assure maximum manpower utilization, provide quality assurance and promote cost containment. While we appreciate the attempt by the Social and Rehabilitation Service to increase the availability of home health services through these regulations, we seriously doubt that they will assure maximum manpower utilization, provide quality assurance or promote cost containment. While the regulations may

increase the number of home health agencies, whether they will increase the services available in rural and underserved areas is questionable.

"In this time of fiscal crisis when we are urging smaller agencies to merge their resources by establishing linkages, centralizing administrative practice and policy, etc., to provide cost/benefit effective management, we believe these regulations could conceivably slow down or abort this process."

Senator Al Ullman

"I ask the Department to reconsider the home health regulations in light of my comments, and those of the National Association of Home Health Agencies."

A copy of N.A.H.H.A.'s response to the proposed regulations is contained in the Appendix

III. Comment and Recommendations

Home health care, in existence for many years, has been "discovered" by a great many people in the past few years - legislators, health professionals, health insurance companies, and profit-seeking organizations. Rightly or wrongly, a substantial amount of the current interest stems from the costs of home care when compared to those of acute-care or long-term care institutions. The fact that qualified studies have confirmed that large numbers of persons, particularly the elderly, have been needlessly placed in institutions at government expense, has simply accelerated efforts to find alternatives.

It is also fact that restrictive regulations have not allowed the home health care industry to grow as it should in order to accommodate people for whom home care would be appropriate. Since substantial provision of Medicare funding is contingent on hospitalization, there is an over-dependence on this source of financing by most providers. Medicaid funds are spent on hospitalization and nursing home care. Less than one percent of Medicare expenditures and four-tenths of one percent of Medicaid expenditures have been for home health care.

In its urgency to expand the use of home health care, the Social and Rehabilitation Services has promulgated regulations that would open the door to uncontrolled use of home care. No studies have been conducted to determine the comparative quality of home health services rendered by either non-profit or for-profit agencies. S.R.S. would propose to monitor possible abuse through its regular fraud and abuse program but its present operations have been described as undermanned and ineffective in respect to other H.E.W. programs.

The critical issue is one of standards that will apply equally to all providers-non-profit or proprietary. At least a dozen states have licensure laws at present and a majority of the rest are considering their establishment. For the states and the federal government, it is important to have both sound national standards and others which are uniquely suitable to the operations of each state and locality.

1. Need for NTE Funds for Home Health Agencies

need input from } agencies, consumers, providers (MD, etc)

Leave agreement NHA, League NAHHA
to do something

(2200 agencies — very small)

2. No studies made before HCFA made regulations.

3. Need commission to get people together

is there a president?

To move in haste will indeed confirm the fears of many that home health care could be burdened with all of the concomitant scandals and problems that occurred within an unregulated nursing home industry.

RECOMMENDATIONS

1. That the Department of Health, Education and Welfare withdraw its proposed regulations related to home health care services under Medicaid.

2. That a national commission be established under the President's Domestic Council for the purpose of establishing standards for home health care to be applicable to both Medicare and Medicaid programs. This would include examination of the appropriate role of home health services in the health delivery system.

3. That the Secretary of H.E.W. authorize appropriate studies of the quality of home care provided by all types of agencies.

DM:JPB:lds
2/6/76

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APPENDIX

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Associated Home Health Service

federal register

THURSDAY, AUGUST 21, 1975

THE NATIONAL ARCHIVES OF THE UNITED STATES
LITTERA SCRIPTA MANET
1934

PART II:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service

■

MEDICAL ASSISTANCE PROGRAMS

Home Health Services

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service

[45 CFR Part 249]

MEDICAL ASSISTANCE PROGRAM

Home Health Services

Notice is hereby given that the regulations set forth in tentative form below are proposed by the Administrator, Social and Rehabilitation Service, with the approval of the Secretary of Health, Education, and Welfare. The purpose of the proposed regulations is to remove certain restrictions and ambiguities in current regulations which have prevented full realization of the benefits of home health services in State Medicaid programs (title XIX, Social Security Act).

In light of the statutory requirement under title XIX to provide home health services to all individuals entitled to skilled nursing facility services under a State's Medicaid plan, the Department's efforts to develop alternatives to institutional care, and Congressional interest in expanding the use of home health care, the following revisions are proposed in order to increase the availability of such services and encourage their use in appropriate cases:

1. Currently, participation under Medicaid as a home health service provider is restricted to those agencies which meet the statutory Medicare requirements, i.e., they must provide skilled nursing services and one other service. This has meant that agencies such as small visiting nurse associations are unable to participate because they cannot offer the second service (there are approximately 500–700 VNAs which have been prevented from participating because of this requirement). It has also served to deter creation of new agencies. Since there is no similar statutory requirement in Medicaid, the problem can be alleviated by expanding the types of agencies qualified to provide services. Under the proposal, the limitation would be removed and agencies offering nursing or home health aide services may qualify if they meet the prescribed standards. The standards are basically those used under Medicare, appropriately adapted to reflect inclusion of additional provider types.

