

HOME CARE AND COMMUNITY-BASED SERVICES: OVERCOMING BARRIERS TO ACCESS

Y 4. AG 4: S. HRG. 103-663

Home Care and Community-Based Servi...

HEARING BEFORE THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE ONE HUNDRED THIRD CONGRESS SECOND SESSION

KALISPELL, MT

MARCH 30, 1994

Serial No. 103-16

Printed for the use of the Special Committee on Aging



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CONTENTS

	Page
Opening Statement of Senator Conrad Burns, Acting Chairman	1
CHRONOLOGICAL LIST OF WITNESSES	
Nancy Heyer, RN, Director of Clinical Services, Partners in Home Care, Inc., Missoula, MT	3
Ann F. Cook, director, Foster Grandparent and Senior Companion Programs, Missoula Aging Services, Missoula, MT	9
Bridget McGregor, Director of Clinical Services, West Mont Home Health, Helena, MT	15
Linda Iverson, manager, Kalispell Medical Equipment, Kalispell, MT	27
Jerry Stoick, registered pharmacist, Stoick Drug, Kalispell, MT	37
Robert J. Grady, registered pharmacist, Option Care, Kalispell, MT	45
Joyce DeCunzo, supervisor, Home and Community Services Section, Montana Medicaid Services Division	56
Casey Blumenthal, director, Flathead County Home Health Agency, Kalispell, MT	64
Judy Graham, health care provider, Kalispell Regional Hospital Home Care Agency	73

APPENDIX

Written testimony with attachments from the Flathead County Area IX Agency on Aging, submitted by Jim Atkinson, director	81
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HOME CARE AND COMMUNITY BASED SERVICES: OVERCOMING BARRIERS TO ACCESS

WEDNESDAY, MARCH 30, 1994

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Kalispell, MT.

The Committee met, pursuant to notice, at 9 a.m. at the Best Western Outlaw Inn, 1701 Highway 93 South, Kalispell, Montana, Hon. Conrad Burns (acting chairman of the Committee) presiding.

Present: Senator Burns.

Staff Present: Patty Deutsche.

OPENING STATEMENT OF SENATOR CONRAD BURNS, ACTING CHAIRMAN

Senator BURNS. Good morning, and thank you for coming this morning as we hold our field hearing for the Special Committee on Aging. We had this time up in the Flathead and we were setting our schedule up to do some things up here, and this was one of them. We had never really sat down and talked about taking testimony to go back to be considered by the full Committee on Aging. So we thank you for coming.

Though this hearing will be less formal than the hearings that we hold in Washington, DC, it is nonetheless just as important. The proceedings of this will be taken back, transcribed by a reporter here, and entered into the Senate record. In other words, this testimony will be official and be considered when we start making decisions with regard to the subject at hand.

I'm sorry I wasn't able to bring a couple of my colleagues with me, but it is Easter break and a lot of Senators and Congressmen take this time to go home. This is family time for them, the week before Easter, and of course we're traveling on both sides of the Easter break, but they usually take 1 week for their family and then next week, well, they'll be back on the road again.

This is sort of a sad time for me because the young rancher that was found murdered over in central Montana is a very, very dear friend of mine and we've known each other a long, long time. And so we're going to have to change our schedule around a little bit in order to get over into central Montana. Ever since the first time I came to Montana many years ago and then the second time I came to live here I was traveling for the American Polled Hereford Association and Wayne Stevens, I met him early on when I came here and we have been friends in the cattle business and the livestock business and the agricultural business for many, many, many years. It's a very, very sad time and our thoughts and our prayers

go out to that great family that live north of the Gap, which is over in the Judith Gap country.

