

Perspectives on Aging: A Multidisciplinary Approach.

By Catherine DeLorey, MPH, DrPH

Home health care at the beginning of the 21st Century is a microcosm of all that is both good and bad with our total health care system. It has highly dedicated and committed workers and organizations attempting to provide services in an imperfect system. Meanwhile, it is functioning in a morass of changing and cumbersome regulations within confusing reimbursement mechanisms.

Home care services are a complex array of services ranging from assistance for activities of daily living, to highly technical health care services. Providers of these services range from informal, untrained family members to sophisticated highly trained health care professionals. Perhaps the only underlying consistency is that these are health services offered outside an acute or long term care facility. Although many organizations, agencies and health professional are involved in providing home health care, home health care is essentially an issue of midlife and older women. The role of the untrained family member, most often a woman, in home health services is a major contribution to the services provided and although difficult for the caregiver, provides a substantial financial savings to health care. More than

72% of informal caregivers are daughters or wives of home care patients, and women receive the bulk of long term care services, including home health care. (HRSA 2003, Katz 2000, Levine 1999)

This disparity not only impacts on women within the health care system, but has societal ramifications, as cited by Senator Hillary Rodham Clinton in testimony before a joint senate committee: (Aging Subcommittee 2002)

- 1. Women outnumber men among the aging population. Thus women suffer disproportionately from our failure to develop a coherent long-term care financing system, a problem exacerbated by the fact that older women are also twice as likely as men to live in a nursing home, and twice as likely to live in poverty.**
- 2. An underlying reason our care giving system is in disarray, and why these important functions are undervalued, under-financed, and too often uncompensated in our society is because it was work that women performed in the homes. We too often take for granted the contribution that women made as caregiver. For too long, this work was "invisible," no one paid for it, and it didn't show up in the GDP.**
- 3. Just because family caregiving is unpaid does not mean it is costless. The costs include not just time, and lost economic opportunities, but**

also personal strain and fatigue, and poor health. These costs should be recognized and this caregiver must be supported, through respite care and other services.

4. We are quickly realizing that our country is suffering not just from a budget deficit, but what has been called, "a care deficit."

Medicare's Role in Home Health Care

Medicare was one of the most important entitlements of the Older American's Act of 1966. However, in 1996 Medicare redefined home care to include only those selected functions and prescribed circumstances that were reimbursable. It created a narrowly defined, fragmented, and uncoordinated set of acute-care services not well adapted to the chronically ill at home.

Through Medicare, home health care was established as an alternative to institutional care. Therefore, service selection and delivery patterns were based on institutional patterns rather than seeing home health care as a unique to the continuum of appropriate care for elders.

The History of Home Health Care

To begin to understand the complexities of home health care today, we must first visit its interesting and varied history. We will see that home health care did not grow out of perceived need and then plan to meet that need. Instead,

it developed out of an array of motivations, from the benevolent "Lady Bountifuls" of the 19th Century, to health departments, voluntary agencies, and insurance companies with their own incentives. This led to a great deal of overlap in services and a strange amalgam of means to finance these services. Throughout this history, the goal and function of home health care has changed as those who managed and paid for it determined what it is. (Rosen 1993) We have yet to overcome this legacy.

We will focus on how home health care has been provided to all persons, not just to older persons, because the history of home health care is rich, complex and reflective of the social history of each era surrounding it, not just to older persons. Knowing this history helps us to understand the roads home health care has traveled, and helps to give us insight into where it may be going. Putting elders into the picture expands the complexity and highlights the ambivalence of what home health care is, or should be.

Home health care has existed for millennia but the contemporary path of home health care parallels that of increased urbanization and the development of the profession of nursing. At the beginning of the 19th century, home health care was a part of familial life. The person with medical

needs was cared for by family, servants or neighbors. However, for those without those resources, there were few options.

It is from an observation of this condition, that one of the first formal home care providers, the Ladies Benevolent Society of Charleston, South Carolina focused on caring for the sick at home. At mid-century, both in the north and south of the United States, upper class, affluent women, also known as “Lady Bountifuls” worked together to address the social needs of their communities. This naturally led them to the dilemma of caring for the sick at home who hired other women to provide services. Yet even then, need was always greater than available resources.

