

## DOCUMENT RESUME

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**Home Health: The Need for a National Policy To Better Provide for the Elderly.** February 22, 1978. 8 pp. + 2 enclosures (2 pp.).

**Testimony before the House Select Committee on Aging; by Gregory J. Ahart, Director, Human Resources Div.**

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The true cost of maintaining the elderly and sick at home has been largely hidden because the greatest portion of that cost represents the value of services provided by families and friends rather than those provided at public expense. The point on the impairment scale when home service costs equal institutional costs falls at the mid-point of the greatly impaired group when families and friends are providing about \$287 per month for every \$120 spent by agencies. About 10% of noninstitutionalized older people fall in the area above the break-even point. On the average, it would still cost the public more to institutionalize these people because agencies spend less per person for home care services than for institutional care. The cost impact of possible changes to the Medicare program which would increase the availability of services and provide services not currently covered by the program would be: elimination of limits on number of visits under Parts A and B--\$12.5 million; elimination of skilled care requirement under Parts A and B--\$1.25 billion; elimination of prior hospitalization requirement under Part A--\$12.5 million; elimination of homebound requirement under parts A and B--\$92.5 million; and adding housekeeper/chore services--\$75 million. The agencies delivering home services have developed differing criteria for eligibility, duration, scope of covered services, and method of reimbursement, and because of these varying criteria, effective coordination seems almost impossible. (RR5)

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STATEMENT OF  
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UNITED STATES GENERAL ACCOUNTING OFFICE  
BEFORE THE  
SELECT COMMITTEE ON AGING  
HOUSE OF REPRESENTATIVES  
ON  
HOME HEALTH--THE NEED FOR A  
NATIONAL POLICY TO BETTER PROVIDE  
FOR THE ELDERLY

Mr. Chairman and Members of the Committee:

We are pleased to be here today to summarize and discuss our report to the Congress entitled, "Home Health--The Need For A National Policy To Better Provide For The Elderly". Your letter of August 6, 1976, which lead to the issuance of our report on December 30, 1977, requested us to identify the circumstances under which home health care is less expensive than institutional care. You also asked us to provide information on the cost impact of possible changes to the Medicare program liberalizing home health benefits and to evaluate the coordination of various home health and home service programs authorized under various titles of the Social Security Act and the Older Americans Act.

COST OF HOME SERVICES COMPARED  
TO INSTITUTIONALIZATION

Because of an extensive data base already being developed in our review of the Well Being of Older People in Cleveland, Ohio, we chose this city as our model for a comparative cost analysis of home health care

versus institutionalization. The cost of services received by older people in Cleveland, however, should not be considered indicative of what expenditures would be if a comprehensive federally funded program was established to provide home care services for older people--partially because our analysis was based on services actually received as opposed to services which might be considered as necessary or desirable and thus reimbursable under some structured criteria.

In comparing the costs to maintain older people in their homes rather than in an institution, each group was analyzed separately. The first group analyzed was noninstitutionalized people, which nationwide comprise about 95 percent of the 23 million persons 65 years of age or over. The second group was the remaining 1.2 million people who are institutionalized. A comparison was then made for both groups to determine at what level of impairment the total cost to keep an older person at home (including the value of the services provided by family and friends) equals the cost of institutionalization.

While we do not believe that a decision to institutionalize an individual who wants to remain at home should be based on cost comparisons alone, we believe that these comparisons provide some insight as to the economic, physical, and social factors which have influenced such decisions.

The true cost of maintaining the elderly and sick at home, as demonstrated by the graph (see attachment 1), have been largely hidden because the greatest portion of such cost represents the value of services provided by families and friends rather than those provided at public expense. But there is a point on the impairment scale when home service costs, including the value of services provided by families and friends,

equal institutional costs. This point falls at the mid-point of the greatly impaired group where, for the group as a whole, families and friends are providing about \$287 per month for every \$120 being spent by agencies. About 10 percent of the noninstitutionalized older people fall in the area above the break-even point. However, on the average, it would still cost the public more to institutionalize these people because agencies are spending less per person for home services than for institutional care.

Two major differences emerged when institutionalized and noninstitutionalized people were compared. One is the level of impairment. Elderly people in institutions are older and more impaired than those not in institutions. The second major difference is a person's living arrangement. Few institutionalized people had a spouse or lived with their children at the time they were institutionalized.

Knowing these two major differences, the status of the noninstitutionalized population can be examined and the identification of those older people that have a high probability of being institutionalized can be made. These people will be the 31 percent of the 3.7 million greatly or extremely impaired who live alone. While they comprise about 5 percent of noninstitutionalized older people, 66 percent of those institutionalized are from this group.