The focus of this hearing as you all well know is overcoming barriers to home care. This is an issue that is dear to my heart. I recently lost my father and of course my wife's father, and we went out of the grandfather business in 45 days with Mr. Kuhlman dying on my wife's birthday just a year and a half ago—and then just 45 days later losing my dad. And both of them died at home, and so we are looking at ways of improving home health care and maybe some better ways of doing things in taking care of our elderly. They're very independent men and women who have stayed at home and we want to keep them at home as long as we possibly can. Not just to save money, but because that is where they are the most comfortable and that's where they just want to be. They are familiar with the surroundings and the sites and the sounds and the smells, and they're surrounded by those that love them.

There's something else to be said for that because I believe there are benefits also in the area of mental health. They were lucky, both of our fathers were. Both of them went fairly quickly. They never needed home care, although dad had the county nurse come out to help my mom, who is still living. She's 84. But we were very fortunate that the spouse was able to take care of them. But if they had needed help, home health care would have been that choice.

So we need to start by defining home health care. It encompasses both health and social services that can be delivered to the recovering, disabled, or the chronically ill person in their home environment. Though the home medical equipment industry is often considered separate, we are looking at both today as a means of enabling our folks to stay at home.

There are rules and regulations that go along with qualifying for home care. Just last week a woman called me. Her 83-year-old mother lives in Missoula and is by all intents and purposes homebound. She is able to stand on her own for only a minute or so, cannot bathe herself, and if she falls, that's where she stays until she can summon 911. But every Sunday a friend comes and takes her to church. By Medicaid standards she is no longer homebound and no longer qualifies for home care. Her options are to pay for it herself from her limited Social Security income or enter a more costly nursing home or managed care facility. And it sounds like a large barrier to me.

I also hear from those who provide home care that the paper work involved is almost strangling. Nursing aides are tough to come by and even tougher to hang onto. Coordination of care can be a challenge and reimbursement can be a real problem. And I want to look at those problems today.

In many cases home care is a cost-effective service not only to those who are recuperating from a hospital stay but also for those who, because of functional and cognitive disabilities, are unable to take care of themselves. So I want to examine how these services are financed and look at some of the barriers there.

How can we make home health care more readily available to those who need it? Do we need to make special provisions for such rural areas as we live in here in Montana? And what do we need to do to recruit and retain home care personnel? I don't have the

answers to those questions, but I'm hoping that you will give me some suggestions, viable solutions, that I can take back and put into play as the debate rages on in Washington, DC.

With health care reform being so often discussed these days, it is prime time to find ways to make home health care a more viable option. Mrs. Clinton said last week she wants to keep people at home as long as possible. So even if the Clinton's health care plan doesn't move 1 more inch, the national health care debate is likely to result in a greater demand for home health care services in the future. Home health care is a cost-effective and a compassionate form of health care.

I won't go on any further because I really want to hear from our distinguished panel, those folks who live and work in the arena everyday. In other words, they are where the rubber hits the road. I'm truly honored to have such a terrific panel of witnesses before us today.

We'll start off by looking at education and training. If you want to go in that order, that's fine with me. But for the benefit of the audience, you are the first panel, Nancy Heyer—and, Nancy, you might want to move up here. Nancy Heyer wears two hats. She is Director of Clinical Services for Partners in Home Care in Missoula and she also sits on the Montana Board of Nursing. Also, Ann Cook, who is with us from the Montana Aging Service, and Bridget McGregor, who is Director of Clinical Services at West Mont Home Health in Helena. And thank you for coming today* and we are ready to start taking testimony and taking time out from your valuable schedules to give us testimony that we can take back with us to Washington. So Nancy, we will start with you.

STATEMENT OF NANCY HEYER, RN, MISSOULA, MT

Ms. HEYER. Thank you. My name is Nancy Heyer. I am a Montana native. I was educated in Montana. I've been a registered nurse for 25 years, 20 of those years, 20 out of 25 of my career years, have been in home health care. I am here to provide a point of view. I want to emphasize that I am not an educator. I have worked in nursing service all of the time and so I do not come from an educator's bias, nor do I have a vested interest other than being a provider.