A major additional change with respect to provider participation is removal of the current limitation which restricts proprietary agencies from qualifying as home health providers unless the State licenses such agencies. This is a statutory provision for Medicare. In the proposed regulation, such agencies may participate in Medicaid if they are certified to meet the prescribed standards and execute a provider agreement with the State Medicaid agency. The Department believes that this change will further the goal of expansion of services and that proper enforcement of standards and monitoring of performance will provide adequate safeguards against abuse. (§ 249.150)

2. The existing regulation is ambiguous as to the minimum set of home health services which States must provide under their State plans. It has been interpreted that the States are required to provide only one of the specified services (nursing, home health aide, supplies and equipment), when it fact it was intended that all of these were required to be available. The proposal now clarifies that States must make available, as determined necessary by the recipient's physician and included in the plan of care, nursing services, home health aide services, and medical supplies, equipment and appliances suitable for use in the home. At State option, physical, occupational or speech therapy may be provided to home health patients whether or not they are generally provided to all recipients under the State plan. (§ 249.10(b)(7))

3. Limitations on use of the services have also resulted from the practice of some States of adopting Medicare requirements specifying that the patient must be in need of skilled nursing or other professional services. Thus, a person who does not require "skilled" services but for example, only home health aide services, would not be eligible for home health services. Some States have also limited eligibility by applying inappropriate requirements of post-hospitalization. The proposed revision clarifies recipient eligibility by incorporating an explanation of entitlement previously issued as policy interpretation. (§ 249.10(a)(4))

4. In addition to specifying the standards which agencies must meet in order to qualify under the expanded regulation, the procedures for certification by the State agency and provisions relating to provider agreements with the State title XIX agency are also set forth. (§ 249.151)

In summary, then, the proposed revisions:

permit certain types of qualified health service agencies, in addition to those which meet Medicare standards, to provide home health services under State Medicaid programs;

prescribe the standards which those agencies must meet, which parallel those for Medicare but are appropriately adjusted for differing needs under Medicaid;

permit proprietary agencies to participate if they meet the standards, whether or not the State has a licensing law;

clarify that States must make available under the State plan the three main types of services needed in home care: nursing, home health aide, and supplies and equipment, and also permit them to provide various therapies as home health services;

clarify the Medicaid recipients to whom home health services must be available, specify the requirements for a physician's determination of medical needs recorded in a plan of care and periodically reviewed, and clarify that Medicare requirements relating to need for "skilled" care or to post-hospitalization do not apply under Medicaid.

Prior to the adoption of the proposed regulations, consideration will be given to written comments, suggestions, or objections thereto addressed to the Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, P.O. Box 2366, Washington, D.C. 20013, and received on or before September 22, 1975. Comments are particularly solicited on the potential for cost increases that might result from adoption of the proposed regulations.

Such comments will be available for public inspection in Room 5223 of the Department's offices at 330 C Street, SW., Washington, D.C., beginning approximately two weeks after publication of this Notice in the FEDERAL REGISTER, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (area code 202–245–0950).

AUTHORITY: Section 1102, 49 Stat. 647 (42 U.S.C. 1302). (Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

It is hereby certified that the economic and inflationary impacts of this proposed regulation have been carefully evaluated in accordance with OMB Circular A–107.

Dated: August 4, 1975.

JOHN A. SVAHN,
Acting Administrator, Social and Rehabilitation Service.

Approved: August 8, 1975.

CASPAR W. WEINBERGER,
Secretary.

Chapter II, Title 45, Code of Federal Regulations, is amended as follows:

1. Section 249.10 is amended by revising paragraphs (a)(4) and (b)(7) to read as set forth below:

§ 249.10 Amount, duration, and scope of medical assistance.

(a) * * *

* * * * *

(4) Provide for the inclusion of home health services which, as a minimum, shall include nursing services, home health aide services, and medical supplies, equipment and appliances as specified in paragraph (b)(7) of this section. Under this requirement, home health services must be provided to all categorically needy individuals 21 years of age or over; to all categorically needy individuals under 21 years of age if the State plan provides for skilled nursing facility services for such individuals; and to all corresponding groups of medically needy individuals to whom skilled nursing facility services are available under the plan. Eligibility of any individual to receive home health services available under the plan shall not depend upon his need for, or discharge from, institutional care.

* * * * *

(b) * * *

* * * * *

(7) *Home health services.* (i) This term means the following services and items provided to a recipient in his place of residence. Such residence does not include a hospital, skilled nursing facility or intermediate care facility, except that

these services and items may be furnished as home health services to a recipient in an intermediate care facility if they are not furnished by the facility as intermediate care services. Any such service or item provided to a recipient of home health services must be ordered by his physician as part of a written plan of care which is reviewed by his physician at least every 90 days. Those services listed in paragraphs (A), (B) and (C) are required to be made available by the State as home health services; those listed in paragraph (D) may be provided as home health services at State option.

(A) Nursing service, as defined in the State Nurse Practice Act, provided by a qualified agency or, in the case where no such agency is available to provide nursing services, by a registered nurse or licensed practical nurse who is currently licensed to practice in the State and who is under the direction of the patient's physician.

(B) Home health aid services provided by a qualified agency.

(C) Medical supplies, equipment and appliances suitable for use in the home.

(D) Physical therapy, occupational therapy or speech therapy provided by a qualified agency or by a facility licensed by the State to provide medical rehabilitation services.

(ii) In order to participate under a State title XIX plan as an agency qualified to provide home health services, such agency must meet the conditions and standards set forth in § 249.150 of this chapter, as determined in accordance with the applicable provisions for the certification and execution of valid provider agreements under § 249.151 of this chapter.

2. A new § 249.150 is added to Part 249, as set forth below:

§ 249.150 Standards for agencies qualified to provide home health services.

