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REPORT TO THE CONGRESS 09482

Home Health Care Benefits Under Medicare And Medicaid

B-164031(3)

Department of Health, Education, and Welfare

*BY THE COMPTROLLER GENERAL
OF THE UNITED STATES*

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COMPTROLLER GENERAL OF THE UNITED STATES
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01 To the President of the Senate and the
Speaker of the House of Representatives

This is our report on home health care benefits under Medicare and Medicaid. Medicare and Medicaid are administered by the Social Security Administration and the Social and Rehabilitation Service, respectively, of the Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

James B. Stacks

Comptroller General
of the United States

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C o n t e n t s

	<u>Page</u>
DIGEST	i
CHAPTER	
1 INTRODUCTION	1
Medicare	1
Medicaid	2
Home health care	3
2 HOME HEALTH CARE AS AN ALTERNATIVE TO INSTITUTIONAL CARE	8
Need for alternatives to institu- tional care	8
Cost benefits of home health care	9
HEW efforts regarding alternatives to institutional care	9
3 DEVELOPMENT OF HOME HEALTH CARE BENEFITS UNDER MEDICARE	12
Problems resulting from delays in clarifying services covered	13
Statutory limitations of Medicare home health benefits	16
Disparities in extent of benefits paid for by intermediaries	18
Information provided to beneficiaries can be confusing	19
Limited physician and hospital involve- ment	21
Financial difficulties experienced by home health agencies	24
Conclusions	27
Recommendations to the Secretary, HEW	28
Agency comments	29
4 DEVELOPMENT OF HOME HEALTH CARE BENEFITS UNDER MEDICAID	31
Covered services vary	31
States' views of home health as an alternative to institutional care	37

CHAPTER

Page

Encouragement needed for States to increase payment rates to stimulate greater utilization	38
Conclusions	39
Recommendations to the Secretary, HEW	40
Agency comments	40

5	SCOPE OF REVIEW	42
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APPENDIX

I	Letter dated June 11, 1974, from the As- sistant Secretary, Comptroller, Depart- ment of Health, Education, and Welfare, to the General Accounting Office	43
II	Principal HEW officials responsible for administering activities discussed in this report	48

ABBREVIATIONS

AOA	Administration on Aging
BHI	Bureau of Health Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
MSA	Medical Services Administration
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

D I G E S T

WHY THE REVIEW WAS MADE

Because of indications that the number of agencies providing home health care was declining thus resulting in cutbacks in such services, GAO reviewed the benefits provided under Medicare and Medicaid.

Further, GAO wanted to see which elements of these benefits might relate to alternatives to institutional care.

Medicare and Medicaid are administered at the Federal level by the Department of Health, Education, and Welfare (HEW).

Home health care is generally defined as health care prescribed by a physician and provided to persons in their own homes.

GAO visited home health agencies in 4 States and sent questionnaires to 11 additional States.

FINDINGS AND CONCLUSIONS

Need for home health care

Home health care, while not a substitute for appropriate institutional care, is generally a less expensive alternative when such care would meet the patient's needs. The Congress and the health field

have realized the need for developing alternatives to institutional care. (See p. 8.)

For example, reports prepared (2) for the Senate Special Committee on Aging pointed out that many of the Nation's elderly are unable to carry out their daily activities because of chronic disease and disability. 5500

Another report pointed out that in-home services are a major component of a comprehensive health system and that top national priority must be given to developing comprehensive in-home services for the whole population.

Several studies--focusing on savings realized by early transfer of patients from hospitals to home care programs--have pointed out that such care can be less expensive than institutional care. (See p. 9.)

HEW has also recognized the need for alternatives to institutional care and has funded projects to study this area. (See p. 9.)

Developments under Medicare

Home health coverage under Medicare, administered by the Social Security Administration (SSA), 26 experienced significant difficulties in its early stage.

Although some problems have been alleviated, obstacles continue to diminish its overall effectiveness.

In recent years expenditures under Medicare for home health benefits have been declining--from \$115 million in fiscal year 1970 to about \$75 million in fiscal year 1973.

During the period 1969 to 1971 the number of home visits and the number of nurses and home health aides on some agency staffs decreased also. GAO noted the following factors in its review of the development of home health benefits under Medicare. (See pp. 12 to 30.)

In the early stage of the Medicare home health benefits program, claims for nonskilled care were paid because services covered under home health had not been clarified by SSA. About 3 years after home health benefits began, SSA, in an attempt to restore statutory integrity of the benefits program, issued guidelines to clarify the coverage. SSA believes that this problem has been alleviated considerably. (See p. 13.)

Medicare coverage is oriented, by law, to the need for skilled care and does not cover nonskilled services. Medicare, therefore, is not able to cover preventive care. (See p. 16.)

Intermediaries have established different guidelines for the periods and the number of home health visits covered for various illnesses. As a result there are disparities in the extent of benefits paid for by intermediaries. (See p. 18.)

Information provided to beneficiaries by SSA on allowable care has not

always clearly spelled out limitations of the coverage. Accordingly, beneficiaries, at times, have been confused regarding the coverage and limitations of home health benefits. (See p. 19.)

Physician and hospital involvement is essential to a successful home health care program. Physician involvement, however, has been limited and hospitals have not always encouraged effective use of home health care. (See p. 21.)

A major problem for home health agencies and beneficiaries had been denial of payments after services had been furnished by home health agencies. Although this problem has subsequently been reduced, some agencies still have denial problems.

To further reduce the denial problem, the Social Security Amendments of 1972 provided for, effective January 1, 1973, advance approval for home health care services and the establishment of periods of time during which beneficiaries would be presumed to be eligible to receive home health benefits.

The amendments also included a provision for a waiver of liability for certain types of denials.

Since coverage under the advance approval provision is presumed only for an initial period, the provision probably will not totally eliminate the problem. (See pp. 24 to 27.) SSA has not yet issued regulations to implement this provision.

SSA should increase its efforts to assure more effective and uniform

interpretations of existing regulations and guidelines regarding Medicare home health benefits by intermediaries, home health agencies, and beneficiaries.

In addition, SSA should encourage home health agencies to increase the health field's awareness and support of home health care.

Developments under Medicaid

3/ The Medicaid home health benefits program, administered by the Social and Rehabilitation Service (SRS), 179 allows preventive, skilled, and non-skilled care and thus has a potential to serve as an alternative to institutional care.

This potential, however, has not been fully developed. To do so SRS needs to provide more guidance to the States on

- objectives of the program and
- scope of allowable services.

SRS also should encourage the States to establish adequate payment rates to stimulate greater utilization of home health care. (See pp. 31 to 41.)

GAO found:

- Services covered under the States' programs vary significantly. (See p. 31.)
- Some States have adopted Medicare eligibility criteria for skilled nursing care which are more restrictive than intended by Medicaid. (See p. 32.)
- States' payment rates for

home health care have not been adequate. (See p. 38.)

RECOMMENDATIONS

Regarding Medicare, the Secretary of HEW should direct SSA to:

- Increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding various coverage requirements for home health services.
- Review screening guidelines used by intermediaries and where significant differences exist in service limitations, explore the feasibility of requiring more uniform screening guidelines.
- Explore methods of further clarifying home health benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.
- Encourage and where considered feasible, assist home health agencies in their efforts to increase the health field's awareness and support of home health care.
- Establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of post-hospital home health services.

--Determine whether implementation of the advance approval and waiver of liability provisions is effective in minimizing the problem of denials and, if necessary, advise the Congress that the amendments need modification to correct the problem. (See p. 28.)

Regarding Medicaid, the Secretary of HEW should direct SRS to:

- Impress upon the States that home health care generally is a less expensive alternative to institutional care and because of this, it is intended to be used as such when home health care would meet the patient's needs and reduce costs.
- Clarify for States the specific home health services which are eligible for Federal financial participation and define these services for the States.
- Encourage States to establish payment rates for home health care at a level that will stimulate greater utilization of such care.
- Encourage and assist home health agencies in their efforts to increase the health field's awareness and support of Medicaid home health care benefits as an alternative to institutional care. (See p. 40.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW concurred in GAO's recommendations regarding Medicare and advised GAO that a Health Coordinating Committee was established early in 1974 as a part of SSA's Bureau of Health Insurance (BHI) to make a full-scale review of home health. According to

HEW, the Committee will work with SSA in implementing GAO's recommendations.

Further, BHI intends to broadly assess the statutory and administrative dimensions of home health care coverage to make sure its policies and procedures are as supportive as the law permits.

HEW has some reservations on the degree to which SSA can legitimately assist home health agencies to increase the medical profession's awareness and support of the home health care program. SSA expressed strong convictions that

- home health agencies themselves must first work toward achieving professional community acceptance and
- efforts undertaken by SSA on behalf of the agencies could be counterproductive to this acceptance. (See pp. 29 and 30.)

HEW concurred also with GAO's recommendations regarding Medicaid. To expand use of home health care, SRS will emphasize importance of careful appraisals of alternatives to institutional care and will look for ways to encourage support of the program by the medical profession.