I also want to comment before I begin on education and training that the individual that you had mentioned earlier as having a barrier in terms of being homebound. One of the "friends" who picks her up to go to church is my husband. I am morally and ethically in a bind because as a provider, it is the government that puts up those barriers, i.e., those definitions of homebound, on a lady like Virginia. She rides in the back seat of my car every week or so to go to church. It is very, very difficult for her to get out of the car. However, if you consider the provider's point of view, our agency would be in big trouble from the intermediary and from HCFA if we did not follow the letter of the regulations. So the problem is not necessarily the provider. It is the regulation, and I am very encouraged that you think that's a problem, too.

I also want to preface my statements that I have written testimony and I'm not going to read what I have submitted.

Senator BURNS. If you can do that, please. By the way, your written testimony will be entered into the record.

Ms. HEYER. Thank you. I do not believe that education and training should be considered barriers. The perspective that I bring is that these are the things that are minimal and would enhance the quality of home care and improve access to home care.

Regarding professional providers, I want to start with physicians. Medicare subsidizes medical education. The public should understand that a study of medical school curricula showed that there is literally no exposure, either in didactic or practicum form, for doctors for training in home care. They don't receive theory; they do not do home visits. Less than 10 percent of medical schools in our country that are subsidized by Medicare expose physicians to the concept. And I think it's important to understand this because physicians are expected to understand home care, sign off on it, prescribe it, and yet our system only reimburses home physicians for providing services in nursing homes or hospitals. They do not get reimbursed for providing home care.

In terms of professional nursing, it is the backbone of home care. Advanced practice nurses in the State of Montana, since the Montana State Board of Nursing, has been given authority to grant prescriptive authority to them, could be allowed to certify home care clients for home care. I believe that advanced practice nurses should receive third-party reimbursement. They are graduate educated and they have almost as much education as physicians.

With regard to registered professional nursing, the basic nursing programs, do provide some exposure to community health and home health if it is a bachelor's-level program. I believe that the nurse of the future should always be educated at a bachelor's level if possible because I think there's an anticipation that home care and hospice care in the future is going to be like a hospital without walls. It already is. We're seeing an increase in high technological care and the need for skills and ability of nurses to practice in very unpredictable and obstacle-ridden circumstances. You referred to the home situation as being happier, homier, a more wonderful place for a person to be, and I truly believe that, having been in home care for 20 years. It's risk-filled in terms of the practice area. When a person goes into a hospital, it is a controlled environment. Homes are different. If you go down one single city block in any city in Montana and see 12 homes those are going to be 12 different environments. I strongly advocate support for professional nursing education because right now providers are having to turn nurses into home health nurses. In other words, when they graduate from their nursing programs, they do not have the technical skills that we need to have them be functional right away. That cost is now borne by the provider.

The same holds true with licensed practical nurses. I want to state that there is a role for licensed practical nurses in home care. It is limited. It should be limited, particularly because of the variety of educational levels at which LPN's are prepared. They were never intended to be independent practitioners, however, they are a potential contributor to the home care plan of care.

Finally, for paraprofessionals, I think Bridget will be talking about them later I believe, and the General Accounting Office

agrees with me, that there is a projected growth in that occupation by about 70 percent between 1988 and 2000. However, the irony is that the paraprofessional level is the most needed, closest to the patient, and yet is the most fragmented part of the health care system in home care right now.

Senator BURNS. Say that again, Nancy.

Ms. HEYER. It's very fragmented. There is stratification and fragmentation of paraprofessional services. You can go anywhere from a Title III aide all the way up to a certified home health aide. Their training varies so much that people are not able to move from one setting to another without additional training that is provided and paid for by the provider. The paraprofessional might be a personal care assistant that is paid and reimbursed by Medicaid but their training and education are different than a certified nurse aide.

If I can emphasize nothing more, underscore nothing more important, that I personally believe, as does the National Association for Home Care—if we're going to have Federal funding available to provide this level of care, we need to standardize it because that's what most people need. People need minimal help more than they need skilled help to keep them at home. We've got tons of data out there to demonstrate that. The difference is that you have so many stratified layers of paraprofessional help, which is defined right now by the training and the ability, and it's very confusing to the public.