(a) *Type of agencies qualified to provide home health services.* The requirement to provide home health services under State plans for medical assistance is specified in § 249.10(a)(4) of this chapter; the services included are defined in § 249.10(b)(7). This section describes the agencies which qualify to provide the nursing, home health aide and therapy services specified in § 249.10(b)(7).

(1) Home health services may be provided under the title XIX State plan by any agency which is certified under title XVIII of the Act to provide such services and which executes a valid provider agreement with the title XIX State agency.

(2) Home health services may also be provided under the title XIX State plan by a public or private agency or subdivision thereof (e.g., the home care unit of a hospital) which is primarily engaged in providing medical or health care services, of which one must be nursing, or home health aide services, and which meets the standards set forth in this section; and which executes a valid provided agreement with the title XIX agency.

(3) Therapy services may be provided as home health services by an agency specified in paragraph (a)(1) or (2) of this section, or by a facility licensed by the State to provide medical rehabilitation services, and which meets the other conditions set forth in this paragraph. Such a rehabilitation facility must be operated under competent medical supervision and is one which provides therapy services for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of (i) medical evaluation and services, and (ii) psychological, social, or vocational evaluation and services. The major portion of the required evaluation and services must be furnished within the facility and the facility must be operated either in connection with a hospital or as a facility in which all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

(b) *Compliance with Federal, State and local laws.* An agency providing home health services under paragraph (a)(2) of this section must be in compliance with all applicable Federal, State, and local laws and regulations. If State or local law requires licensure of agencies but exempts certain types (e.g., public agencies) from the licensure requirement, the exempted agencies must meet the licensure standards even though a license is not actually issued. This determination must be made by the State survey agency and recorded in writing.

(c) *Organization, services, administration.*—(1) *Delegation of responsibility.* Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in writing and readily identifiable. Administrative and supervisory functions shall not be delegated to another agency or organization. Services performed by subunits of the agency shall be monitored and controlled by the agency and appropriate administrative records shall be maintained for each subunit.

(2) *Subcontracting.* Patient care services may be subcontracted except that the agency shall provide at least one patient care service directly. All services not provided directly shall be monitored and controlled by the primary agency (the agency responsible for the service rendered to patients and for implementation of the plan of care). (See also paragraph (c)(7) of this section for provisions relating to personnel under contract.)

(3) *Governing body.* The governing body or designated person so functioning shall, at each local administrative level,

(i) Have full legal authority and responsibility for the operation of the home health program;

(ii) Appoint a qualified administrator;

(iii) Arrange for the establishment and continuing operation of an advisory committee;

(iv) Adopt and periodically review written bylaws or an acceptable equivalent;

(v) Oversee the management and fiscal affairs relating to home health services;

(vi) Supply full and complete information to the survey agency as to the identity:

(A) Of each person who has any direct or indirect ownership interest of 10 percentum or more in the agency or who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the agency or by any of the property or assets of the agency;

(B) Of each officer and director of the corporation if the agency is organized as a corporation;

(C) Of each partner if the agency is organized as a partnership; and promptly report any changes to the State survey agency which would affect the current accuracy of the information supplied under this paragraph.

(4) *Administrator or director of home health services.* The administrator or director shall be a licensed physician, a registered nurse, or a person with training and experience in health service administration and at least one year of supervisory or administrative experience in home health care or related health programs. The administrator or director shall be appointed by the governing body or the designated person so functioning and shall:

(i) Organize and direct the agency's ongoing operation with respect to home health services;

(ii) Maintain ongoing liaison among the governing body, the professional advisory committee (see paragraph (d) of this section), and the staff;

(iii) Employ only personnel who meet the qualifications prescribed in 20 CFR 405.1202 (k), (l), (q), and (r) and 405.1101 (m), (n), (q), (r), (s), and (t), in the occupational categories defined in such sections;

(iv) Provide for and evaluate ongoing inservice training for all staff;

(v) Ensure the accuracy of public information materials and activities; and

(vi) Implement an effective budgeting and accounting system.

(5) *Supervising physician or registered nurse.* The home health services provided shall be under the supervision and direction of a physician or a registered nurse. This person, or a supervisory staff member of another discipline, shall be available at all times during operating hours and shall participate in all activities relevant to the professional services provided, including the developing of qualifications and assignments of personnel.

(6) *Personnel policies.* Personnel practices and patient care shall be supported by appropriate, written personnel policies. Personnel records shall include job descriptions, qualifications, licensure, performance evaluations, and health examinations, and shall be kept current.

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(7) *Personnel under hourly or per visit contracts.* If personnel under hourly or per visit contracts are utilized by the agency to provide home health services, there shall be a written contract between such personnel and the agency clearly designating:

(i) That patients are accepted for care only by the agency,

(ii) The services to be provided,

(iii) The necessity to conform to all applicable agency policies including personnel qualifications,

(iv) The responsibility for participating in developing individual plans of care,

(v) The manner in which services will be controlled, coordinated, and evaluated by the agency,

(vi) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation, and

(vii) The procedures for determining charges and reimbursement.

(8) *Coordination of patient services.* All personnel providing home health services shall maintain liaison with each other to assure that their efforts effectively complement one another and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences shall establish that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report for each patient shall be sent to his physician at least every 90 days.