SRS plans to improve home health benefits through clearer explanations of eligible services and emphasizing to the States the importance of realistic payment rates. These measures and the effects of recently enacted legislation should have favorable results. (See pp. 40 and 41.)

MATTERS FOR CONSIDERATION
BY THE CONGRESS

This report contains information on developments in home health care which have limited its effectiveness.

This information should be useful to the Congress in its deliberations on the costs of health care and possible alternatives to institutional care.

CHAPTER 1

INTRODUCTION

The Social Security Amendments of 1965 established two health benefit programs--Medicare and Medicaid. Medicare is a federally defined, uniform package of medical care benefits for most persons age 65 and over. Effective July 1, 1973, the Social Security Amendments of 1972 extended Medicare protection to (1) individuals under age 65 who have been entitled to social security or railroad retirement benefits for at least 24 consecutive months because they were disabled and (2) insured individuals under age 65 who have chronic kidney disease. Medicaid is a Federal-State medical assistance program which allows each State, within certain limits, to define the extent of health care benefits to be provided to the financially and/or medically needy.

MEDICARE

Medicare, administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), provides two forms of insurance protection. One form, Hospital Insurance Benefits for the Aged and Disabled (Part A), covers inpatient hospital services and posthospital care in a skilled nursing facility or in a beneficiary's home (home health care). Part A is financed by social security contributions paid by employers, employees, and self-employed persons. For fiscal years 1967 through 1972, Part A payments amounted to about \$27.2 billion--93 percent of which was for inpatient hospital services.

Under Part A, as of January 1, 1974, the beneficiary is responsible for paying \$84 for the first 60 days of inpatient hospital services (the deductible) and \$21 a day for the 61st through the 90th days during a benefit period (the coinsurance). The beneficiary is responsible for paying \$42 a day for the 91st through the 150th days if he elects to use his

60-day lifetime reserve of hospital benefits.¹ Part A benefits pay for all covered services in a skilled nursing facility for the first 20 days after a hospital stay and all but \$10.50 a day for up to 80 more days during a benefit period. Part A also pays for all covered services--for as many as 100 home health visits--furnished by a home health agency for up to a year after a hospital stay.

The second form of protection, Supplementary Medical Insurance Benefits for the Aged and Disabled (Part B), covers physicians' services and certain medical and health benefits, including home health care. Part B is a voluntary program, financed by premiums collected from participating beneficiaries matched by Federal funds. Under Part B, beneficiaries are responsible, with certain exceptions, for paying the first \$60 for covered medical services each year (the deductible) and 20 percent of allowable charges in excess of \$60 (the coinsurance). Medicare pays the remaining 80 percent.

The Social Security Amendments of 1972 eliminated the coinsurance requirement for beneficiaries for home health care effective January 1, 1973. (Prior to these amendments, home health beneficiaries were required to pay the coinsurance amounts.) For fiscal years 1967 through 1972, Part B benefit payments amounted to \$9.9 billion, of which about 91 percent was for physicians' services.

MEDICAID

Medicaid--a Federal-State program--is administered at the Federal level by HEW's Social and Rehabilitation Service (SRS), but States are primarily responsible for its operation.

¹Under the hospital insurance portion of Medicare, the benefit structure is built around a spell of illness or benefit period. A benefit period starts when a beneficiary is hospitalized or receives covered services in a skilled nursing facility, and ends when a beneficiary has not been an inpatient in any hospital or institution primarily providing skilled nursing care for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary may have. In addition, the law provides for a lifetime reserve of 60 additional days, which is like a bank account of extra days, which can be drawn upon if more than 90 days in one benefit period is needed. Each lifetime reserve day used permanently reduces the total remaining.

Medicaid authorizes medical care to certain categories of persons entitled to public assistance under the Social Security Act. In addition, States may provide services to persons whose incomes or other financial resources exceed State public assistance standards but are not enough to pay for necessary medical care. The Social Security Act requires that State Medicaid programs provide the following services: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing home services; early and periodic screening, diagnosis, and treatment of those under age 21; family planning services; physician services; and home health care services. States may also provide additional services specified by the act, such as dental services and prescription drugs.

The Federal Government pays from 50 to 81 percent of a State's Medicaid costs depending on a State's per capita income. Federal outlays for Medicaid in fiscal year 1972 were \$4.6 billion. The Federal budget for fiscal year 1974 estimates these outlays for fiscal years 1973 and 1974 to be \$4.3 and \$5.2 billion, respectively.

HOME HEALTH CARE

Home health care is generally defined as health care prescribed by a physician and provided to persons in their own homes. Although home health care benefits are provided under both Medicare and Medicaid, the philosophies, coverages, and administrations differ.

Medicare

The Medicare home health care benefits are, by law, skilled care oriented. They were not designed to provide coverage for care related to help with activities of daily living unless the patient requires skilled nursing care or physical or speech therapy.

Home health services, as defined by the Social Security Act, include:

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

- physical, occupational, or speech therapy;
- medical social services¹ under the direction of a physician;
- to the extent permitted in regulations, part-time or intermittent services of a home health aide;²
- medical supplies (other than drugs and other medications including serums and vaccines), and the use of medical appliances, while under such a plan; and
- in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital.

The Act specifies that these services can be furnished to individuals under the care of a physician, by a home health agency or by others under arrangements with them by such agency, under a plan established and periodically reviewed by a physician. These services are to be provided generally on a visiting basis in a place of residence used as such individual's home. Under certain circumstances these services can be provided also on an outpatient basis at a hospital or skilled nursing facility or at a rehabilitation center.

¹Medical social services include such services as are necessary to assist the patient and his family in adjusting to social and emotional conditions related to the patient's health problem.

²Home health aide services include, among other things, helping the patient with bathing and care of the mouth, skin, and hair; helping the patient to the bathroom and in and out of bed; helping the patient to take self-administered medications ordered by a physician; and helping the patient exercise.

Home health services covered under Medicare are furnished by home health agencies which must meet specific requirements of the Act to participate in the program. The Act defines a home health agency as a public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services. Medicare regulations state that in addition to skilled nursing services, the home health agency must provide at least one of the following other therapeutic services--physical, speech, or occupational therapy, medical social services, or home health aide services.

To be eligible for coverage for home health care under Medicare a person must be confined to his residence, be under the care of a physician, and need part-time or intermittent skilled nursing service and/or physical or speech therapy. The need for such care must be prescribed by a physician. If these requirements are met, a person is eligible to receive other covered home health services. To qualify for home health care benefits under hospital insurance (Part A of Medicare), a person must have been in a hospital for at least three consecutive days prior to entry into home care. The care to be provided must be for a condition for which the person received services as a bed patient in the hospital and must be provided within the year following hospitalization or after a covered stay in a skilled nursing home following such hospitalization. Under Part A, a person's coverage is limited to 100 home care visits after the start of one spell of illness and before the beginning of another. A person may qualify for home health care benefits under medical insurance, (Part B of Medicare), without prior hospitalization provided certain conditions are met. In such cases a person is limited to 100 home care visits in any one calendar year.

The Bureau of Health Insurance (BHI) of SSA is responsible for establishing policy, and developing operating guidelines, and in collaboration with the Public Health Service, for prescribing standards for the participation of home health agencies under Medicare. SSA has entered into agreements with public and private organizations and agencies to act as fiscal intermediaries in the administration

of home health care benefits under Part A and Part B.¹ Among other things, these fiscal intermediaries are responsible for (1) making payments for services provided, (2) communicating to home health agencies information or instructions furnished by BHI and serving as a channel of communication between home health agencies and BHI, and (3) assisting home health agencies in establishing and applying safeguards against unnecessary use of services under the program.

From the inception of the program in fiscal year 1967 through fiscal year 1973, Medicare home health care outlays were about \$506 million. Outlays are expected to increase after fiscal year 1972 because of improvements in the Medicare program provided by recent legislative changes (Public Law 92-603). Among these are the extension of coverage to disabled persons.

Medicaid

Home health care became a required service under Medicaid effective July 1, 1970. Home health agencies which are qualified to participate in the Medicare home health care benefits program are considered to be qualified for participation in Medicaid. Under Medicaid, States may administer their own programs or may contract with private organizations for assistance in administering their programs. The functions and responsibilities assigned to the contractors--referred to as fiscal agents--vary among the States which use fiscal agents and may include any of those functions and responsibilities assumed by the State in its approved State plan.

Any person eligible for skilled nursing home services, and for whom home health services are prescribed by a physician, is eligible to receive home health care. Medicaid home health services include, but are not limited to, nursing

¹With respect to Medicare, SSA generally enters into agreements with fiscal agents, called intermediaries, to reimburse institutions for Part A benefits. The fiscal agents which reimburse for noninstitutional care under Part B benefits are called carriers, (generally insurance companies). However, under the home health care section of both Part A and Part B, reimbursement is made only by intermediaries for home health care benefits.

services on a part-time or intermittent basis, home health aide services, medical supplies, equipment, and appliances.

The Medicaid home health care benefits differ from Medicare benefits in that they do not require that a person need skilled nursing care or physical or speech therapy. Also, they do not provide for medical social services. In contrast to Medicare Part A, a person does not need prior hospitalization to be eligible for Medicaid home health benefits.