In Missoula, for example, a PCA, a certified nurse aide and a home health aide and possibly a home care aide coming from a private service company all have different levels of training. A solution to the problem, is that there should be a nationwide coordinated testing and training program that measures competency. People already do not want to go into this field. It's low pay. It's the lowest paid position, but the most key. That's what's so ironic about it.

Senator BURNS. We're out of balance.

Ms. HEYER. It is out of balance. And the problem is that as a provider, I have trouble recruiting these people. I am constantly recruiting, recruiting, recruiting. The turnover in nursing homes is 120 percent. I don't know how they can provide quality care to my 93-year-old grandmother with 120 percent turnover. In home health it is a bit lower. Ours runs around 25 to 30 percent, which is about average. But it is constant. We're always recruiting, always looking. And we all search from the same pool in the community. People are not looking for minimum wage jobs as careers. They're transitional people. They're students. They're not people looking for careers. And we need to make this to be an honorable part of the health care system so that people will say, "You know, I would really like to be a home aide and help people at home, and I would like to be able to make a living." The providers then would not have to bear the cost of constantly reshifting, revamping and retraining and recruiting, retraining and recruiting. It's extremely expensive, and we know, turnover can equal poor quality.

So in summary, in my written testimony I've given you some statistics, but I really believe that the world is changing, as you said, from institutional-based to home-based. It's unpredictable. We do need education and training, and I believe that education is not a

barrier. It is preventative money spent. When you spend a dollar on prevention, that dollar lasts a lot longer. Thank you.

[The prepared statement of Ms. Heyer follows:]

My name is Nancy Heyer, RN, from Missoula, Montana. I am a Montana native, educated in Montana, and have been a Registered Nurse for 25 years. I have worked in the field of Home Health Care for 20 years from a staff level to Executive Administrator level. I am currently employed by Partners in Home Care as the Director of Quality Improvement and Risk Management. I serve on the Board of Directors of the National Association for Home Care. I am the current President of the Montana State Board of Nursing.

I am here to provide a point of view that is shaped largely by my extensive experience working in home health care for two decades. I will address Education and Training of Home Health Care Personnel in the following areas:

1. Professional Providers:

Physicians: A study of Medical School curricula indicated that few Medical schools contain even didactic education to medical students about home health care. Physicians are not educated to understand the complexities of provision of care at home, yet most home health care requires physician authorization and prescription for home care services. Furthermore, physicians are expected to oversee care in all settings, but are only currently reimbursed for their time when patients are in the hospital or nursing home.

Congress should mandate all residents and interns to spend time in the home setting as part of their Medicare-subsidized graduate medical education.

Professional Nursing: Advanced Practice Nurses, such as Nurse Practitioners, Certified Anesthetists, Certified Nurse Midwives and Clinical Nurse Specialists are Registered Nurses with advanced education and clinical expertise. Their contribution to health care is essential in improving access to care in rural and urban settings. The Montana State Board of Nursing grants prescriptive authority to these advanced nurses so that clients can receive high quality care, which includes nursing diagnosis and treatment of illness. Nurses with graduate education are exceptionally prepared to provide primary health care independently.

Congress should allow Advanced Practice Nurses to certify plans of treatment for home care clients for Medicare-certified agencies.

Congress should allow third party reimbursement for Advance Practice Nursing care as independent providers.