(d) *Advisory committee.* (1) An advisory committee shall be established which shall include at least one physician, one registered nurse (preferably a public health nurse), one representative of a therapy discipline (if the agency offers any therapy as a home health service), and one representative of recipients. The majority of members shall be neither owners nor staff members of the agency.

(2) The committee shall annually evaluate the agency's policies including services offered to home health patients, admission and discharge, medical supervision, plans of care, emergency care, clinical records personnel qualifications, and standards of professional service. Results of the evaluation in the form of recommendations shall be reported for appropriate action to the governing body and to the State survey agency.

(3) The committee shall meet at least quarterly to advise the agency on professional issues, participate in evaluation of the agency's program, and assist the agency in maintaining liaison with other health care providers in the community and in its community information program. Its meetings shall be documented by dated minutes.

(e) *Acceptance of patients, plan of care, medical supervision*—(1) *General.* Patients shall be accepted for treatment on the basis of a reasonable expectation that the patient's health needs can be met adequately by the agency in the patient's place of residence. In all cases, an initial home evaluation visit shall be made by a registered nurse. Care shall follow a written plan established and reviewed at least every 90 days by the patient's physician and shall continue under the physician's supervision.

(2) *Development and content of plan.* The plan of care developed in consultation with appropriate agency staff shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care which cannot be completed until after the evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and duration of such therapy services.

(3) *Periodic review of plan.* The total plan of care shall be reviewed by the patient's physician and agency personnel as often as the patient's condition requires, but at least once every 90 days. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.

(4) *Conformance with physician's orders.* Drugs and treatments shall be administered by agency staff only as ordered by the physician. The nurse or therapist shall immediately record and sign such recording of oral orders and obtain the physician's countersignature in a manner consistent with good medical practice. Agency staff shall check all medicines a patient may be taking to identify possibly ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication, and promptly report any problems to the physician.

(f) *Registered nurse services.* As appropriate, registered nurses providing home health services shall: (1) Make the initial evaluation visit, (2) regularly reevaluate the patient's health needs, (3) initiate the plan of care and necessary revisions, (4) provide those services requiring substantial specialized nursing skill, (5) initiate appropriate preventive and rehabilitative nursing procedures, (6) prepare clinical and progress notes, (7) coordinate services, (8) inform the physician and other personnel of changes in the patient's condition and needs, (9) counsel the patient and family in meeting the patient's nursing and related needs, (10) participate in inservice programs, and (11) supervise and teach other nursing personnel.

(g) *Licensed practical nurse services.* Licensed practical nurses providing home health services shall be under the supervision of a registered nurse. As appropriate, they shall: (1) Provide routine nursing services, (2) prepare clinical and progress notes, (3) assist the physician and/or registered nurse in performing specialized procedures, (4) prepare equipment and materials for treatments observing aseptic technique as required, (5) assist the patient in learning appropriate self-care techniques, and (6) participate in in-service programs.

(h) *Therapy services.* (1) As appropriate, physical, occupational or speech therapists performing home health services shall: (i) Assist the physician in evaluating level of function, (ii) help to develop the plan of care (revising as necessary), (iii) prepare clinical and progress notes, (iv) advise and consult with the family and other agency personnel, and (v) participate in inservice programs.

(2) Services may be provided by a qualified physical therapist assistant or qualified occupational therapy assistant under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant shall perform services planned, delegated, and supervised by the therapist, assist in preparing clinical notes and progress reports, and participate in educating the patient and family, and in inservice programs.

(3) Speech therapy services may be provided only by or under supervision of a qualified speech pathologist or audiologist.

(i) *Home health aide services*—(1) *Assignment and duties.* The home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Duties shall include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs, and completing appropriate records.

(2) *Supervision.* (i) *Standard: Supervision.* The registered nurse, or appropriate professional staff member, if therapy services are provided, shall make a supervisory visit to the patient's residence at least monthly, alternating the visits when the aide is present and not present to assess relationships and determine whether goals are being met.

(3) *Training.* All home health aides shall receive basic orientation and training consisting of not less than 40 hours. The training will include as a minimum content in each of the following areas:

(i) Basic techniques of personal care such as the activities of daily living;

(ii) Health and hygiene;

(iii) Food preparation and nutrition;

(iv) Interpersonal relationships meeting the social, emotional, and physical needs of patients;

(v) Basic household management;

(vi) Child care.

(4) *In-service education.* There shall be continuing in-service programs on a regularly scheduled basis with on-the-job training during supervisory visits and more often as needed.

(j) *Records*—(1) *Clinical records.* A clinical record containing pertinent past and current findings in accordance with accepted professional standards shall be

maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes (clinical notes shall be written the day service is rendered and incorporated within a week of such service); copies of summary reports sent to the physician; and a discharge summary.

(2) *Retention of records.* Clinical records shall be retained for a period of 3 years (as described and qualified by part 74, subpart D, of this title, "Retention and Custodial Requirements for Records"), after completion of services. When a patient is transferred from care of the agency, a copy of the record or abstract shall be sent to the accepting agency or facility.

(3) *Protection of records.* Clinical record information shall be safeguarded in accordance with the requirements of § 205.50 of this chapter.

(4) *Clinical record review.* At least quarterly, appropriate agency health professionals shall review a 10 percent randomly selected sample of both active and closed clinical records to assure that established policies are followed in providing services (direct services as well as services under contract or arrangement).