For fiscal years 1972 and 1973 States made expenditures of about \$24.9 million and \$28.6 million, respectively, for home health benefits under their Medicaid programs. The Federal share was about \$13.6 million and \$15.7 million, respectively.

CHAPTER 2

HOME HEALTH CARE AS AN ALTERNATIVE TO INSTITUTIONAL CARE

Although home health care is not intended to be a substitute for appropriate institutional care, it offers in some instances a less expensive and/or more effective alternative to institutional care.

NEED FOR ALTERNATIVES TO INSTITUTIONAL CARE

Much attention has been given to the need for developing alternatives to institutional care. Studies prepared for the Senate Special Committee on Aging in 1971 and 1972 pointed out that a large portion of the elderly in the Nation are unable to carry out their daily activities because of chronic disease and disability and that home health services of good quality are an essential component of any system of comprehensive health care.

A July 1973 paper on the current status of home health services in the United States issued as a committee print by the Senate Special Committee on Aging summarized proceedings of a June 1972 Conference on "In-Home Services" and pointed out that these services are a major component of a comprehensive system of health care services and that in the absence of in-home services, no system may be considered either comprehensive or effective. The study also stated that top national priority must be given to developing a system of comprehensive in-home services for the whole population.

In testimony before the Subcommittee on Health for the Elderly, Senate Special Committee on Aging, in July 1973, HEW officials discussed the impact of Federal programs in providing home health care as an alternative to institutionalization. They discussed the need to provide household and incidental non-health services, the restrictiveness of Medicare home health benefits and its effect on Medicaid, and the lack of knowledge by many physicians of the advantages of home health care and the resistance by some to utilize home health care.

Also, other publications have pointed out that the need for home health care is becoming increasingly important in

view of the changing age composition of the population and the proportionate increase in long-term illness and disability.

COST BENEFITS OF HOME HEALTH CARE

Several studies have pointed out that home health care can be considerably less expensive than care in a hospital or skilled nursing facility. These studies have generally focused on the savings realized by early transfer of patients from hospitals to home care programs. A study by the Rochester, New York, Home Care Association showed an estimated reduction of 13,713 patient-days and a savings of \$1,055,000 in calendar year 1970 and an estimated reduction of 12,579 days and a savings of \$1,068,000 in calendar year 1971 as a result of early release of patients from hospitals to home health programs.

Another study by the Denver Department of Health and Hospitals on the results of its Early Hospital Discharge Program showed that savings of \$515,729 in hospital costs for Medicare patients were achieved in calendar year 1970 as a result of early discharge of 292 patients from hospitals to home care programs.

A 1970 report prepared by officials of the Health Services Research Center, Kaiser Foundation Hospitals in Portland, Oregon, described a particular home care project. The project involved home care and extended care, such as that available under Medicare, being provided to a select population of more than 100,000 people under 65 years of age in a comprehensive, prepaid group practice program. The study reviewed the impact of these services on the use of hospital care by the population. The comparative daily costs were \$5.26 for home health care, \$39.08 for an extended care facility, and \$72.62 for a hospital. The study cautioned, however, against applying these cost comparisons to a different medical care system because the Kaiser clinics, which were studied, operate on a concept different from other health care plans.

HEW EFFORTS REGARDING ALTERNATIVES TO INSTITUTIONAL CARE

HEW has recognized the need for alternatives to institutional care and has funded projects to study this area. Most

of these projects were funded by the Public Health Service's Health Services and Mental Health Administration¹ or the Administration on Aging (AOA) of HEW, or jointly by these two agencies. Projects were also funded by the Medical Services Administration (MSA) of SRS.

During 1972 AOA and the Health Services and Mental Health Administration jointly contracted with the Massachusetts Executive Office of Elder Affairs for a 3-year demonstration and evaluation of the cost effectiveness of providing home care in lieu of nursing home care. The research portion of the project was estimated to cost about \$700,000, of which an estimated \$195,000 was spent in fiscal year 1973.

MSA has developed a series of demonstration project models to test various approaches to providing alternatives to institutional care. The models emphasize formation of a single organizational entity responsible for providing or arranging for the provision of a broad range of services. An AOA official told us that, for fiscal year 1974, AOA is providing total funding for four projects--a "Day Hospital" and three "Day Care Centers"--at a cost of about \$907,000. AOA's projected fiscal year 1975 funding for these projects is about \$981,000.

In a memorandum dated July 25, 1973, an official of MSA outlined a proposal for eight additional project models to test various alternatives to institutional care. These projects, which were being considered by MSA for funding, were estimated to cost about \$1.75 million in fiscal year 1974.

Other HEW grants and contracts cover such areas as the development of a manual for training homemaker services personnel, day care as an alternative to institutional care, integration of a home health program with a neighborhood health center, and a study of alternatives to institutional care.

One project, which was completed in August 1972, was funded by an SRS grant of \$100,000 to American University,

¹Effective July 1, 1973, the Health Services and Mental Health Administration was abolished and the responsibility for these projects was assumed by the newly established Health Resources Administration.

Washington, D.C. The purpose of the study was to evaluate alternatives to long-term institutional care. The study identified several problems that must be overcome if greater use is to be made of these alternatives.

Among these were:

- The decision to institutionalize a person is often made because the services needed at home are not available or because patients' families do not know what services are available or how to use them. Assessment of a patient's needs and development of a plan of care, focusing on home care, before the patient is discharged from the hospital could lead to a reduction in the use of institutionalized care.
- Many persons who are aged, disabled or chronically ill do not fit into the existing service structure. Some services such as homemaker services are too expensive for persons of moderate means who do not qualify for welfare.
- Publicity is often lacking in promoting the effective use of noninstitutional care.
- Current incentives encourage institutional care. For any noninstitutional alternatives to be valid, it will be necessary to develop appropriate incentives to encourage their growth and development.

The Social Security Amendments of 1972, enacted in October 1972, authorize the Secretary of HEW, either directly or through grants and contracts, to develop experiments and demonstration projects to determine whether coverage of intermediate care facilities' services, which are designed to provide less intensive care than skilled nursing home care, and homemaker services would provide suitable alternatives to benefits presently provided under Medicare.

As of January 1974 no demonstration projects had been started under this section of the law. However, five proposals were being prepared to solicit bids for demonstration projects.

CHAPTER 3

DEVELOPMENT OF HOME HEALTH

CARE BENEFITS UNDER MEDICARE

Home health coverage under Medicare experienced some significant difficulties in its early stage. Although some problems have been alleviated, other obstacles continue to diminish the overall effectiveness of home health care benefits.

During the period covered by our fieldwork, reimbursements to home health agencies, the number of visits to Medicare beneficiaries, and the number of nurses and home health aides on some agency staffs decreased significantly. In fiscal year 1970, the peak year for expenditures for home health benefits under Medicare, SSA expended about \$115 million for such benefits. By fiscal year 1973, the amount had decreased to \$75 million. Over the same period the number of persons age 65 and over has steadily increased.

We believe that the circumstances that existed at the time of our fieldwork had arisen as a result of the following:

- efforts by SSA to clarify and more strictly enforce limitations on the types of services covered (previously, these had not been so rigidly enforced nor were they as adequately defined);
- statutory limitations of Medicare home health benefits;
- disparities in extent of benefits paid for by intermediaries;
- information provided to beneficiaries can be confusing;
- limited physician and hospital involvement in home health care, and

--financial difficulties experienced by some home health agencies caused, in part, by the denial of payment after services had been provided.

Responses to questionnaires that we sent to selected home health agencies in 11 States, showed that activities under the Medicare home health benefits program had dropped considerably from 1968 to 1971. The table below illustrates this trend.

Summary of Selected Data Obtained From
GAO Questionnaires Sent to Various Providers (note a)

<u>Description</u>	<u>Calendar year (note b)</u>		<u>Percentage decline</u>
	<u>1968</u>	<u>1971</u>	
Reimbursement from Medicare care	\$12,289,705	\$6,486,181	47
Home visits to Medicare patients	619,622	359,050	42
Home health agency staff:			
Nurses	22,642	13,254	41
Home health aides	753	382	49

^aQuestionnaires were sent to 91 home health agencies in 11 States. Data in this table are from the 65 responses we received.

^bIn some cases, the information reported was for a 12-month period but not a calendar year.

SSA officials acknowledged that the Medicare benefits program had been beset by some problems which had a serious impact on some agencies but for the most part these problems had been overcome.

PROBLEMS RESULTING FROM DELAYS
IN CLARIFYING SERVICES COVERED

Guidelines for the Medicare home health care benefits program provide that benefits are intended to cover skilled care in the home. Initially, however, considerable confusion existed as to what care was covered, with the

result that noncovered home care was apparently paid for by the intermediaries from inception of the program until about August 1969.

Home health agency representatives informed us that they had submitted and were paid for claims for nonskilled care during this period because home health coverage had not been clarified for them and they did not know precisely what was covered. Officials of several intermediaries told us that prior to August 1969 they had not received sufficient guidance from SSA on which services were covered under home health care and, consequently, they paid claims submitted for noncovered care.