From the beginning there were questions concerning who were the worthy recipients of care. This reflects the conundrum in all of social welfare services at that the time - who were the “worthy poor.” The Ladies benevolent Society continued until the end of the century, constantly dealing with how to pay for services, what services to offer and to whom,

As immigration to the United States increased and cities enlarged, affluent women in northern cities also took up the challenge of providing care for the poor sick in the cities. By this time they were impressed with the British

model of providing trained nurses to visit in the homes to give care. Thus, was the beginning of the Visiting Nurse Associations (VNA).

Throughout the end of the 19th century and beginning 20th century, VNAs as voluntary, women-dominated organizations developed. Yet as these organizations and their scope grew, they needed more professional management. These women leaders of the VNAs complemented their managerial skills and supplemented their own financial contribution through fundraising activities and solicitations among their peers. This growth and development of the voluntary VNAs became the initial expression of formal home health care in the United States.

Trained nurses in the home focused on providing direct care, including dealing with contagious illnesses. Since most of this care was to the evolving and revolving poor, immigrant communities, the role of the trained nurse evolved into that of health educator with care giver. The trained nurses were for the sick poor and dealt primarily with the dangerous sick, that is, persons with communicable diseases. These attracted the attention of benefactors as well as caregiving organizations. The ‘uninteresting sick’ were those persons with chronic diseases, who at that time were seen only as passive individuals needing nothing more than custodial care. Lillian Wald, a graduate nurse

from an affluent New York family, was the first to coin the phrase, public health nurse, after visiting some neighborhoods of the lower east side of New York City. She saw the squalor and illnesses there as a breakdown of society's infrastructure, not just the impact of contaminants or bacteria.

Although the voluntary agencies were effective, advances in technology in the mid-1900's gradually made care in an institutional setting more economical and home care became less popular. Home care continued to diminish with the boom of employer-paid health benefits during World War II. Finally, the idea of the house call and home care became archaic.

As home care organizations developed, other players entered the arena. In addition the voluntary organizations, private organizations and health departments became a part of the scene. This was not necessarily a positive development as home health care evolved to be responsive to social changes rather than a leader to determine how to meet health needs outside of institutions. This unbridled growth became so uncoordinated that by 1909, in NYC there were 58 organizations which sent out 372 nurses (Buhler-Wilkerson, 2001).

Because there were no societal regulations or formal planning of the growth of the home health care industry, the unchecked growth of agencies let

to an overlap of responsibilities of voluntary, private, and public organizations. Health departments are by statute, responsible for the general health of the community and concerned with prevention of disease and health promotion.

Because of the formal role of health department some of the unintended consequences of the increased use of nurses by health departments were that publicly supported nurses were seen to be for prevention and home care of the sick was left to the voluntary agencies, or VNAs. This dichotomy is still prevalent.

By 1911 a new era evolved in home care as the Metropolitan Life Insurance Company was convinced that by providing for nurses to visit in the home it would be cost saving for the company. The rationale being that it would save the insurance company revenues by keeping people healthier through the intervention of Public health nurses. This was a forward thinking and dynamic program. But, as hospital growth increased and it seemed that home visits were not financially efficient, Metropolitan Life Insurance slowly exited its home care services.

Although home care generally decreased during the 1940s, it was at this time that Montefiore Medical Center in the Bronx began its "hospital without

walls" program. Physicians, nurses, and other clinical professionals successfully administered care to community residents in their homes, and the program ultimately served as a model for modern home health agencies.

The uncharted growth of health care agencies continued so that by the 1950's there was a patchwork of funding mechanisms, including:

1. Community Chests, (United Way), providing 44% of home health care costs
2. Private patient fees, providing 16% of home health care costs
3. Municipal funds, providing 15% of home health care costs
4. Private contributions, providing 10% of home health care costs
5. Public welfare, including Veterans Administration, providing 15% of care costs

As with all aspects of health care, home health care has influenced and been influenced by larger societal trends and social history. Its role and function has evolved through the constant pull of economic and social trends.

Among these has included the ambivalence in United States culture between individual responsibilities versus community responsibility. This was a conflict at the time of the Ladies Benevolent Society - and it continues today. Who are the worthy sick and who is not deserving of society's beneficence. How do we decide what to pay for, how much to pay, and what we will ask the individual to pay?