(k) *Utilization control.* The agency shall participate in a program of utilization control of services as prescribed by the title XIX State agency pursuant to § 250.18 of this chapter which, as a minimum, shall include provisions for:

(1) Review of patient records by a team of professional persons (at least a physician, public health nurse and one additional health professional) not involved in the direct care of the individual patient, for each 90-day period of service with respect to any patient receiving continued services during such period, in order to make recommendations to the agency providing service as to the necessity for continued service, the adequacy of the plan of care and the appropriateness of continued service; and

(2) A continuing program of home health evaluation studies by a team of professional persons (which may be the same team as specified in paragraph (k)(1) of this section), which shall identify and analyze trends, problems and patterns of care and make recommendations to the State title XIX agency for improvement of the quality of home health care.

(l) *Determination of qualifications.* The determination that an agency providing home health services meets the conditions and standards for participation shall be made in accordance with the applicable provisions for certification and the execution of valid provider agreements set forth in § 249.151 of this chapter.

3. A new § 249.151 is added to Part 249 as set forth below:

§ 249.151 Home health agencies: Requirements for agencies qualifying as home health service providers.

(a) *Certification of agencies not participating under title XVIII.* Prior to the execution of a provider agreement and participation in the title XIX program as a provider of home health services, the State survey agency designated under § 250.100 of this chapter shall survey the home health agency and certify as to whether it is found to be in compliance with the conditions and standards set forth in § 249.150 (a)(2) and (b)-(1).

(1) The findings of the State survey agency with respect to each of the standards shall be adequately documented. Where the State survey agency certifies that a provider agency is not in compliance with the standards, such documentation shall include, in addition to the description of the specific deficiencies which resulted in the agency's finding, a report of all consultation which has been undertaken in an effort to assist the provider to comply with the standards, a report of the provider's responses with respect to the consultation, and the State agency's assessment of the prospects for such improvements as to enable the provider to achieve compliance with the standards within a reasonable period of time.

(2) If a provider is certified by the State survey agency to be in compliance with the standards or to be in compliance except for deficiencies not adversely affecting the health and safety of patients the following information will be incorporated into the finding:

(i) A statement of the deficiencies which were found, and

(ii) A description of further action which is required to remove the deficiencies, and

(iii) A time-phased plan of correction developed by the provider and concurred in by the State survey agency, and

(iv) A scheduled time for a resurvey of the agency to be conducted by the State survey agency within 90 days following the completion of the survey.

(3) If, on the basis of the State certification that an agency meets standards, and such other information as it possesses, the State title XIX agency executes a provider agreement with the provider agency, the information described in paragraph (a)(2) of this section will be incorporated into a notice to the provider.

(4) Initial certifications and recertifications by the State survey agency to the effect that a provider is in compliance with all the standards will be for a period of 12 months. State survey agencies may visit or resurvey providers more frequently where necessary to evaluate correction of deficiencies, ascertain continued compliance, or accommodate to periodic or cyclical survey programs. The State survey agency shall evaluate such reports as may pertain to the health and safety requirements and, as necessary, take appropriate action to achieve compliance or certify to the State title XIX agency that compliance has not been achieved. A State finding and certification that a provider is no longer in compliance will supersede the State's previous certification.

(5) The State survey agency will certify that a provider is not or is no longer in compliance with the standards where the deficiencies are of such character as to substantially limit the provider's capacity to render adequate care or which adversely affect the health and safety of patients.

(6) If a provider is found to be deficient with respect to one or more of the standards, it may participate in the State title XIX program only if the provider has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time acceptable to the State survey agency. The existing deficiencies noted either individually or in combination must neither jeopardize the health and safety of patients nor be of such character as to seriously limit the provider's capacity to render adequate care.

(7) If it is determined during a survey that a provider is not in compliance with one or more of the standards in accordance with paragraph (a)(6), it will be granted a reasonable time to achieve compliance. The amount of time will depend upon the nature of the deficiency and the State survey agency's judgment as to the provider's capabilities to provide adequate and safe care. Ordinarily a provider will be expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies but the State survey agency may grant additional time in individual situations, if in its judgment it is not reasonable to expect compliance within 60 days, e.g., a provider must obtain the approval of its governing body, or engage in competitive bidding.

(b) *Execution of provider agreements with all agencies providing home health services.* (1) The State agency shall not execute a provider agreement, under this section, with an agency providing home health services unless the agency is certified to provide such services under title XVIII of the Act, or is certified as meeting the standards specified in § 249.150 of this chapter in accordance with the applicable provisions of this section.

(2) (i) The term of an agreement may not exceed a period of one year and the effective date of such agreement may not be earlier than the date of certification. (ii) Execution of a provider agreement shall be for the term and in accordance with the provisions of certification determined by the survey agency, except that the single State agency for good cause based on adequate and documented evidence may elect to execute a provider agreement for a term less than the full period of certification, or may elect not to execute a provider agreement, or may

cancel a provider agreement for participation by an agency certified under the State plan. (iii) Notwithstanding the provisions of this paragraph the single State agency may extend such term for a period not exceeding two months where the survey agency has notified the single State agency in writing prior to the expiration of a provider agreement that the health and safety of the patients will not be jeopardized thereby, and that such extension is necessary to prevent irreparable harm to such agency or hardship to the individuals being furnished items or services or that it is impracticable within such provider agreement period to determine whether such agency is complying with the provisions and requirements under the program. An extension of the provider agreement for more than two months may be granted if it is necessary to implement the State survey agency's determination under paragraph (a)(7) of this section to allow the provider additional time to correct deficiencies.