Although SSA had issued various guidelines since the inception of the program, it was not until August 1969-- about 3 years after Medicare began--that SSA, in an attempt to restore the statutory integrity of the home health benefits program, issued guidelines to intermediaries to clarify the services covered. The guidelines, issued as Intermediary Letter 395, stated in part:

"The home health benefits provided under Parts A and B were intended only for those beneficiaries whose conditions do not require the 'around-the-clock' medical and related care provided in hospitals and extended care facilities, but nevertheless, are of such severity that the individuals are under the care of a physician and confined to their homes. Accordingly, payment may not be made for home health services unless the services were required because the individual needed skilled nursing care on an intermittent basis, or physical or speech therapy. The purpose of this letter is to clarify several areas of confusion which have arisen in the application of this statutory requirement. * * * If the physician's plan of treatment does not indicate a need for skilled nursing care or physical or speech therapy but prescribes only the provision of supportive services, such as personal care which are rendered by a home health aide, the patient cannot be considered as meeting the certification requirements and is, therefore, ineligible for home health benefits. Consequently, when an intermediary receives an SSA-1487 (claim form) which shows charges for only, say home health aide visits or

for only medical supplies and appliances, the intermediary should investigate the claim to ascertain whether the physician has certified to the need for skilled nursing services or physical or speech therapy services and made provision for such services, and whether the provision of skilled nursing services represents a needed element in the treatment of the patient's illness or injury."

The guidelines set out in Intermediary Letter 395 resulted in numerous denials of claims and caused considerable concern to home health agencies and patients. Consequently, in May 1971, SSA issued Intermediary Letter 71-10 which dealt with the issue of skilled nursing care and encouraged intermediaries to be more definitive in explaining to providers the reasons for denying claims.

Despite SSA's efforts to clarify its definition of skilled nursing care, home health agencies continued to disagree with the intermediaries concerning the interpretation of SSA guidelines; and claims for care they considered skilled were denied as nonskilled.

Officials of some agencies told us at the time of our fieldwork that the application of the definition of skilled nursing care continued to be a problem in administering the program.

SSA officials readily acknowledged that prior to August 1969 the supervision of intermediary adjudication regarding home health claims was insufficient and that home health claims were submitted for services that were not covered and were allowed by intermediaries in an almost cursory review process.

They stated that they could not take exception to our observation that this was the result, in substantial part, of the failure of BHI to furnish definitive guidelines for adjudicative review in this benefit area. SSA officials now view the period from 1969 through 1971 as an educational process within the home health field and with intermediaries in which both parties had to be made aware that BHI could

not administratively violate its statutory obligation to comply with the law.

STATUTORY LIMITATIONS OF MEDICARE
HOME HEALTH BENEFITS

Medicare is oriented, by law, to the need for skilled care and does not cover services considered non-skilled in nature regardless of the patient's needs. Determination as to whether skilled care is required sometimes appears complicated as illustrated in the following example given us by an SSA official:

- If no one is available to fill the syringes for a blind diabetic who is able to inject himself, Medicare will not pay for having the syringes filled on the basis that this is not a skilled service. On the other hand, if the blind diabetic is unable to inject himself, Medicare will pay for a visit by a nurse to give the injection on the basis that this is a skilled service.

Lack of Medicare coverage in cases such as this could result in institutionalization, at a probable higher cost than that of home health care, since the beneficiary would be unable to receive the needed care at home.

Medicare will pay for part-time, intermittent care--defined as more than one visit. An SSA official, informed us that this reasoning is based on the premise that most persons could afford to pay for one visit.

Preventive care is another area not covered under Medicare law. There are instances when it would be less expensive and more beneficial to the patient if preventive care was covered. For instance, visits made by a nurse to take the vital signs, (temperature, pulse, respiration, and blood pressure) of a patient during a period of stability would not be covered. As pointed out by a home health agency official, the agency can obtain reimbursement for caring for this kind of patient only after he regresses.

For example, if a homebound person had recovered from a heart attack, visits made by home health agency personnel to

monitor temperature, respiration, pulse, and blood pressure would not be covered. Although monitoring of these vital signs is helpful in detecting changes in condition which could lead to another heart attack, the visits are not covered. However, if the patient's condition became worse or if another heart attack occurred, subsequent visits would be covered until the patient's condition again stabilized.

The Director, BHI, pointed out in a statement on home health care under Medicare that:

"The purpose of this part, (home health services under part A), of the Medicare law is essentially to cover cases in which illness or injury requires one of the three skilled services (skilled nursing care, physical therapy, speech therapy) * * * for proper treatment of the patients at home. This is, of course, a smaller group than the one made up of patients who require only supportive or personal-type care. Obviously, elderly patients often have need for many kinds of home health care which Medicare does not cover. But the cost of covering all levels of care under Medicare would exceed the amount of funds available for the program. There would also be the question of whether this kind of additional coverage should take priority over various other coverages that might be included under Medicare, if additional funds were available."

The Commissioner of SSA stated in a January 1971 report to the Secretary of HEW that,

"while it is recognized that many people who are not in need of either skilled nursing care or of physical or speech therapy could be maintained in their homes if the services of a home health aide were available to them on a regular basis, thereby preventing their institutionalization, the law does not cover these types of cases nor would any of the legislative proposals which have been under consideration."

Although Medicare does not provide for coverage of home-maker services, the Social Security Amendments of 1972 authorized the Secretary of HEW--either directly or through grants to or contracts with public or nonprofit private agencies,

institutions, and organizations--to develop and engage in experiments and demonstration projects to determine whether homemaker services would provide suitable alternatives to benefits presently provided under Medicare. Homemaker services, generally understood to be assistance with preparing meals, assistance with house work, and errand-running, are provided by local organizations.

DISPARITIES IN EXTENT OF BENEFITS PAID FOR
BY INTERMEDIARIES

One of the functions of intermediaries is to assist home health agencies in applying safeguards against unnecessary utilization of services. The screening guidelines established by intermediaries for this purpose vary. Our review of guidelines used by intermediaries indicates that there are disparities in benefits among program beneficiaries.

As of June 30, 1971, 85 intermediaries administered the Medicare program. Most of the home health agencies used those intermediaries. The others submitted their claims directly to SSA.

Generally, intermediaries establish limits, by type of illness, on the number of home care visits that can be made to a person before they question the need for future visits.

The intermediary screens claims to determine whether limits have been exceeded and whether the program covers the service provided.

Screening is generally carried out by clerks, however, some intermediaries employ registered nurses to perform this function. In either case, when medical questions arise in the screening process, claims are referred to the intermediary's medical review section for evaluation and disposition. The medical review section is composed of physicians and registered nurses.

We compared service limits by three intermediaries located in three States for five diagnoses or illnesses. This comparison shown on the following page, illustrates the difference in the duration of care and visit limitations. A

provision in the Social Security Amendments of 1972 may help alleviate the disparities in the extent of benefits paid for by intermediaries. This provision is discussed in further detail on page 25.

<u>Diagnosis or Illness</u>	<u>Intermediary</u>		
	<u>A</u>	<u>B</u>	<u>C</u>
Post-cataract care	Services for 1 month with <u>unlimited visits.</u>	Services for 1 month; <u>15 visits allowed.</u>	Services for 1 month; <u>20 to 30 visits allowed.</u>
Cerebral vascular accident (stroke)	Service for <u>4 months</u> ; unlimited visits for the first month, and 16 visits per month for the next 3 months.	Services for <u>2 months</u> ; 8 visits for the first month and 4 visits for the second month.	Services for <u>3 months</u> ; 8 to <u>30</u> visits allowed.
Parkinson's disease	Services for <u>3 months</u> ; 12 visits for the first month and 8 visits per month for the next 2 months.	Services for <u>3 months</u> ; 4 visits for the first month and 2 per month for the second and third months.	Services for <u>1 month</u> ; 4 to <u>12</u> visits allowed.
Cancer	Services for <u>4 months</u> ; unlimited visits for terminal cancer; unlimited visits for the first month and 16 visits per month for the second through fourth months for nonterminal cancer.	Services for <u>4 months</u> ; unlimited visits for the first month and 16 visits per month for the next 3 months.	Services for <u>2 months</u> ; 4 to <u>30</u> visited allowed.
Hip fracture	Services for first <u>4 months</u> ; unlimited visits for the first 2 months, 12 visits for the third month, and 8 visits for the fourth month.	Services for <u>4 months</u> ; unlimited visits for the first 2 months, 12 visits for the third month, and 8 visits for the fourth month.	Services for <u>2 months</u> ; 8 to <u>32</u> visits allowed.

INFORMATION PROVIDED TO BENEFICIARIES CAN BE CONFUSING

Information provided to beneficiaries on allowable home health benefits did not always clearly spell out the limitations of the benefits. Representatives of several home health agencies informed us that beneficiaries were confused regarding the coverage and limitations of Medicare home health care benefits.

"Your Medicare Handbook," a booklet published by SSA and provided to persons when they become eligible for Medicare, outlines the benefits of home health care. Early editions of this booklet did not specifically state the limitations on types of care covered under Medicare. Later editions (after 1971) have been improved.