With the advent of Medicare in 1965, home care began to gain momentum. By the end of the 1980s, the number of Medicare-certified home care agencies had tripled [Gunderson 1999]. Home health care has gone in and out of favor, but in all its iterations it has never really been defined and lacks a distinct identity that describes it in more than the obverse of other types of health care.

Home Health Care Defined

In its simplest definition, home health care is health care offered in the home. But, there the simplicity stops. It is actually more than health care - it is a full range of services, complementing health care to keep the individual as healthy as possible in the non-institutional setting.

Because we are focusing on the elder population, we will only address home health care as it relates to older persons, but we cannot lose sight of the fact that home health care is offered to individuals of all ages, from the spewing infant sent home with a major congenital anomaly who needs habilitation, to the young person who has a bullet lodged in the spine, to the person with a chronic condition needing ongoing care. Home care has always been the subject of controversy. Home care includes, persons of all ages who are receiving health and medical care in the home - from persons who are

post-operative, to persons receiving rehabilitative care, to persons receiving maintenance care for chronic disease conditions and to persons receiving end of life care through home hospice, which will be discussed in Chapter 10, End-of-Life Care.

The wide range of services can mean personal care like bathing, toileting, and dressing, or it can mean highly skilled care with complex medical procedures, similar to those received at acute care facilities, such as kidney dialysis.(Calkins 1999, Campion 1995)

These services are delivered at home to recovering, disabled, chronically or terminally ill persons in need of medical, nursing, social or therapeutic treatment, and/or assistance with the essential activities of daily living. One could even consider care offered in an assisted living facility as home health care, since it is care offered in the resident's home, and the health care services are not offered by the institution.

Aging brings many changes for our parents, most important among these changes is the fight for independence as they may lose the ability to drive, enjoy hobbies, see, hear or simply complete daily activities of living. However, in planning for retirement, older people tend to focus their efforts on financial, legal and estate issues. What are often mistakenly overlooked are

the issues of housing and care. These needs are left until a medical trauma occurs and, as a result, we are forced to make uniformed care decisions with considerable pressure and speed. These decisions may seriously impact a caregiver life. More than one in four caregivers have quit, retired or experienced other job changes as a result of their care responsibilities.

Generally, home care is appropriate for a person who needs ongoing care that cannot easily or effectively be provided solely by family and friends, but does not need to be in a hospital or other facility. More and more older people, electing to live independent, non-institutionalized lives, are receiving home care services as their physical capabilities diminish. (Fried 2000, Gunderson 1999, Naylor 1999, O'Leary 1999) As hospital stays decrease, increasing numbers of patients need highly skilled services when they return home. Other patients are able to stay at home to begin with, receiving safe and effective

Although Medicare altered the definition of home health care to being an alternative to institutional care, rather than a service in its own right, providers of home care have continued to abide by the principles of public health prevention while providing their services in an ever changing health care environment (Welch, 1996). Older persons with a health conditions

serious enough to warrant home health care do not just receive custodial, unplanned care.

Health Promotion: Primary, Secondary, and Tertiary Prevention

In addition to acute health care services, care is provided that includes the three levels of prevention basic to any public health practice. Primary, secondary and tertiary prevention are as relevant to care for older persons with chronic conditions as in any other health care domain. Health promotion and disease prevention improves the health status of older persons without increasing the costs, in the long run (Lubitz, 2003).

Primary prevention is intervention or care provided to individuals to prevent the onset of a condition (U.S. Preventative Services Task Force 2000). This can include health education, health communication, social marketing to prevent or stop smoking, as well as interventions such as immunizations. In home care for elders these activities could consist of the provider recommending flu or pneumonia immunizations, education to client and family on appropriate nutrition, or safety factors in the home.

Secondary prevention measures as those that identify and treat persons who have developed risk factors or preclinical disease but in whom the condition may not be clinically apparent. Examples of these activities focus on

early case finding to avoid further complications. Screening tests are examples of secondary prevention activities. With early case finding, the natural history of disease, or how the course of an illness unfolds, can often be altered to maximize well-being and minimize suffering. In the arena of elder home care these interventions can consist of screening for anemia, diabetes, hypercholesteremia and making appropriate counsel. A very important role of the nurse providing care in the home is anticipatory guidance. Since the nurses are really caring for the whole family unit, not just the elder client they can look to the future to anticipate issues that might arise and help the family and client prepare for them. Palliative care and issues of death and dying are significant tasks to help families prepare for in a manner appropriate for all.