(iv) Any agency whose agreement has been cancelled or otherwise terminated may not be issued another agreement until the reasons which caused the cancellation or termination have been removed and reasonable assurance provided the survey agency that they will not recur.

(3) With respect to home health agencies certified to participate under title XVIII of the Act, the term of a provider agreement between such agency and the State title XIX agency shall be subject to the same terms and conditions and be coterminous with the period of participation specified by the Secretary under title XVIII. Upon notification that an agreement with an agency under title XVIII has been terminated or cancelled, the State title XIX agency will take the same action under title XIX as of the effective date of the title XVIII action.

(c) *Disallowance of Federal financial participation when agency is found not to meet all requirements for certification.* A provider agreement between the title XIX State agency and an agency specified in § 249.150(a)(2) of this chapter shall not be considered valid evidence that such agency meets all requirements for certification pursuant to § 249.150, if the Secretary establishes on the basis of on-site validation surveys, other Federal reviews, State certification records, or such other reports as he may prescribe, that:

(1) The survey agency failed to apply the Federal standards for the certification of such agency as required under § 249.150 of this chapter;

(2) The survey agency failed to follow the rules and procedures for certification set forth under § 249.151 of this chapter;

(3) The survey agency failed to use the Federal standards and such forms, methods and procedures as are established under § 250.100(c)(1) of this chapter; or

(4) The terms and conditions of a provider agreement do not meet the requirements of this section.

States upon request shall receive a reconsideration of any disallowances of Federal financial participation resulting from the Secretary's determination under these provisions, in accordance with section 1116(d) of the Act, and § 201.14 of this chapter.

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NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES
LEGISLATIVE COMMITTEE

NAHHA

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John A. Svahn
Acting Administrator
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P.O. Box 2366
Washington, D.C. 20013

Re: "Medical Assistance Programs, Home Health Services," August 21, 1975, Federal Register

Dear Mr. Svahn:

The National Association of Home Health Agencies is writing to respond to the Proposed Medicaid Regulations as published in the August 21, 1975 Federal Register.

We strongly support the clarification of covered home health services provided by the Title XIX program, however we strongly oppose the development of two levels of care and any dilution or weakening of the Medicare standards for Home Health Agencies.

We would like to commend the department for clarifying that Medicaid is not bound to the Medicare definitions of "Skilled Nursing" and "Prior Hospitalization".

We support the proposed changes in S249.10 with five exceptions. These are summarized as follows.

249.10 (b)(7) (B) Home health aide services provided by a qualified agency be clearly defined in this section. The definition should include the performance of simple procedures such as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, helping with meal preparation including special diets and assisting in usual household duties such as budgeting, marketing, housekeeping, laundry, etc.

249.10 (b)(7) Include item (D) as part of the required services and add a new section (E) as the services which may be provided at the State option. Section (E) should read as

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follows:

"(E) Nutritional counseling, therapeutic diets and medical social service for patients with emotional problems."

249.10 (b) (7) (A) Add to this section a requirement that the State Agency conduct a public hearing in the local area to determine that there is no home health agency service available before permitting the State Agency to reimburse for services be provided by a licensed nurse.

249.10 (b) (7)(D) Add the following phraseology to this section "when it is determined that these services are not available through a qualified agency."

249.10 (b) (7) (ii) Change this section to read "In order to participate under a state Title XIX plan as an agency qualified to provide home health services, such agency must be certified under Title XVIII of the act to provide such services".

We believe each program should pay for the combinations of services needed by their respective target populations. The Medicaid covered services should include as a minimum all Medicare covered services plus those additional services needed to develop realistic alternatives to institutional care and to encourage the use of home health services in appropriate cases.

Therefore, we urge immediate adoption and publication of the above recommendations and deletion of sections 249.150 and 249.151. in the final regulations.

The National Association of Home Health Agencies member--ship includes public, voluntary, and profit making Home Health Agencies. The question raised by sections 249.150 and 249.151 in the Proposed Regulations does not relate to profit vs. non-profit - the question is "Do the regulations establish verifiable quality services, reduce fragmentation and focus upon the needs of the Medicaid population"?

After reviewing the Proposed Regulations, we are convinced these regulations set up another level of care for the indigent and dilute the quality of patient care.

REDUCE QUALITY

These regulations will lower the standards of care which providers of home health care are currently required to maintain. These Proposed Regulations change or eliminate the following Medicare requirements.

- Under Medicare a proprietary organization must be licensed as a home health agency pursuant to state law, and, if no state law exists for the licensure of such type agency,

it cannot be certified for participation. The proposed rules removes the prohibition.

- Changes the Medicare periodic review of patient services from 60 days to 90 days.

- Deletes the existing Medicare requirement that a proprietary agency provides all services directly, through agency employees (405.1221(a).

- Deletes the Medicare requirement that there is an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense.

- Deletes the medicare requirement that a capital expenditure proposal must be submitted to the designated planning agency for approval.

-Deletes the Medicare requirement that an overall plan and budget is prepared under the direction of the governing body, the administrative staff and the medical staff.

-Deletes the medicare requirement that the overall plan and budget is reviewed and updated at least annually by the governing board.