Although SSA has provided intermediaries criteria for defining skilled nursing care, intermediaries continue to differ in interpreting the definition. Misunderstanding on the part of beneficiaries sometimes results. As one home health agency representative observed--"How can a beneficiary understand a term that the home health agencies and intermediaries do not agree upon?"

The Medicare handbook also states that a condition for home health care eligibility is that a doctor determine that such care is needed. This sometimes leads the patient to believe that if his doctor decides home care is needed it is covered by Medicare, although there are other conditions which must be met.

After each claim has been processed the patient is mailed a form by SSA which shows how many visits he has received and the number of additional visits he can receive during the remainder of the year. Hospital insurance pays for all covered services--for as many as 100 home health visits--furnished by a home health agency for up to a year following a hospital stay. Beneficiaries often assume that they are entitled to all the remaining visits. The number of future visits that will be paid by Medicare, however, is based on (1) a determination that the patient continues to need skilled nursing care or physical or speech therapy and (2) limitations imposed by intermediaries (see p. 19) and not necessarily the remaining visits shown on the record.

Although the form tells the beneficiary that visits shown as still available will not be paid unless all Medicare requirements are met, it also adds that the beneficiary should see the Medicare handbook for a detailed explanation of Medicare requirements. This leads the patient back to the language of the handbook, which has confused some patients.

Home health agency officials told us that confusion arises because the physician recommends home care and the claim form indicates to the beneficiary that he is entitled to receive the remaining visits but the intermediary nevertheless denies reimbursement for the care on the basis that skilled nursing care or physical or speech therapy was not needed.

As a result, beneficiaries may become irate and apprehensive because they have been led to believe they are entitled to additional visits, and their care, although recommended by a physician, is not eligible for payment under Medicare.

LIMITED PHYSICIAN AND HOSPITAL INVOLVEMENT

Physician and hospital involvement is essential to the success of home health care. Physician involvement, however, has been limited and hospitals have not always encouraged the effective use of home health care.

Physicians' involvement

Medicare requires that a physician establish a plan of treatment (1) stating the specific care needed by a patient and (2) certifying that a patient is homebound and requires skilled nursing care or physical or speech therapy on an intermittent basis. The physician is required to recertify periodically that these factors still apply.

To find out about the problems that physicians have encountered in home health care, we talked with physicians and officials of home health agencies in the States we visited. They supplied the following reasons for the physicians' reluctance to participate.

- Some physicians do not have a thorough understanding of Medicare home health benefits. A representative of the California Medical Association stated that little information on home health care is included in medical school programs. Further, some home health agencies have not been forceful in promoting through public relations, home health care.

- Physicians believe there is no incentive for them to refer their patients to home health care because they are not paid for additional work incidental to maintaining patients in home health programs (e.g., preparing treatment plans and recertifications).
- There is a potential for conflict between physicians and intermediaries. Medicare regulations provide intermediaries the authority to assist in applying safeguards against unnecessary utilization of services. Even though a physician prescribes care and certifies that it is needed, a claim based on such care can be denied by the intermediary. Some physicians are concerned because they believe their judgment is being questioned and because they must frequently attempt to explain to their patients why the claim was not paid by Medicare even though the physician might not know why the intermediary denied the claim.

The following example illustrates this situation:

Patient

Age: 71

Diagnosis: Stroke

Treatment: Speech therapy, physical therapy, skilled nursing, and home health aide.

Action by intermediary: Paid for 4 months except for skilled nursing; 5th month only speech therapy paid; 6th month denied because patient had stabilized.

Physician's comments: Appealed to intermediary after receiving concurrence from the county medical society that the care was needed.

Final disposition: Appeal not successful and payment for the care still denied. Agency wrote off approximately \$716 for care given the patient that was not allowed by the intermediary.

Physicians practicing in a small town that had recently discontinued its home health care agency, partially because of the lack of physician referrals, cited three reasons for their reluctance to use home health care:

- Convalescent homes in the area are not full, and these homes have pressured the physicians to refer patients to them in lieu of using home health care.
- Families resist home care since it is easier to put an older person in an institution.
- Physicians do not have time to devote to learning about home health care.

Some additional reasons were pointed out in our report to the Congress entitled "Study of Health Facilities Construction Costs" (B-164031(3), Nov. 20, 1972), as follows:

- A physician's method of treatment does not often require an organized home care program.
- Home care is seen as a disrupting influence on the doctor-patient relationship.
- Physicians view home care as primarily a social welfare program.

However, it is possible for a home health agency to obtain the support of physicians. For example, the number of referrals by physicians to a home health agency in Michigan increased 229 percent, from 200 in 1967 to 658 in 1971. The agency director informed us that she had worked with the medical community and agencies that provided related services for over 10 years to obtain support for home health care.

Hospitals' involvement

More cooperation is needed from hospitals to channel persons into home health care programs. In some areas where hospitals have discharge systems, the number of referrals to home health programs is generally sufficient to support the

program. Responses to our questionnaire from numerous home health agencies stated that a lack of effective discharge planning was a significant problem in home health care. According to the home health agencies, the problem may be that hospital personnel do not understand home health care.

Another barrier to hospitals' referring patients to home health care is the low occupancy rate in some hospitals.

As pointed out in our health facilities construction cost report referred to above, hospital administrators informed us that low occupancy rates in hospitals seriously affect the use of any type of out-patient services. Since physicians and hospitals play key roles in home health care programs, the success of the programs requires their involvement. However, obtaining the support of physicians and hospitals can take a great deal of time.

SSA officials recognized their responsibility to assure that beneficiaries qualifying for home health coverage should not be deprived of such services through any administrative insufficiency but expressed apprehension about any campaign to influence the health field in its health care delivery practices. SSA officials expressed the opinion that home health agencies themselves should play the primary role in encouraging the increase of professional acceptance of home health agencies.

FINANCIAL DIFFICULTIES EXPERIENCED BY HOME HEALTH AGENCIES

Financial problems have caused some home health agencies to limit their patient loads to persons for which they are certain to receive payment for care provided. At the time of our fieldwork there were four primary sources of payment for home health care--Medicare, Medicaid, community funds and grants, and the patient. The problems associated with payment for home health care under Medicaid are discussed in Chapter 4.

Denial of payment for services provided

The denial of payments to home health agencies for services which they have provided to Medicare patients, but which an intermediary subsequently determines not to be

reasonable or necessary (a retroactive denial), developed into a significant problem in the early stages of Medicare. A basic problem which has caused retroactive denials is that, at the time care was provided to Medicare beneficiaries, home health agencies were often not sure whether the care was covered by the program.

Current SSA regulations do not require advance approval of care for payment under Medicare. The Social Security Amendments of 1972, however, authorize that advance approval may be obtained under the Part A Medicare home health care benefits effective January 1, 1973, and that SSA establish periods of time during which beneficiaries would be presumed to be able to receive home health care services. (See p. 26.) However, as of January 1974, SSA had not issued regulations to implement this provision.

Several home health agencies informed us that retroactive denials have caused financial problems for them. Generally, when an intermediary denies a claim for a service provided, the only recourse of home health agencies is to attempt to collect payment for their costs from charitable organizations and/or Medicare beneficiaries. If unsuccessful, the home health agency must absorb the cost. Some Medicare beneficiaries cannot afford to pay for their care, and billing them for the cost of the care frequently causes confusion. Beneficiaries believe that, if a physician has prescribed a plan of treatment for them and they are otherwise eligible for benefits, Medicare will--and should--pay for the care.

Home health agencies often receive funds from charitable organizations, such as the United Fund, to assist in providing services. These organizations, however, do not provide as much financial support to some home health agencies as they did before the Medicare home health benefits program was enacted. Some home health agencies we visited stated that financial support from charitable organizations cannot always be depended upon because of the need for funds by many other worthy causes that they support.

We discussed the issue of retroactive denials with SSA officials. They stated that initially retroactive denials had serious impact on some agencies but the problem of

retroactive denials had been reduced considerably. They stated that these agencies had oriented themselves toward the delivery of noncovered services and encountered some difficulties in redirecting their service orientation toward the delivery of covered care under the new criteria. (See pp. 13 to 16.)

SSA officials provided us statistics that showed that the retroactive denial rate had peaked at 4.9 percent during the second quarter of fiscal year 1971. During fiscal years 1972 and 1973 the denial rate ranged from 1.7 to 2.1 and 1.5 to 1.6 percent, respectively. For the first quarter of fiscal year 1974, the denial rate was 2.1 percent. SSA also stated that the number of claims received and the number of home health agencies now participating in the program are only slightly less than the pre-1970 level.

As previously mentioned, the Social Security Amendments of 1972 provide for advance approval of home health care, under Part A only (hospital insurance), effective January 1, 1973. The advance approval provision authorizes the Secretary of HEW to establish in regulations, according to medical condition, limited coverage periods during which a patient would be presumed to require a specified level of posthospital home health services. Periods would vary depending on the patient's illness and physician's diagnosis.

We believe that the advance approval provision should help to further reduce the denial problem and create greater uniformity among intermediaries in establishing visit limitations. (See p. 18 of this report for a discussion of the lack of uniformity among intermediaries in establishing visit limitations.)