Registered Professional Nurses for the future should be educated at the Baccalaureate level. With anticipation that home care and hospice care will be hospitals without walls, we can expect a significant transfer of high tech care to be provided in homes. While the home is where the patient will be happy and recover more quickly, the home setting is variable, unpredictable and will provide obstacles to provision of care. Psychosocial, cultural and economic factors play a huge role in the outcomes of care. It will require RNs who have traditionally practiced in a very controlled environment, ie, the hospital, to go out into the community and provide these complex services. Montana State Board of Nursing is about to adopt rules which will allow Licensed nurses to delegate nursing functions to non-licensed personnel. This effort is one example of removing barriers, but at the same time assuring the protection of the public. Delegation is risk-filled activity. Nurses who delegate in the home setting will require broad-based nursing education with community health practicums. These nurses of the future will be doing more directing and teaching of others to either do the hands on care or to teach clients to do self-care. In the long run these efforts of delegating authority to perform tasks will achieve significant cost savings, especially with a Nursing Model instead of the current Physician-Nursing model. Currently, home health providers do not hire new graduates because their initial education does not provide enough clinical experience in the home setting, thus the burden and cost of making a nurse competent in basic home health is borne by the provider. Home care providers ought to expect a level of competency at the basic graduate level. Orientation and Preceptorships are extremely costly and translate into costs for care.

Congress should provide for nurse education monies to allow schools of nursing to not only provide baccalaureate education to new nurses, but provide flexible and accessible programs for Registered Nurses who do not have bachelor's degrees.

Licensed Practical Nurses by their nature function under the direction and supervision of Registered Nurses or Physicians. Their education is essential to provide nursing skills which are technical in nature, and with appropriate and adequate education can provide direct nursing care. Society must be cautioned that the role of the LPN, while absolutely essential, was never intended to be independent. Current educational preparation ranges from 9 month, high school programs (not in Montana), to 15 month programs at Vocational Technical Programs.

Congress should provide training monies, and standardize curricula to at least two years of study to allow for adequate time to practice skills. This would result in a more flexible competency going from state-to state and save providers from having to provide extra training AFTER the individual is hired.

2. Paraprofessionals:

A recent General Accounting Office report projects increased public funding of long-term care services. Since more long term care will be provided by a variety of providers in the community, it is projected that the home care aide profession is one of the fastest growing occupations with growth projections of nearly 70% between 1988 and 2000. Current stratification and fragmentation of various aide services due to fragmented reimbursement has created a wide variation of competency among this level of worker. Current problems that exist are:

1. High turnover due to low pay, low status and non-incentives account for the reason individuals are not attracted to or remain in aide work, yet the demand is increasing.
2. This results in huge costs to individual providers to have to repeatedly recruit and train.
3. States vary in the requirements for competency training and testing, which provide incredible barriers for workers moving from state to state.
4. States vary in the regulation, training and testing of these individuals from State Boards of Nursing to Department of Health.
5. Nursing Home and Home Health Aide training are coordinated in Montana, but requirements are cumbersome, costly and lack uniformity in implementation from facility to facility.
6. Personal Care Attendants funded under Medicaid do not have to meet same competency requirements as other Aides.

Ultimately the coordination of training and regulation of aide care will allow greater access to properly-trained paraprofessionals, improve access to various services and reduce costs by reducing repetitive training and testing. This cost is currently heavily borne by providers. It will be never-ending until these mandates occur:

Congress should pass legislation that requires coordination of aide testing and training programs which will encompass a range of aide services from basic minimal personal care to complex care in institutional or home care settings.

If any program will receive federal funding for aide care, it should be required to hire personnel who meet uniform training and competency standards.

In summary, the world is changing from institutional-based care to home-based care. We can achieve quality and access by committing dollars to improve current systems of education and training on all levels of health care providers such as physicians, nurses and paraprofessionals. These are preventative dollars that provide ongoing benefits to American citizens.

Thank you.

Senator BURNS. Thank you, Nancy.
Ann Cook.

STATEMENT OF ANN F. COOK, DIRECTOR, FOSTER GRANDPARENT AND SENIOR COMPANION PROGRAMS, MISSOULA AGING SERVICES, MISSOULA, MT

Ms. COOK. Good morning. My name is Ann Cook. I'm representing Missoula Aging Services. I am the Director of the Foster Grandparent and Senior Companion Programs and the National Vice-President of the Association of Foster Grandparent Director. I am here to speak on behalf of alternative programs which are key and integral to the health care industry and which could support the home health care delivery in the home.