- Deletes the medicare requirement that services provided under contract may not exceed an amount which would have been reasonably paid if the services had been paid in an employment relationship.

- Deletes the Medicare requirement that under contracted services patients are only accepted for care by the primary home health agency.

- Changes the medicare supervisory visit requirement from once every two weeks to at least monthly.

Therefore, we must take issue with those statements in the regulations which state that, " The standards are basically those used under Medicare,... and that proper enforcement of standards and monitoring of performance will provide adequate safeguards against abuse."

FRAGMENTATION

For Home Health Care services to become a viable alternative to institutional care, these services must be provided by an organization that is held accountable and is responsible for delivering a comprehensive range of services but only the amount and type of services needed by the individual. No more. No less.

Under the Proposed Regulations, single service agencies will proliferate, causing duplication of services, lack of coordination and an increase in costs due to wasteful inefficiencies.

Setting up standards which cater to those agencies which are unwilling to expand the scope of services and will ensure that those same agencies will continue to provide only minimal services, thus penalizing those patients who need and will benefit from comprehensive care at home.

When different standards are required for qualified providers to participate for Title XIX than for Title XVIII, the following will result. Different standards will fragment services - providers - and payors; be difficult, and expensive to monitor; be confusing for agencies attempting to meet them; require different rules to be applied to each patient dependent on the source of payment; prevent adequate fiscal controls from developing; and encourage over-utilization of services.

The issue of uniform standards for skilled nursing facilities under Medicare and Medicaid was addressed by Section 246 of PL 92-603 (The 1972 Social Security Amendments). The Senate Finance Committee Report address the issues raised in the foregoing paragraphs as follows:

> "The Committee believes ... that it would be desirable to apply a single set of requirements to skilled nursing facilities under both Medicare and Medicaid.
>
> The amendment would ... provide that facilities which satisfy the new definition of "skilled nursing facility" under one program shall be eligible to participate in the other provided it agreed to contract terms. The amendment would incorporate the present Medicare definition and requirements for an extended care facility...
>
> A single consolidated survey would be performed . . . to determine a facility's qualifications for both Medicare and Medicaid.
>
> The committee's amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities.
>
> This amendment incorporates the general thrust of an amendment previously developed by the committee and included in H.R. 17550."

LOCAL CONTROL

The Proposed Regulations circumvent local controls. The Federal Legislation, notably the Comprehensive Health Planning Act and the 1972 amendments to the Social Security Act has mandated and supported certificate of need, rate review and consumer involvement. These regulations ignore this legislation.

The lack of local review is self-defeating, expensive and contrary to other public policies. State licensing, certification of need, budget review, contract review and other mechanisms are needed to provide for local review. Without such monitoring, the government will be providing an expensive Welfare Program for providers NOT services for the sick and disabled.

We believe that local controls must be encouraged not circumvented by Federal Regulations. Effective Home Health Service programs require that local consumers, providers and government officials share the responsibility of improving local services to meet the unique needs of the individuals in their community. Such controls as State Licensure, certificate of need, rate review, contract review should be supported by all Federal Agencies.

LACK OF ADEQUATE FUNDS FOR SURVEILLANCE

Without funds for staff at the federal, state or local level to survey, certify, verify or monitor providers, a bureaucratic "jungle" is created where patients become secondary.

The survey agency of each individual state must monitor the operation and performance of each provider of home health services. Yet these regulations do not establish any performance guidelines to assure that there will be adequate surveillance.

This cannot be accomplished without budgeting funds for the state survey agencies to gear up and provide adequate surveillance. However this can be easily and economically accomplished by using the Medicare certification.

We agree with congress that the existence of separate requirements (which may differ only slightly) and separate certification processes for determining provider eligibility to participate in Medicaid is administratively cumberson and unnecessarily expensive.

Therefore, we believe there should be a single uniform federal standard for all Home Health Agencies which should be based on the Medicare Certification. Such standard should include a provision for local controls, including state licensure and certificate of need, as a minimum. Changes to improve Medicare Certification should be made by legislation and not by each Federal Agency that reimburses for home health services. For example, hospitals use a single definition in all federal programs while nursing homes were defined separately by various federal programs. Many problems can be avoided by using a single uniform definition for a Home Health Agency.

We will actively oppose any attempt to REDUCE QUALITY, to establish different levels of care for the Medicaid population, to circumvent local planning agencies and state licensure laws because these activities have been developed to prevent exploitation of various federal programs. Exploitation of the Home Health sector must be prevented.

We trust that the Department will seriously consider the points we have raised and include our recommendations in the final regulations.

As we have stated on previous occasions we are willing to assist HEW staff in any effort to improve the quality and avaliability of a comprehensive renge of home health services needed to make home health a viable alternative to institutional care.

Sincerely,

Donald D. Trautman

Donald D. Trautman,
Chairman

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES
LEGISLATIVE COMMITTEE

1715 E. Burnside Street
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STATEMENT OF

JOHN BYRNE, PRESIDENT

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

OCTOBER 28, 1975

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NAHHA Oral Statement, John Byrne 10/28/75

Chairman Moss, Chairman Pepper, and members of the Senate and House Committees on Long-Term Care, I appreciate the opportunity to appear before you today to discuss the impact of the Proposed August 21, 1975 Medicaid Regulations on the future quality of Home Health Services.