As of February 1974, SSA had not issued regulations to implement the advance approval system. We were not able, therefore, to assess the impact that this provision might have on the program. However, SSA officials said that, in their opinion, advance approval would not solve the entire problem of retroactive denials because coverage of care is presumed only for an initial limited number of visits.

The Social Security Amendments of 1972 also provide for a waiver of liability that will affect retroactive denials. Under this provision a home health agency will be paid for noncovered services under both Parts A and B if it "did not know and could not reasonably have been expected to know that payment would not be made for such items or services." In the past, the home health agency had to absorb the cost of these services if payment was denied because the intermediary believed the services were not reasonable and necessary. As of February 1974, SSA had not issued regulations to implement this provision. SSA officials advised us, however, that interim instructions were issued in March 1973 and cases were being processed under this provision effective with services furnished on or after October 30, 1972.

CONCLUSIONS

There have been some significant difficulties in the full implementation of home health benefits under Medicare. Some of these difficulties are due to SSA's administration of the program, and others relate to securing the support and cooperation of medical service providers, including physicians, hospitals, nursing homes, and home health agencies. The problem of denial of payments after services have been furnished by home health agencies still exists to some degree although the severity of the problem seems to have been alleviated.

Provisions in the Social Security Amendments of 1972 for (1) the Secretary of HEW to establish presumed periods of coverage for home health care under the hospital insurance part of Medicare and (2) payments for services that the home health agencies "did not know and could not reasonably have been expected to know" were not covered should further reduce the denial problem. However, since under the advance approval provision coverage is presumed only for an initial limited number of visits, this provision probably will not totally eliminate the problem.

The provision in the Social Security Amendments of 1972 that the Secretary of HEW provide for and conduct experiments and demonstration homemaker projects may be important in providing workable alternatives to

institutional care. It is therefore important that these projects be established to test the feasibility of providing these services.

The success of the Medicare home health benefits program depends, to a large degree, on involvement by physicians and hospitals because persons are eligible for home health benefits under the program only upon discharge from a hospital (Part A) and on a physician's recommendation (Parts A and B).

RECOMMENDATIONS TO THE SECRETARY, HEW

We recommend that the Secretary of HEW direct SSA to:

- increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding the various coverage requirements for home health services.
- review screening guidelines used by intermediaries and where significant differences exist, explore the feasibility of requiring intermediaries to apply more uniform screening guidelines.
- explore methods of further clarifying program benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.
- encourage and where considered feasible, assist home health agencies in their efforts to increase the awareness and support by the health field of home health care.
- establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of post hospital home health care services.

- determine whether implementation of the advance approval and waiver of liability provisions is effective in minimizing the problem of denials and, if necessary, advise the Congress that the amendments need modification to correct the problem.

AGENCY COMMENTS

By letter dated June 11, 1974, HEW furnished us with its comments on our findings and recommendations. (See app. I.) HEW concurred in our recommendations and advised us that a Home Health Coordinating Committee was established early in 1974 as a part of SSA's BHI to make a full-scale review of the home health provision under Medicare. The Committee will be soliciting input from all major organizations interested in home health care as well as from home health agencies presently participating in the Medicare program.

According to HEW, BHI intends to broadly assess statutory and administrative dimensions of this area of coverage to make sure that its policies and procedures are as supportive of home health care as the law permits.

Actions planned by SSA and its Committee are as follows:

- To assure more effective and uniform interpretation of instructions regarding coverage requirements, the Committee will review all issuances for needed clarification or added emphasis. It will also identify, through various reviews, those intermediaries and home health agencies appearing to need additional training in the coverage requirements of the home health benefit.
- The Committee will review the screens or parameters now used by intermediaries for their consistency with program guidelines and the characteristics of medical practice in intermediary service areas. Where they are found to be out of line, SSA will seek to have them corrected.
- SSA plans to (1) expand the explanation of program benefits and limitations section in its forthcoming revision of "Your Medicare Handbook," which will be sent

to each beneficiary, and (2) review all other informational materials and expand or clarify them where needed. Also, the Committee will make a special study to determine the need for additional communication material for beneficiaries and for those who act in an advisory or assistive capacity to beneficiaries.

- The Committee will explore the extent to which SSA can assist home health agencies in their efforts to increase the medical profession's awareness and support of the home health care program. There appear to be some reservations, however, on the degree to which SSA can legitimately pursue the matter. SSA expressed strong convictions (1) that home health agencies themselves must first work toward achieving professional community acceptance and (2) efforts undertaken by SSA on behalf of the agencies could be counterproductive to this acceptance.

- SSA expects to issue regulations soon to implement the advance approval provision of the Social Security Amendments of 1972. After the amendments have been in operation for a while, the Committee will analyze the effectiveness of the advance approval and waiver of liability provisions. In March 1973 SSA issued interim instructions to implement the waiver of liability provision.

These plans for the most part, if effectively carried out, should substantially improve the home health benefits program. The matter of professional community acceptance obviously will require time and careful application of SSA assistance.

CHAPTER 4

DEVELOPMENT OF HOME HEALTH CARE BENEFITS

UNDER MEDICAID

Because the Medicaid home health care benefits program allows States to provide preventive, skilled, and nonskilled care, it has the potential to serve as an alternative to institutional care in participating States. However, this potential has not been fully developed because SRS needs to provide more guidance to the States.

In our review of Medicaid home health benefits we found that:

- Services covered under the States' programs vary significantly.
- Some States have adopted Medicare eligibility criteria regarding the need for skilled nursing care which are more restrictive than Medicaid intended.
- States' payment rates for home health care have not been adequate.

COVERED SERVICES VARY

Under the Social Security Act, States are required to provide home health services to eligible persons who are entitled to skilled nursing home care under Medicaid. HEW regulations provide that home health services may be any of the following.

- Intermittent or part-time nursing services furnished by a home health agency.
- Intermittent or part-time nursing services of a professional registered nurse or a licensed practical nurse under direction of the patient's physician,

when a home health agency is not available to provide nursing services.

- Medical supplies, equipment, and appliances.
- Services of home health aides when provided by a home health agency.

Range of services provided

The four States we visited were providing significantly different ranges of home health care services and had different interpretations of the objectives of home health. (See p. 37 for a discussion of States' interpretations of the objectives of home health benefits.)

Under Florida's Medicaid program, home health care consists of paying for unlimited nursing and home health aide visits for persons under age 65. However, Medicare beneficiaries, also entitled to Medicaid, age 65 and over, eligible for home health care, receive such services under Medicare (Part B) rather than Medicaid. This is accomplished by the State's "buying in" these persons in the Part B Medicare program.

The buy-in program, established by section 1843 of the Social Security Act, provides that States may enroll eligible welfare recipients in the Medicare program. Buy-in involves the State's Medicaid program paying the Medicare beneficiary's share of monthly premiums, and, in some cases the deductible, and coinsurance costs under Part B. Buy-in, however, was not established as a substitute for Medicaid.

The manner in which Florida administers its program is contrary to Medicaid regulations which provide that:

"A State plan for medical assistance under Title XIX of the Social Security Act must: * * * provide that the medical and remedial care and services made available to a group (i.e. either the

categorically needy or the medically needy¹) will be equal in amount, duration, and scope for all individuals within the group * * *."

Massachusetts allows extensive care to be provided under its home health care program. State Medicaid officials informed us that the program paid for a wide range of home health services. We were not able, however, to determine the extent of services provided because Massachusetts requires its health agencies to submit only summary information on the claims submitted, claims paid, or services provided to home health beneficiaries.

Since May 1972 Massachusetts has required advance approval by a State-employed physician for all home care beyond the first 60 days. The first 60 days of care without advance approval were to be paid for on the basis of a recommendation of a patient's physician. The State's guidelines allow payment for skilled nursing care; home health aide services; physical, speech, and occupational therapy; and medical-social services.

Michigan considers its Medicaid home health benefits to be similar to Medicare home health care benefits in that to be eligible a person must need part-time or intermittent skilled nursing care or regular physical therapy. The services covered by Michigan's program are skilled nursing care, home health aide services, physical therapy, oxygen administration, and patient evaluation visits by registered nurses. The Michigan position for home health benefits coverage was stated in its guidelines to home health agencies as follows:

"The home health benefits provided under Medicaid were intended only for those beneficiaries whose conditions do not require around-the-clock medical and related care provided in hospitals and extended care facilities, but, nevertheless, are

¹Categorically needy are persons receiving financial assistance under Titles IV and XVI of the Social Security Act. Medically needy are persons whose income or other financial resources equal or exceed standards set by States to qualify for public assistance programs but are not sufficient to meet the costs of necessary medical care.

of such severity that the individuals are under the care of a physician and confined to their homes. Accordingly, home health benefits are covered only where a physician certifies to medical necessity of skilled nursing care on an intermittent basis, or physical therapy on a regular basis to a homebound patient."

We believe that the Michigan standards of providing home health benefits only to people who need skilled nursing care or physical therapy, impose a restriction on the Medicaid home health care benefits not intended by SRS under the regulations.