#### COST IMPACT OF MAKING CHANGES TO MEDICARE'S HOME HEALTH PROGRAM

The Social Security Administration actuaries estimated that for fiscal year 1978, the cost impact of possible changes to the Medicare

program which could increase the availability of services and provide services not currently covered by the program would be as follows:

	<u>Estimated cost (millions)</u>
Elimination of:	
Limits on number of visits under parts A and B	\$ 12.5
Skilled care requirement under parts A and B	1,250.0
Prior hospitalization requirement under part A	12.5
Homebound requirement under parts A and B	92.5
Adding homemaker/chore services	75.0

The estimated costs of the above changes were computed separately and should not be totaled because if more than one limitation were removed there would be interactions.

Except for removing the requirements that beneficiaries need skilled care, the proposed modifications to the program will not be costly. Although experiments in the program regarding homemaker/chore services are still continuing, some evidence shows that the addition of homemaker/chore services could provide disincentives to institutionalization for individuals who are greatly or extremely impaired which might help to offset the additional cost of this service.

Removing the limitations on the number of visits under Medicare would not be costly because few people presently exhaust such benefits. The elimination of the prior hospitalization requirement under part A would not be costly and would tend to eliminate the institutional bias of this program. However, because home health care is limited to individuals under the care of a physician whose services are covered under part B,

access to home health services under part A without coverage under part B seems to us to be of limited value.

To be eligible for home health care, a physician must certify that the patient is confined to his or her home. A homebound person is permitted infrequent or brief absences. The estimated cost of eliminating the homebound requirement is \$92.5 million; however, \$36 million, or 40 percent of the estimated increased cost, pertains to providing home health aides to individuals with end-stage kidney disease who dialyze at home. The House has already passed legislation (HR 8423) in September 1977 which would, in effect, provide such benefits for end-stage kidney disease patients. This bill is designed to provide incentives to use home dialysis as an alternative to the more costly dialysis in institutions. Thus, consideration is already being given to legislation which would have the effect of eliminating or significantly diluting the homebound requirement for one group of Medicare beneficiaries.

#### DIFFICULTIES IN COORDINATING PUBLIC IN-HOME SERVICES

Home health and other home delivered services are available through many different programs. The agencies administering these programs, through regulations, have developed differing criteria for the eligibility, duration, scope of covered services and method of reimbursement. Because of these varying criteria, effective coordination seems almost impossible. During November 1976 at a HEW task force meeting on home health, the members of the task force generally agreed that under current legislation, home health services as provided by various agencies, defied coordination.

The services being provided to the elderly are not accessible through a single entry point that would assess the individual's entire need.

Older persons can qualify for home health and other home delivered services under various Federal programs. Each program was developed to meet a specific need. The principal Federal programs providing home services are titles XVIII, XIX, and XX of the Social Security Act and titles III and VII of the Older Americans Act. Each program is designed to provide health or social services to specific population groups, Medicare for the aged and disabled; Medicaid for the poor or public assistance recipients; and various social and support services under title XX of the Social Security Act, and titles III and VII of the Older Americans Act with emphasis on persons with low incomes.

A number of the services provided are similar in nature. Our chart (see attachment II), which represents an analysis of the home-related services being provided under the various Federal programs in Florida shows that a number of the services are similar in nature. Although similar to each other, and to the support services provided by family and friends, the eligibility and scope of covered services differ.

Some States have made an effort to coordinate home health services by entering into interagency and/or intra-agency agreements. But State and local officials still agree that there is a lack of coordination in providing home health services to the elderly.

For example, in Dade County, where some coordination existed, a January 1977 study of home health related and supportive social services by the Health Systems Agency of South Florida--a nonprofit organization

authorized by the National Health Planning and Resources Development Act of 1974--concluded that better coordination was needed. The study stated that