Specifically one of those programs is the Senior Companion Program. Senior companions enter the homes of those for whom long-term care is a daily reality. In Missoula senior companions serve over 130 frail or homebound clients every week. They see the needs and they provide the care and support and the comfort. And as such, they are a vital link between agencies, families, and clients. And in a financially constrained world, they are a real bargain. Senior companions are low-income elders. They serve for an hourly stipend of \$2.45 an hour, and for that small amount of money they serve 20 hours a week, and both the elderly person receives a stipend and a homebound elder receives support. Their perspective provides some very real and important insights into barriers, strengths and weaknesses in the home care system.

I've been working in the aging network for over 20 years. When I began my tenure, home care was something that was almost unheard of. It was very rare. People occasionally if they had great family support were able to maintain a home environment until their last days. But home care was not ever considered to be a norm. Home care is now considered to be a norm. And whether or not it's more effective, it's an alternative that's going to be with us to stay. And so I think what the senior companions have seen in their years of service is that the provision of care in the homes has changed and it has changed drastically just in the last 10 years and probably just in the last 5.

When Irma began serving one of her clients, she had a care plan that described exactly what she was to see, a frail, 90-year-old woman who had a complicated medical regimen and who was receiving the assistance at least twice a week of a personal care attendant. What Irma found was a woman who was severely over-medicated because her medical regime was complicated and there was nobody going in that home everyday to see that the medication was being taken correctly. The home care aide who was providing services was a well-intentioned 19-year-old student who had no idea that it was her responsibility to report something like possible over-medication. But Irma was trained to do that because as a member of the Senior Companion Program she had been receiving ongoing training and so she was able to get in contact with her host agency and get help.

When Pat went into a home she knew one of the aspects of the care plan specified the person was getting a home-delivered meal. What she also found was that was the only food aside from cat food

in the house. And the woman was largely living on cat food. Again, that kind of a problem would not have been reported because the delivery system is so diverse. Who would report it if Pat wasn't there? A personal care attendant? A nurse who happened to go in once a quarter or once a month? Who's job is it to look for the range of problems that accompany home health care?

Bob went into a home and what he found was a person in intense pain dying of cancer. There are excellent pain control modalities that are in existence now but they are not used if it's not reported they're needed.

These statements are not at all a condemnation of the home health care system. It's a system that really is in its infancy. Standards are just developing. It's very easy to have standards for hospitals and nursing homes when the supervision and the monitoring is there on a daily basis. But in home care the majority of the care that is given is low technological, it's unskilled and it is provided far from the eyes of physicians, supervisors, or even the funders. And because that care is provided in such divergent situations the quality of care is very divergent. Families often have to take the services they can get and there oftentimes is very little choice.

I think the existence of the Senior Companion Program substantiates the importance and the value of models which can enhance quality control, and quality control in the delivery of home-based services is critical.

Training and supervision makes a difference. Training and a lack of training and education should not be seen as hindrances. The barrier should be that there is a lack of training. The reality should be that training and supervision make for a far better health care delivery system. The fact is, as Nancy Heyer said, we have to professionalize the paraprofessional industry.

One of the things our senior companions report all the time is the experience of going into the homes of these people who feel almost victimized by having a turnover rate of every 2 or 3 months when they get a new home care attendant. When someone is providing a very, very personal level of support for a person who feels like he or she has lost a great deal of dignity, that kind of turnover is painful. We need to find a way to say, even though these most important front line skills are delivered in the home, they have to be delivered with a degree of support from that profession and that support makes it a desirable field to enter.

Standards for care must be integrated throughout the whole delivery system, and that includes something like a certification program that is nationwide. But it shouldn't be a situation where one level of care is possible in Missoula, a much different level of care is seen in Glasgow, something far less might be seen in Circle. That kind of care status does not enhance the dignity of those who are receiving it. Those standards will shape appropriate use, and that is very, very important because one thing that we don't know about home care is how much it is really going to grow or how much home care will be used.