The Code of Federal Regulations pertaining to services and payment in Medical Assistance Programs state, under 45 CFR 249.10(a)(4) that:

"A State plan for medical assistance under Title XIX of the Social Security Act must * * * provide for the inclusion of home health services for any eligible individual who, under the plan, is entitled to skilled nursing home services * * *."

Under its home health care benefits, California requires advance approval for home visits and pays for skilled nursing care; home health aide services; medical social services; and physical, speech, and occupational therapy.

The range of services provided under the States' home health care benefits--from Michigan's restricted services to Massachusetts' extensive services--points out the need for SRS guidance to achieve greater uniformity among the States' programs by specifying required and optional services.

Eligibility for home health care

Home health services were an optional service under Medicaid until the 1967 amendments to the Social Security Act made home health services mandatory for all persons eligible for skilled nursing home care.

Near the end of calendar year 1972, SRS conducted a survey, using a checklist approach on a State-by-State basis to determine compliance, strengths, and weaknesses in the

Medicaid home health benefits and the need for additional assistance to the States by HEW's 10 regional office staffs. The survey was completed in mid-January 1973.

The survey showed that the single greatest problem limiting home health care benefits was the States' interpretations of eligibility for home health services. An agency participating in Medicaid must also be certified by Medicare or be qualified to be certified. Some States have interpreted this to mean that the services are limited to those individuals needing admission to or discharge from a skilled nursing home.

Medicaid regulations provide no such limit and are, in effect, available to all persons eligible for skilled nursing home services under Medicaid. There is no requirement that only skilled services be provided. The SRS staff reviewers noted the following problems repeatedly.

- State legislatures' low priorities for funding provided no incentive to expand home health services.
- Reimbursement rates were so unrealistically low that home health agencies could not meet their financial obligations and many were going out of business.
- Retroactive denials of payment had prevented agencies from publicizing their services as they were uncertain that payment would be allowed.
- Only one or two home health agencies planned hospital discharge because there was no organized effort to consider home health as an alternative to institutional care.
- Physicians were accustomed to practice in institutions and they either actively resisted using home health services or were unaware of such services. Where public agencies provided the service, there was greater resistance, by physicians, than in those areas where voluntary or proprietary agencies operated.
- Communications were poor between the single State agency and the home health agencies in many States.

--Where the single State agency chose not to use the services of individual licensed nurses, the program was limited to urban areas.

--There were no clear mandates as to the amount, duration, and scope of home health services under Medicaid, and State tended to go the route of least expense.

SRS found at least 15 States limiting home health services to skilled care only.

In February 1973 SRS issued a policy information memorandum which stated:

"There seems to be some misunderstanding about 'entitlement for home health service.' Some States have limited the services to those who are potential admissions to skilled nursing homes or to patients being discharged from such facilities. The narrow interpretation given by some States to the title XIX home health regulation has denied home health services to some persons who are eligible and in need of such services.

"The law (P.L.90-248 subsection 224(c)(ii)) states that home health services must be available 'to any individual who is entitled to skilled nursing home services.' Any person who is eligible for Medicaid and is 21 years of age is automatically eligible for home health services if the care is ordered by his physician, whether or not he may need admission to a nursing home. If the State plan provides skilled nursing home services for individuals under age 21, they too are automatically eligible for home health services. In contradistinction to Medicare, title XIX has no requirement that these be 'skilled' services; i.e., reimbursement may be made for services that are less than skilled. For example, home health aide services or medical supplies and equipment can be provided without requiring that another skilled service be needed by the patient.

"States which have adopted an eligibility definition not in conformity with the above

description should be advised of the appropriate scope of the program and requested to either submit a plan amendment or revise operating procedures in order to bring their home health care program in conformity with the title XIX statute and implementing regulations."

Some States, like Michigan, have adopted the Medicare requirement of a need for skilled nursing care or physical therapy as an eligibility prerequisite for Medicaid home health benefits. These States are therefore applying more restrictive eligibility requirements for Medicaid benefits than the program intended.

The policy information memorandum should help to clarify this situation.

STATES' VIEWS OF HOME HEALTH AS
AN ALTERNATIVE TO INSTITUTIONAL CARE

Although Medicaid home health benefits are intended to offer an alternative to institutional care, some States have not administered them as such because SRS has not conveyed the benefit program's intent to the States.

In August 1967 the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, in hearings on the Social Security Amendments of 1967, explained that the rationale for making home health care a required service under Medicaid was that it would provide a major alternative to institutionalization for persons with minimal health needs. In November 1967, the Senate Finance Committee in its report on the Social Security Amendments of 1967, stated that home health services are needed under Medicaid to insure the availability of a more economic alternative to skilled nursing home and hospital care. SRS, which is responsible for establishing policy and developing operating guidelines for the Medicaid home health care benefits program, also views the program capable of serving as an alternative to institutional care.

Michigan Medicaid officials agreed that home health care is one alternative to institutional care. Florida Medicaid officials stated that, though they have not implemented home health care as an alternative to institutionalization because of inadequate funding, they have always viewed it

philosophically as an alternative. State Medicaid officials in California agreed that the program was not operating as an alternative at the time of our fieldwork but said they intended to pursue the idea of using home health care as an alternative to institutional care. Massachusetts Medicaid officials viewed home health care as an alternative to institutional care and appeared to be developing means to attain this objective.

ENCOURAGEMENT NEEDED FOR STATES TO INCREASE PAYMENT RATES TO STIMULATE GREATER UTILIZATION

Title XIX of the Social Security Act, as amended, provides that reasonable costs be paid for inpatient hospital services, subject to Medicare limits, and that effective July 1, 1976, reimbursement of skilled nursing homes and intermediate care facilities be on a reasonable cost-related basis. Other providers of Medicaid services may be reimbursed at a rate which may be less than reasonable costs. States' payment rates for home health services differ significantly and some States have established extremely low rates which have had an adverse financial impact on the program. SRS has not provided States enough guidance on establishing payment rates to encourage greater utilization of home health care.

SRS regulations relating to payment for medical services under Medicaid, including home health care services, require States to establish fee structures which are designed to enlist participation of a sufficient number of providers of services so that medical care and services are available to eligible persons to the same extent that they are available to the general public. Regarding home health care the regulations provide that payments be limited to customary charges that are reasonable for comparable service considering the standards and principles for computing reimbursement to home health agencies under Part B of the Medicare program.

However, for skilled nursing care, Medicaid payments are considerably below Medicare payments in some States. In California, for example, home health agencies that responded to our questionnaire received an average payment per visit of \$19.51 under Medicare for providing skilled care, but for

providing the same service under Medicaid agencies received a flat rate of \$13.13. In Florida, the average payment was \$8.68 under Medicare and \$5 under Medicaid.

Payment rates in Florida and California for home health care are established by the respective State agencies on the basis of a flat fee per service and are paid to home health agencies statewide. The Massachusetts Rate Setting Commission establishes payment rates in Massachusetts; in Michigan and five other States, home health agencies are paid on a reasonable cost basis using the same standards and principles established for Medicare.

Florida spent about \$51,000 during fiscal year 1972 to provide home health care under Medicaid. State Medicaid officials acknowledged that their payment rates were low but informed us that the State could not afford to pay higher rates. Home health agencies in Florida, responding to our questionnaire, reported costs of providing skilled nursing care ranging from \$9.15 to \$14.17 per visit and the costs of home health aide services from \$6 to \$7.98 per visit. In California, home health agencies reported costs of \$12 to \$31 for a skilled nursing visit in the home and \$6.50 to \$20 for the hourly services of home health aides.

CONCLUSIONS

Medicaid home health benefits have the potential for becoming an effective alternative to institutional care when home health care would meet the patient's needs. To fully realize this potential, however, SRS needs to provide more guidance on (1) the objectives of the program, and (2) the scope of allowable home health care services. Also, SRS should encourage the States to establish adequate payment rates to stimulate greater utilization of home health care.

This additional guidance is needed to overcome the States' differing interpretations of the program's objectives; their confusion concerning the scope of allowable services; and problems associated with low payment rates that result in home health agencies being reimbursed at less than their cost of providing the services.

RECOMMENDATIONS TO THE SECRETARY, HEW

To improve the administration of the Medicaid home health care benefits program, the Secretary should direct SRS to:

- Impress upon the States that home health care is generally a less expensive alternative to institutional care and is therefore intended to be used when home health care would meet the patient's needs and reduce costs.
- Clarify for the States the specific home health services which are eligible for Federal financial participation and define these services.
- Encourage the States to establish payment rates for home health care at a level that will stimulate greater utilization of home health care.
- Encourage and assist home health agencies in their efforts to increase the awareness and support of the health field regarding Medicaid home health care benefits as an alternative to institutional care.

AGENCY COMMENTS

In a letter to us dated June 11, 1974, HEW concurred in our recommendations and said that the following actions would be taken.

- SRS will emphasize to the States the importance of careful appraisals of alternatives to institutional care and the use of home health care whenever indicated. In this respect HEW observed that the Social Security Amendments of 1972 tightened requirements for the admission of patients to skilled nursing facilities and, as a result, the demand for home health services should increase.
- SRS plans to revise Medicaid home health regulations to include more definitive requirements that will aid in assuring uniformity and preventing misinterpretation as to which services are eligible for Federal financial participation.