Tertiary prevention activities involve the care of established disease, with attempts made to restore to highest function, minimize the negative effects of disease, and prevent disease-related complications. The aim of tertiary prevention in older people is to identify and alleviate established disease at an early stage, in order to improve or maintain functional status. The rationale depends on the ability to prevent disability and handicap, but not necessarily the impairment itself, which may not be amenable to a specific treatment. Unreported need plus multiple pathology and morbidity have a cumulative

effect. So where one problem might be relatively minor, the cumulative effect of several problems may result in loss of function (e.g. poor mobility) and reduction in quality of life.

The Demographics of Home Health Care

Chapter one of this book introduced the reader to the demographics of aging: persons 65 years and older now account for 35 million of the population; by 2030, the older population will number over 70 million (Tepper, 2004). The over-65 population is steadily growing, and it will continue its upward pattern in the coming years. Medical advances, preventive care and a greater understanding of the benefits of a healthy lifestyle have contributed to an increase in the average life expectancy. Upon reaching the age of 65, males may expect to live an additional 16.3 years, and women, 19.2 years (Administration on Aging 2002). This increased longevity has major implications for families and society.

As people age, chances increase that they will develop a chronic condition or a physical or cognitive disability for which they will require assistance. For example, 47% of individuals 50-64 years of age have some type of chronic condition but no disability, while 83% of individuals 85 years of age and older

live simultaneously with chronic conditions, disability and accompanying functional limitations.

Who Are Recipients of Care?

The aging baby boomer generation will soon be more than a prediction, and family members, who often provide at least a portion of care to their aging relatives, are often unprepared to deal with the many issues facing the senior and themselves. From planning a change of residence to communicating effectively, there are many simple, yet overlooked ways to ease caregiving for the elderly and their family members when home care is needed.

Deciding what services and how they will be provided is a complex question, depending where on the continuum of need the person sits, as well as what social supports and family resources are available. (Lieberman 2000)

A person living alone without social or family supports will need intervention before the person with strong supports. This is one reason that women require more health care supports as they age - they have often taken care of a spouse who may have died, or the spouse may not be able to take on the responsibilities needed.

An increasing number of individuals are receiving health care at home or community-based settings rather than in institutions. In 2000, 1,355,300

Americans received home health care services. Of these, females comprised 877,900 (64.8 percent) of recipients. The majority of women receiving home health care were aged 65 years or older (76.1 percent). Women aged 85 and older received 25.6 percent of home health care, followed by women between the ages of 75-79 (18.4 percent) (HRSA, 2003).

In 2000, 73.2 percent of female and 78.3 percent of male home health care patients received skilled nursing services. Additional services commonly provided to home health patients include personal care, physical therapy, and homemaker household services (Ibid, 2003).

Increasing numbers of women and men are turning to hospice care to meet their end-of-life needs. Between 1992 and 2000, the number of hospice care patients increased from 52,000 to 105,500. Women narrowly outnumbered men in the number of hospice care patients, comprising 53.5 percent of patients in 1992 and 57.4 percent of patients in 2000 (Ibid, 2003).

Service Providers in Home Health Care

Home health care agencies, provide much of the care to older people in the community. Some are private, profit-making organizations, and some are non-profit. They provide services such as meals, nursing care (RN's, LPN's, CNA's, and home health aids), occupational therapy, and physical therapy.

The structure of how home care is organized can seem complex. Public Health Nurses, community health nurses, are providing a majority of care.

One of the major characterizations for health professionals doing home health care is that they are not in a clinical setting where they are surrounded by a system of professional and mechanical resources. Home health care worker is guest in patient's home. Home is the patient's domain, not the health workers

This type of care requires a specialized health care professional. Although there are nursing programs that prepare nurses for specialized home health care, these resources are lacking for physicians so that care from physicians is more variable (Wenger 2003).

In 1997, at least 52 million people in the United States provided informal, or unpaid care for family members or friends (National Alliance for Caregiving 1997). Estimates put the value of unpaid care annually at \$196 billion (Arno, 1999, Emmanuel 2000). As important and rewarding as caring for family or friends might be, paid home care services may also be required to supplement informal care because of work responsibilities, geographic distance or the caregiver's own limitations. In 1998, formal, or paid, home care services were used by 28% of individuals aged 50-64 years who required

help with activities of daily living (Gibson, 2003). Only nine percent of the same age group used paid home care services. In the same year, the greatest increase in use of paid home care occurred in the 75-84 year old age bracket. Forty eight percent of the older age group used paid home care and 26% used paid home care (Ibid, 2003).