Right now 80 percent of dependent care is provided by family members. And as legislation changes and as families start to rely more on formal models, we don't know how this is going to affect

the youth cycles. So it's extremely important that we have both quality control and control of access so that we know what services are most essential, what ones can be best used, and in that way we offer a level of protection not only to elders, but to their families. Without that level of protection, there is considerable risk of exploitation of elders and their families as they try to sift through the home care industry and see what needs can or should be met.

Senator BURNS. Thank you, Ann.

Ms. COOK. I have one more point, and that is the role of area agencies on aging is critical in this whole discussion because when you start talking about the delivery of wide-range services, they should be seen as having the role in quality control, in evaluation, in monitoring, possibly even in brokering of some of the services.

[The prepared statement of Ms. Cook follows:]

ISSUES IN THE DELIVERY OF HOME-BASED LONG TERM CARE

Submitted By:

Ann F. Cook
 Director, Foster Grandparent and
 Senior Companion Programs:
 Missoula Aging Services

Home based care is a critical component in long term care management. Current theories of aging emphasize the importance of "aging in place". Theoretically, home based care allows for greater normalization of lifestyle and more active involvement of family members. There is a substantial body of evidence to support those values. Over 80% of the dependent care in this country is provided by families and friends. Less than 6 percent of infirm elderly reside in nursing homes. For every impaired elder in an institution, there are at least 3-5 comparable elders in the community (Morris, 1992). Those numbers have added impact because the over 85 cohort is growing at 7 times the rate of the rest of the population.

It is no wonder Americans express great concern about this issue. National polls consistently show long term care affects nearly everyone, that Americans are terrified of it's financial and emotional consequences and that a solution is desperately desired (McConnell, 1990). Families experience considerable jeopardy because growing numbers of elders find themselves competing for support and care. It is simplistic to blame such competition on family insensitivity or social disregard for elders. While the age of Americans has been increasing, the fabric of society has been changing. Single parent, divorced and re-combined families are more prevalent. Women are more frequently working outside the home. Families find it increasingly difficult to parcel their time and energy. In 1992, according to Newsweek Magazine, the average American adult had more parents than children.

Those realities substantiate the importance of formal home-based services as a complement to the informal service structure. Even when there is tremendous family support, there is a point beyond which families can go no further (Morris, 1992). Minnesota's long term frailty study suggests successful "aging-in-place" requires financial security, access to health care and connectedness or socialization. Like a milk stool, loss of any component jeopardizes stability and well-being. When long term care is mandated, maintenance of that tripod can be challenging. Long term care is primarily nonmedical and low tech. However, it can be complex and uncertainties about projecting risk are substantial (Stone, 1994). For an elder needing in-home support, the menu of proscribed services might include nursing and personal care, homemaking, chore, transportation, companionship and respite assistance. Because elders and their families see home care as a viable alternative to institutionalization, they often want to choose from the complement of services that exists in long term care facilities. An optimal or desired level of services is not always available.

The scarcity of federal and state resources virtually assures competition and some level of rationing in service delivery. The Long Term Care Health Security Act federally mandates eligibility groups. The demand for wide ranging services strongly suggests the growth of for-profit home care industries. Elders and their families face the challenge of selecting which services are critical and which reimbursement rates are appropriate. Policy analysts have the challenge of guessing use rates for available services. Projections are complicated by the fact that changes in financing and the development of new programs could alter use patterns. For instance, the availability of insurance, whether public or private, can influence the use of services. Consumers tend to buy more if the price is reduced. Research suggests long term care financing would increase use of services (Fama, 1990). Induced demand could become a complicated issue if eligibility criteria for home based services was not carefully shaped.