- Although SRS does not have the authority to require States to adopt a certain level of payment for home health care, it will emphasize to them the importance of realistic payment rates as a means of encouraging more frequent use of home health care services.

- SRS will look for steps it can take to encourage support of home health care by the medical profession. At the same time, it believes that significant improvement in physician awareness and support of home health care will be derived from recent legislative action. The Social Security Amendments of 1972 require that, in prescribing institutional care, the physician certify that this represents the best means of treatment for his patient. SRS believes that in making such certifications physicians will have to become more aware of and know more about available home health services. In addition, physicians should become increasingly aware of the benefits of home health because of provisions in the Health Maintenance Organization Act of 1973 which requires participating health maintenance organizations to make home health services available to their members.

We agree that the recently enacted legislative provisions and SRS' plans for further involvement should increase the awareness of and the use of home health services. The administrative actions, which SRS is taking and plans to take, should also prove beneficial to participants and strengthen the program in general.

CHAPTER 5

SCOPE OF REVIEW

The objectives of our review of Medicare and Medicaid home health care benefits programs were basically to determine (1) whether home care, as currently being implemented, has the potential to be a workable alternative to institutional care when medically feasible, and (2) if not, what improvements are needed. To accomplish these objectives we:

- reviewed the legislative history of the home health care benefits programs under Medicare and Medicaid,
- examined HEW's policies and procedures for administering these benefit programs, and
- examined the policies, procedures, and practices followed by selected States, fiscal intermediaries, fiscal agents, and home health agencies in administering the programs.

We visited California, Florida, Massachusetts, and Michigan to obtain detailed information on Medicare and Medicaid home health care benefits. These States were selected because they were geographically distributed in four HEW regions and had substantial combined Medicare and Medicaid expenditures. Written comments on our findings were obtained from these States and were considered in preparing this report.

Also, we sent questionnaires on the Medicare and Medicaid home health care benefits to 11 other States--Connecticut, Illinois, Louisiana, Minnesota, Missouri, New York, Ohio, Oregon, Pennsylvania, Texas, and Wisconsin. We received 65 responses to the 91 questionnaires sent to home health agencies in these States.

In all 15 States, we obtained information from State agencies administering Medicaid, fiscal agents, fiscal intermediaries, and home health agencies.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUN 11 1974

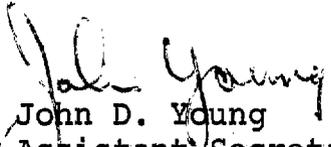
Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary has asked that I respond to your letter of March 14, 1974, in which you requested our comments on your draft report entitled "Development of Home Health Care Benefits Under Medicare and Medicaid." Our comments are enclosed.

We appreciate the opportunity to comment upon your report before it is released in final form.

Sincerely yours,


John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX I

COMMENTS ON GAO'S DRAFT REPORT ON "DEVELOPMENT OF THE MEDICARE AND MEDICAID HOME HEALTH CARE PROGRAMS"

We have carefully reviewed this GAO draft report and concur in its recommendations. In our opinion, the report presents a generally fair and objective appraisal of Medicare and Medicaid coverage in the home health care area. It discusses, in appropriate perspective, both administrative problems and accomplishments in effectuating the home health care benefit within the statutory limitations under which we have to operate.

The measures that we have taken or are taking to implement GAO's recommendations are summarized below.

MEDICARE

Earlier this year SSA established a Home Health Coordinating Committee in the Bureau of Health Insurance to make a full-scale review of the home health provision under Medicare. As part of the review, they will be soliciting input from all major organizations interested in home health care as well as from the home health agencies presently participating in the Medicare program. In short, the Bureau of Health Insurance intends to broadly reassess the statutory and administrative dimensions of this area of coverage to make sure that its policies and procedures are as supportive of home health care as the law permits. The following recommendations and comments relate specifically to the Medicare program.

Recommendation: That SSA increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding the various coverage requirements for home health services.

We concur. The Home Health Services Coordinating Committee will review all substantive and procedural issuances relating to home health services for areas of potential clarification or further emphasis and will identify, through reviews of adjudicative results, those intermediaries and home health agencies who appear to need additional training in the coverage requirements of the home health benefit.

Recommendation: That SSA review screening guidelines used by intermediaries and, where significant differences exist in service limitations, explore the possibility of requiring intermediaries to apply more uniform screening guidelines.

We concur. The Committee will review the screens or parameters now used by the intermediaries and will determine whether they are consistent with program guidelines and with the characteristics of medical practice in the various intermediary services areas. Where they are found to be out-of-line, SSA will take appropriate steps to have them corrected.

Recommendation: That SSA explore the possibility of further clarifying program benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.

We concur. SSA will expand the explanation of home health benefits in the forthcoming revision of "Your Medicare Handbook" which we plan to send to each Medicare beneficiary in August or September of this year. At the same time, SSA will review all other informational issuances and will expand or clarify them where needed. Also, the Home Health Services Coordinating Committee will make a special study to determine the need for additional communication vehicles to better reach beneficiaries and other groups within the general and professional public who act in an advisory or assistive capacity to beneficiaries.

Recommendation: That SSA encourage and, where considered feasible, assist home health agencies in their efforts to increase the medical profession's awareness and support of the home health care program.

We concur. The Committee will explore the extent to which this kind of assistance can be rendered by the Medicare program. The degree to which this effort would be legitimate on Medicare's part will have to be studied since it is SSA's strong conviction, first, that home health agencies themselves must work toward achieving professional community acceptance and, second, that efforts undertaken by SSA or the Medicare program on the agencies' behalf could be counterproductive to this acceptance.

Recommendation: That SSA establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of post hospital home health care services.

We concur. As a matter of fact, SSA expects that these regulations will be ready for issuance under the Notice of Proposed Rulemaking procedures in the very near future.

Recommendation: That SSA determine whether implementation of the advance approval and waiver of liability provisions is effective in minimizing the problem of denials and, if necessary, advise the Congress that the amendments need modification to correct the problem.

APPENDIX I

We concur. The Home Health Services Coordinating Committee will, after the amendments have been in operation for a period of time, make an analysis of the effectiveness of the advance approval and waiver of liability provisions. Depending on the outcome, SSA will take whatever follow-up steps may be appropriate.

MEDICAID

The following recommendations and comments relate specifically to the Medicaid program.

Recommendation: That SRS impress upon the States that the home health care program generally is a less expensive alternative to institutional care and, because of this, it is intended to be used as such when home health care would meet the patient's needs and reduce program costs.

We concur. The Social Security Amendments of 1972 tighten requirements for the admission of patients to skilled nursing facilities and, as a result, the demand for home health services should increase as more careful appraisals are made of alternatives to both skilled nursing and intermediate care facility services. SRS will emphasize to the States' the importance of careful appraisals of alternatives to institutional care, and the use of home health care whenever indicated.

Recommendation: That SRS clarify for the States the specific home health services which are eligible for Federal financial participation and define these services for the States.

We concur. SRS plans, in revising Medicaid home health regulations, to include more definitive requirements that will aid in assuring uniformity and preventing misinterpretation.

Recommendation: That SRS clarify for the States the fact that their payment rates for home health care should be established at a level that will encourage utilization of the home health care program.

We concur. While we do not have the authority to require States to adopt a certain level of payment for home health care, SRS will emphasize to them the importance of realistic payment rates as a means of encouraging more frequent use of home health care services.

Recommendation: That SRS encourage and assist home health agencies in their efforts to increase the medical professions

awareness and support of the Medicaid home health care program as an alternative to institutional care.

We concur. In responding above to GAO's first recommendation relating to Medicaid, we mentioned the Social Security Amendments of 1972. These Amendments also require that, in prescribing institutional care, the physician must certify that this represents the best means of treatment for his patient. SRS believes that physicians, in making these certifications, will have to become more and more aware of, and knowledgeable about, the home health services that are available. In addition, the Health Maintenance Organization Act of 1973 requires participating HMO's to make home health service available to their members. So that, here again, physicians should become increasingly aware of the benefits of home health care. While we believe that the implementation of these legislative provisions should lead to significant improvement in physician awareness and support of home health care, SRS will look for steps that it could take to further encourage such support.

APPENDIX II

PRINCIPAL HEW OFFICIALS
RESPONSIBLE FOR ADMINISTERING
ACTIVITIES DISCUSSED IN THIS REPORT

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ASSISTANT SECRETARY FOR HEALTH:		
Dr. Charles C. Edwards	Apr. 1973	Present
ADMINISTRATOR, SOCIAL AND RE- HABILITATION SERVICE:		
James S. Dwight, Jr.	June 1973	Present
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Dr. Keith Weikel (acting)	July 1974	Present
Howard N. Newman	Feb. 1970	June 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969
COMMISSIONER, SOCIAL SECURITY ADMINISTRATION:		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973
DIRECTOR, BUREAU OF HEALTH INSURANCE:		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967