Home health care is available through hospitals, home health care agencies and public health departments. It encompasses services provided by nurses, therapists and home care aides, including:

- 1. Health care, i.e., nursing, social work, physical and rehabilitative therapy, medication monitoring and medical equipment**
- 2. Personal care, such as assistance with personal hygiene, dressing, bathing and exercise**
- 3. Nutrition including meal planning, cooking and meal delivery**
- 4. Homemaking, including housekeeping, shopping and household paperwork**
- 5. Social and safety needs such as transportation services, companions and a daily telephone check**

Program of All Inclusive Care for the Elderly (PACE)

The PACE programs grew out of the On Lok model of providing health care to frail elders, created in San Francisco in 1971. On Lok means "peaceful, happy abode" in Cantonese (Bodenheimer, 1999). PACE is unique. It is an optional benefit under both Medicare and Medicaid that focuses entirely on older people, who are frail enough to meet their State's standards for nursing home care. (CMS 2003,a)It features comprehensive medical and social services that can be provided at an adult day health center, home, and/or inpatient facilities. For most patients, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services which are integrated into a complete health care plan. PACE is available only in States which have chosen to offer PACE under Medicaid.

Eligible individuals who wish to participate must voluntarily enroll. To be eligible, a person must:

- Be at least 55 years of age**
- Live in the PACE service area**
- Be screened by a team of doctors, nurses, and other health professionals**
- Sign and agree to the terms of the enrollment agreements**

PACE offers and manages all of the medical, social and rehabilitative services their enrollees need to preserve or restore their independence, to remain in

their homes and communities, and to maintain their quality of life. The PACE service package must include all Medicare and Medicaid services provided by that State. At a minimum, there are an additional 16 services that a PACE organization must provide, e.g., social work, drugs, nursing facility care.

Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals.

When an enrollee is receiving adult day care services, these services also include meals and transportation. Services are available 24 hours a day, 7 days a week, and 365 days a year. Generally, these services are provided in an adult day health center setting, but may also include in-home and other referral services that enrollees may need. This includes such services as medical specialists, laboratory and other diagnostic services, hospital and nursing home care.

An enrollee's need is determined by PACE's medical team of care providers. PACE teams include primary care physicians and nurses, physical, occupational, and recreational therapists, social workers, personal care attendants, dietitians, and drivers. Generally, the PACE team has daily contact with their enrollees. This helps them to detect subtle changes in their

enrollee's condition and they can react quickly to changing medical, functional, and psycho-social problems.

Hospice and Home Health Care

A hospice is a facility that provides inpatient, outpatient or home care for the terminally ill person. This care is palliative, not focused on attempting to cure a condition but instead is intended to provide as positive an end of life experience for the client and family by alleviating pain, dealing with symptoms, and make the person as comfortable as possible. (Pearson 1999, Schultz 2003)

When congress passed the TEFRA (Tax Equity and Fiscal Responsibility Act), legislation in 1982, it created a Medicare hospice benefit (PL 97-248).

Hospice services may be provided to terminally ill Medicare beneficiaries with a life expectancy of six months or less - if the disease runs its normal course.

Home Health Care Agency Certification

Effective with the enactment of the Balanced Budget Act of 1997, PL 105-33, (Social Security Online, 2003), the Medicare hospice benefit was divided into the following benefit periods: (1) an initial 90-day period; (2) a subsequent 90-day period, and (3) an unlimited number of subsequent 60-day benefit periods as long as the patient continues to meet program eligibility requirements.

The beneficiary must be recertified as terminally ill at the beginning of each benefit period. The following covered hospice services are provided as necessary to give palliative treatment for conditions related to the terminal illness:

- **nursing care**
- **services of a medical social worker**
- **physician care**
- **counselor - including dietary, pastoral, and other**
- **home care aide and homemaker**
- **short-term inpatient care (including both respite care and inpatient care for procedures necessary for pain control and acute and chronic system management)**
- **medical appliances and supplies, including drugs and biologicals**
- **physical and occupational therapies**
- **speech-language pathology services.**
- **bereavement service for the family is provided for up to 13 months following the patient's death.**

Medicare hospice participation has grown at a dramatic rate, largely as a result of a 1989 Congressional mandate (PL 101-239 that increased rates by

20%. From 1984 to January 2002, the total number of hospices participating in Medicare rose from 31 to 2,265—more than a 73-fold increase. Of these hospices, 1,003 are freestanding, 690 are home health agency-based, 552 are hospital-based, and 20 are skilled nursing facility-based.