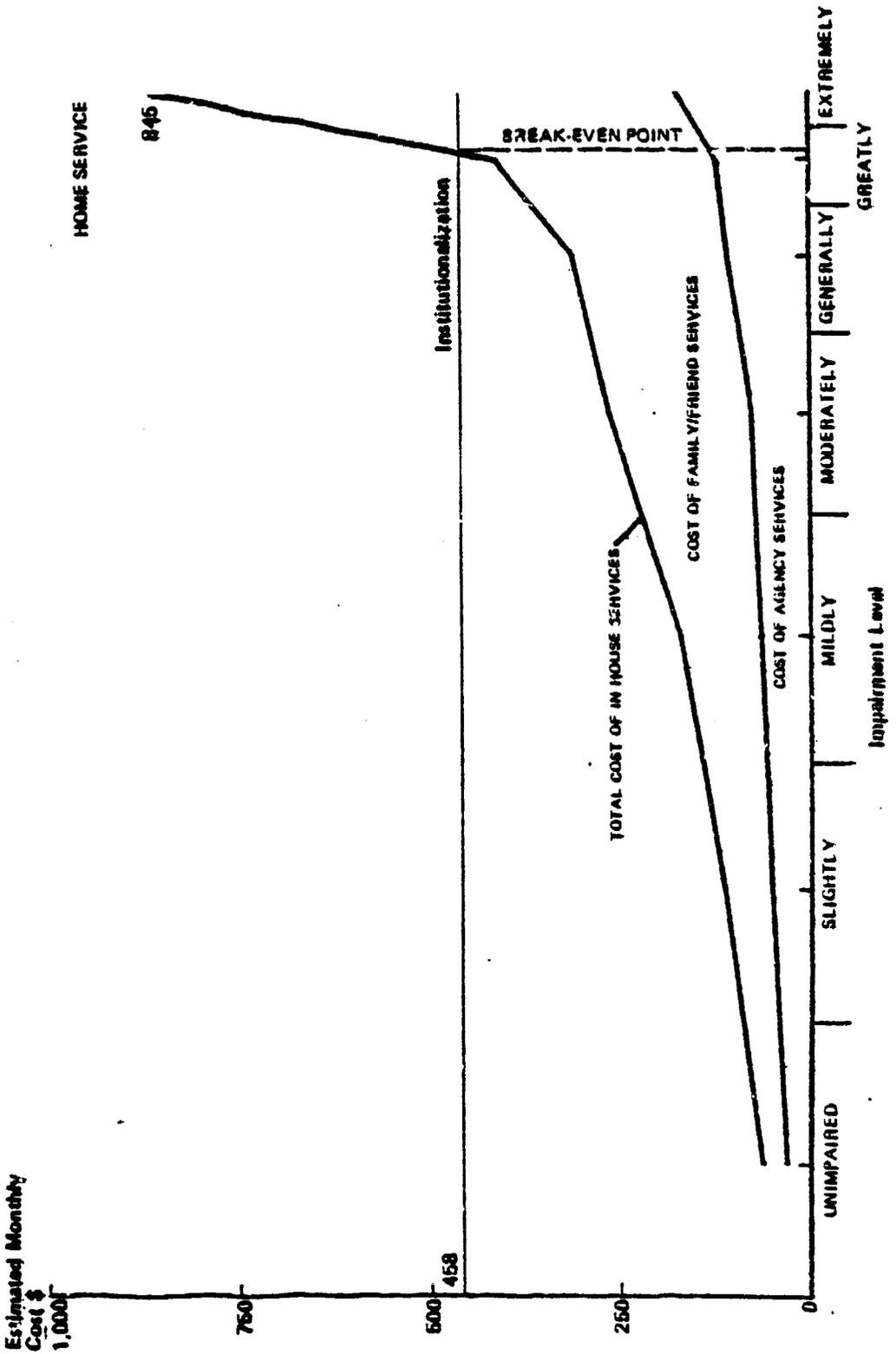
- there is no unified system existing locally to provide an integrated, comprehensive, and coordinated package of health related and supportive social services in the home;
- there is no centralized information and referral systems for home health related services;
- the categorical nature of existing programs providing services in the home results in a fragmented provision of services at the local level;
- the lack of a local coordinated mechanism among providers of health care and supportive social services in the home and between such providers and other providers of health services creates community problems; and
- potential community resources are not fully utilized.

Mr. Chairman, we note that since the issuance of our report, legislation has been introduced to recognize some of the issues discussed in the report. For example, on January 23, 1978, legislation (H.R. 10482) was introduced to amend the Older Americans Act to provide grants to the States to establish community initiatives to assess the long term care needs of the chronically ill or disabled older persons and to provide for the delivery of necessary health and social services in a coordinated and efficient manner. Also, on February 2, 1978, H.R. 10737 was introduced which would establish a Home Health Clearing House within HEW designed

to promote more effective coordination and delivery of home health care by collecting and disseminating information regarding the availability of in-home services under Federal, State, local, and private agencies. In addition, on the same day, H.R. 10738 was introduced which would (1) eliminate the limits on the number of visits and the homebound requirement under parts A and B of Medicare and the prior hospitalization requirement under part A, and (2) add homemaker chore services.

Mr. Chairman, this concludes my statement. We will be happy to answer any questions you or other members of the Committee may have.

COMPARISON OF ESTIMATED MONTHLY COST  
OF HOME SERVICES AND INSTITUTIONALIZATION AT EACH IMPAIRMENT LEVEL PER INDIVIDUAL



## ATTACHMENT II

## ATTACHMENT II

<u>Type of service</u>	<u>Title XVIII</u>	<u>Title XIX</u>	<u>Title XX</u>	<u>Titles III &amp; VII Older Americans Act</u>
Nursing care	X	X		
Home health aide/ homemaker	X	X	X	X
Chore service			X	X
Shopping assistance			X	X
Home delivered meals			X	X
Transportation			X	X
Checking				X
Social and recreational				X
Housing				
Administrative/ legal				
Food, groceries				X
Personal care				X
Continuous supervision			X	