My name is John Byrne. I am Executive Director of The Visiting Nurse Association of Greater St. Louis, President of the National Association of Home Health Agencies and am speaking on behalf of the National Association of Home Health Agencies.

With me is Don Trautman, Chairman of the Legislative Committee of our Association. Both Don and I will be happy to answer any questions the committe may wish to ask following our statement.

I ask permission to have our written statement with attachments included for the record and proceed with our oral statement.

The impact of the August 21, 1975 Proposed Medicaid regulations is important. This set of regulations makes a major policy change that lowers standards for Home Health Service while Congress is developing changes designed to maintain quality while increasing the use of Home Health Services.

The prime purpose of the National Association of Home Health Agencies is to support the delivery of high quality cost effective services to those who would benefit from such services. It is the policy of our association that no

distinction should be made between agencies on the basis of sponsorship, ie between official, non-profit and for-profit agencies.

It appears that home health agencies are facing the same dilemma nursing homes faced in 1967. We want to avoid the problems that developed in the nursing home field during an accelerated growth period. These problems were the result of an increase in quantity at the expense of quality which took about eight years to identify. We cannot stand by silently and permit a similar development in home health services.

The Proposed Regulations include a provision to certify single service agencies as home health agencies. This lowers standards by catering to those who are not willing or interested in being responsible and held accountable for the delivery of a comprehensive range of services. Why change one comprehensive service agency into seven different single service agencies? This is diametrically opposed to the concept of organized and coordinated home health services. We should be raising the minimum requirements not lowering them.

Quality is important. It must assure the user 1) that he will receive services when he needs help, 2) that he will be trained to help himself when he is able, and 3) that he will be able to care for himself as long as possible. Quality eliminates the costly dependency trap.

Quality must guarantee that the user's needs will be routinely reviewed by a group of health workers. Subtle changes need to be noted and the treatment modified to avoid

the development of serious problems.

Quality must be practical and include the user in planning the home treatment program. The home treatment program must put the recipient's needs above that of the "budget" or the "profit and loss statement" of the organization.

Quality includes using the most appropriately qualified person (not necessarily the cheapest) to treat the problem. This includes efficient utilization of staff by matching the task to the level of the worker. It takes Quality to make the best use of staff, to match needs to level of worker, to know when to seek consultation of another, or when to turn the primary responsibility of treatment over to a more qualified person.

We don't expect a carpenter to be a nuclear physicist just because he helped build the physicist's office. By the same token we should not expect a homemaker to know when the patient's overall condition requires the skills of a registered nurse to plan and supervise the services, just because she is providing housekeeping services.

Quality home health service is all of these melted together into a cohesive organization called a home health agency, an organization that uses the best available to do the job right.

Quality is important to home health because 1.) it can help reduce the long-term cost of caring for a person, 2.) it requires nursing and rehabilitation staff to work together, side by side, in the home to help the patient, 3.) it stimulates development of innovative solutions and encourages redesign

of the service systems, and 4.) it tells you when to stop treating, start teaching self-care and finally when to let go.

Our Association's specific recommendations on the Medicaid regulations can be summarized in two groupings.

First, we urge immediate adoption and final publication of the Medicaid regulations as recommended in our September 30 letter to the Commissioner of The Social Rehabilitation Service. This involves deleting sections 249.150 and 249.151 and making the following changes to Section 249.10 (a) (4) and (b) 7.

- Home Health aide services provided by a qualified agency must be clearly defined.
- Include all Medicare home health services as required Medicaid services and add nutrition counseling, therapeutic diets, and medical social services as the services which may be provided at state option.
- Add a requirement that the State Agency conduct a public hearing in the local area to determine that there is no home health agency service available before permitting the State Agency to reimburse for services provided by other than a Medicare Certified Home Health Agency.
- Require that in order to participate under a State Title XIX plan as an agency qualified to provide Home Health Services, such agency must be certified under Title XVIII of the act to provide such services.

Second, we want a committment from both Congress and H.E.W. to develop a single uniform Federal standard for all home health agencies which uses the Medicare Certification as the basis.

The real issue is what type of controls are needed to maintain quality. This is not a question of profit versus non-profit. Different committees in our Association have been meeting with various groups gathering information needed to formulate a policy that will have enough teeth to apply equally across the board to everyone.

Since this is an industry problem as well as a public policy issue, we would like to cooperate with the various administrative agencies and legislative committees to develop the solutions. We would hope that we in the industry would be permitted sufficient time to complete our work and develop a solution that is fair.

We think a key role of the Congress and Administrative Agencies should be to fully explore and carefully review the issues which bear on the quality of service provided to patients. We believe this will result in a public policy that will include the safeguards needed to retain quality while liberalizing payment and expanding the scope of services.

We firmly believe that now is the time to develop a single uniform Federal standard for all Home Health Agencies which should be based on the Medicare Certification. Such standard should include a provision for local controls, including state licensure, certificate of need, and require-

ments for full disclosure of information as a minimum. Changes to improve Medicare Certification should be made by legislation and not by each Federal Agency that reimburses for home health services. Many problems can be avoided by using a single uniform definition for a Home Health Agency.

The National Association of Home Health Agencies actively supports efforts that assure the delivery of high quality cost effective home health and vigorously opposes attempts to REDUCE QUALITY, establish different levels of care, or circumvent local planning agencies and state licensure laws.

We need help. We cannot afford to expand the quantity of Home Health Services at the expense of Quality. Please help us.