For an agency to receive Medicare reimbursement it must be certified by the Centers for Medicaid and Medicare Services. (HCFA 1998) The Outcome and Assessment Information Set (OASIS), the primary method used by Medicare to certify home health agencies, is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient. In addition, it forms the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI).

The OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and is proposed to be an integral part of the revised Conditions of Participation for Medicare-certified home health agencies (HHA).

Most data items in the OASIS were derived in the context of a CMS-funded national research program to develop a system of outcome measures for home health care. Overall, the OASIS items have utility for outcome

monitoring, clinical assessment, care planning, and other internal agency-level applications (CMS 2003).

Paying for Home Health Care

The crazy quilt of reimbursement mechanisms and regulations in home health care reflect what occurs in the larger health care system, but in reality are magnified. As we saw in the discussion of the origins of home health care, it has been responsive to community needs rather than proactive. This results in a service that is constantly changing to meet external forces, rather than to meet the needs of the constituency it serves.

Although there are many players in the reimbursement orchestra for elders, the major player and conductor is Medicare. Not only does Medicare reimburse for services, but by its reimbursement policies it establishes far reaching regulations. When Medicare redefined home care to include only those selected functions and prescribed circumstances that were reimbursable, it created a narrowly defined, fragmented, and uncoordinated set of acute-care services not well adapted to the chronically ill at home. It also established home care as an alternative to institutional care.. Therefore, service selection and delivery patterns were based on institutional patterns rather than the distinct and unique needs of home based health care.

The complexities of deciding how we will pay for home care is a dilemma of economic, professional and social value issues. We need to answer questions that reflect these values:

- 1. When does a person need professional, formal home health care?**
- 2. When do they no longer need home health care?**
- 3. What can our expectations of improvement be?**
- 4. How are we going to pay for this and who should pay for this?**
- 5. Is this appropriate, realistic, cost-effective, for both the client and society?**

Mechanisms for Payment

Although Medicare is the major player for persons over 65 years of age, there are other options for payment of home health care services. These include private payers, Medigap insurance, both private and public, and payment through long term care insurance.

Private Pay. Although not used exclusively, except by the those with access to adequate financial resources, with the various mechanisms of co-payments, deductibles, and co-insurance most older persons make a substantial contribution of their own finances to their health care and home care. Insurance experts estimate that about one-third of all long-term care

services are paid for by individuals out of their own savings or investments. The funds may come from pension plans, employee stock ownership plans, single premium annuities, the cash value of life insurance or savings (Met Life, 2003).

Long-term care insurance. This is private insurance designed to help pay for nursing home or home health care expenses. It is available to individuals and may be available under a group policy. You pay a premium to an insurer in return for protection against the high costs of long-term care. (Mature Market Institute 2003, McCullough 1995)

Home health care services typically covered by long-term care insurance include nursing care, therapy, personal care and homemaking. Generally, home health care agencies and providers must be state-licensed or certified.

Most policies contain a waiting period, during which no benefits are paid. After the person has satisfied the waiting period, the policy pays up to a maximum dollar amount for each day of approved care. A policy may not cover all expenses.

Many policies now offer an inflation adjustment feature that increases the per-day benefit to cover higher costs. Premiums for long-term care insurance can vary widely, depending upon r age and the level of benefits.

The older a person is when first buying a long-term care policy, the higher the premiums probably will be, because the probability of needing long-term care increases with age.

Medicare. There are strict eligibility roles for home health benefits. (Medicare Rights Center 2003) Medicare pays if care is provided by a Medicare-certified home agency and the person requires skilled nursing care, physical therapy or speech therapy. A physician must regularly review the care plan and verify that the patient is homebound. (Palmer 2003)

If a person qualifies for home care reimbursement, which means that they require intermittent, highly skilled technical care, they can have access to physical therapy, occupational therapy, speech therapy, medical social services, home health aides, and durable medical equipment such as hospital beds, and oxygen.

Hospice benefits are in their own category, with services limited to 210 days, since a requirement for hospice services is that the patient will live no longer than six months. Medicare hospice payment covers all the services for

general home care in addition to a contribution of 5% or \$5.00 toward prescription.

The major gaps in Medicare’s long-term coverage are:

- **No coverage for custodial care, either at home or in a nursing home**
- **No coverage in a nursing home without prior hospitalization**
- **No coverage for nursing home care after 100 days**
- **Coverage only in a Medicare-approved facility**

With the enactment of the Balanced Budget Act of 1997, Congress approved the most far-reaching reforms in the 34-year history of Medicare — some 300 provisions that added even more complexity to the program. In the process, Congress greatly expanded the responsibilities of HCFA and the Medicare Payment Advisory Commission, which Congress created to monitor the administration of the program. The reforms were intended to expand the choices among private health plans that beneficiaries may select by creating the new “Medicare+Choice” program and to strengthen Medicare's finances by including policies further constraining payments to providers in the traditional fee-for-service program and in managed-care plans (Iglehart, 1999).

To constrain Medicare home health spending growth, the Balanced Budget Act (BBA) of 1997 replaced Medicare’s cost-based, per-visit payment method

with a prospective payment system (PPS) by fiscal year 2000. Until PPS could be implemented, BBA imposed spending controls under an interim payment system.

For 3 years beginning October 1, 1997, the interim payment system incorporated tighter per-visit cost limits than had previously been in place and subjected each home health agency to an annual Medicare revenue cap, which was the product of an agency specific, per-beneficiary amount and the number of beneficiaries that the HHA served (GAO 2002).

Medicare supplemental insurance (often called Medigap) is private insurance that supplements Medicare benefits and may cover co-payments and deductibles for medical and hospital expenses. Medigap policies generally do not provide coverage for long-term care. The Medicare benefit package is inadequate because it leaves beneficiaries liable for nearly half the cost of their acute care. In addition to deductibles, beneficiaries must pay 20 percent of their physicians' fees; there is no annual cap on the amount. Because of these high out-of-pocket expenses, 85 percent of beneficiaries have supplemental insurance (Moon, 2001).

Medicaid is a joint federal/state program that pays for health care for people with limited income and assets. It is often used as medi-gap insurance

for those who cannot afford private insurance. To receive Medicaid individuals must meet federal poverty guidelines for income and assets and may have to “spend down” or use up most of their assets. Some assets, such as a home, may not be counted when determining Medicaid eligibility..

Medicare managed care. Instead of purchasing a Medigap policy, some people enroll in a Medicare HMO to supplement their Medicare benefits. Such plans may provide more preventive services and charge lower co-payments. However, one is generally restricted to participating providers (physicians, hospitals, nursing homes, etc.). Short-term nursing home care covered by Medicare and Medicare HMO is usually available only in participating facilities.

PACE, the unique program that provides home care to frail elders, receives a fixed monthly payment per enrollee from Medicare and Medicaid. The amounts are the same during the contract year, regardless of the services an enrollee may need. Persons enrolled in PACE also may have to pay a monthly premium, depending on their eligibility for Medicare and Medicaid.

Conclusion

This discussion has presented many of the complexities and frustrations of home health care from its myriad reimbursement mechanisms to its

plethora of service regulations. In a perfect world we would have services and payment designed so they meet the health needs of older persons, wherever they are on the health care continuum. Until that time, health providers and agencies will work within an imperfect system to provide the best care possible. Home health care reflects values of the larger society - how it thinks health care should be provided, who should receive health care, and how it values its elder population.

As a result of escalating aging populations, the spread of communicable disease, threats of bio-terrorism and war, and access to basic resources, care around the world is shifting from management of acute illness to the management of chronic illness. Management of long-term chronic conditions requires coordinated community-based planning and strategies. Home care, hospice and palliative care have the experience and are best equipped to meet these changing needs. They will evolve to be the core of health care and social services in the coming decades.

**(Avoiding Institutional Care: The Home Health Care Option, in Tepper,
L.M. and Cassidy, T. [Ed], (2004) Perspectives on Aging: A Multidisciplinary
Approach. New York: Springer Publishing Company.**

**Home is Where the Heart Is - Home Health Care - Catherine DeLorey, MPH,
DrPH)**