Those socio-economic issues illustrate the competing interests involved in shaping a home-based long term care agenda. Homebased care is going to remain a highly desirable option. Because family members are intrinsically involved in homebased care and that involvement has shaped use and cost patterns, continued family involvement is essential. If homecare is going to be a major component of the long term care agenda, standards and safeguards must be developed. It becomes increasingly important to identify impartial entities (i.e., Area Agencies on Aging) which can serve as brokers and case managers of services. In confronting these realities, policy analysts are faced with a 3 fold task: it is important to assure that a broadening of federal entitlement to home care does not create a reverse incentive to families or services supplying informal care; the array of services most critical in maintaining a normalized environment must be identified and funded; quality standards which shape the delivery and outcome of services must be developed. Each of those issues presents a unique set of challenges and demands an examination and development of appropriate service models.

For several reasons, the Senior Companion Program is one model which merits further examination. Through this program, low income seniors receive an hourly stipend in exchange for services provided to dependent adults. Teams of Senior Companions are assigned to non-profit agencies which provide homebased services. Each Senior Companion divides a 20 hour service schedule among 3-4 clients. Senior Companions, who receive a stipend of \$2.45/hour, are carefully monitored, equipped with individualized job descriptions, and receive monthly inservice training. Each team of Senior Companions meets with agency supervisors, on a monthly basis, and reviews every client assignment. Companions offer personal support, advocacy and assistance with activities of daily living.

The Senior Companion model complements the 3 fold task which shapes the long term care solution. The intensity of Senior Companion support is carefully controlled by the service schedule so that involvement of family members is encouraged rather than discouraged. The assistance and perspective of the Senior Companions provide a critical linkage for the in-home service agencies. Simply put, it means the dollar goes farther. Senior Companions help agencies understand which services are critical and will be acceptable. Senior Companions are alert to potential problems, knowledgeable about service lags and able to target potential duplication. They are quick to spot waste and encouraged to identify creative or innovative solutions. Because Senior Companions mirror the age of the clients, they intuitively understand the dependent adult's desire for a normalized environment. There are few services which are as cost effective or which serve diverse populations equally deserving of help - dependent adults, low-income seniors and caregivers. The Senior Companion Program should be recognized as an important component of the long term care solution.

Experience with the Senior Companion Program further substantiates the importance of quality control standards in the delivery of home-based services. Standards are expected and required in nursing homes and hospitals. Protocols for training, certification, supervision and limits of care are carefully delineated. Patient rights are understood and respected. Patients have some assurances relevant to cost, quality of service and competency of assistance. A person receiving care in an institution will receive a coordinated package.

Those standards have not been universally adopted for in-home services. As a result, the need for support and assistance could place clients and families at considerable risk of exploitation. Providers involved in the most direct caregiving (i.e., personal care) may receive little training or supervision. Homecare relies on paraprofessional care, delivered far from the eyes of primary physicians, regulators and funders (Surpin, 1994). It is distinctly different from any other patient/caregiver relationship in the health care system.

A competency of care process for in-home care is not typically present in the paraprofessional home health care practice (Surpin, 1994). Wages to most home health aides are insufficient and high turnover, low morale and mediocre services are common (Surpin, 1994). Quality management would mandate attention to a re-design of the paraprofessional's job and more thorough outcome research. If federal and state dollars are used to support in-home service models, protocols for assessing, monitoring and evaluating services must be developed and implemented. Cost control and patient use models must be researched. Protocols which resolve barriers to quality care must be developed.

The aging of America will impact the social and health care delivery system. Change in service delivery is inevitable. Research suggests, however, that home based services will remain a priority. It is important to identify issues and examine models which offer effective, efficient and equitable protocols. Elders and their families need and deserve that guidance in order to face the challenges of long term care.

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Senator BURNS. Just a short question real quick and I'll come back to Nancy. I have some questions for her. But while we're on that, I'm afraid I've got a fantastic memory, but short, and I'm afraid I'll forget. In the standards, do you have any suggestions that you would like to make to us on how that law should be changed and what we could do to make that work better? Especially do you think there has to be national standards?

Ms. COOK. I think there does, and I think there has to be national standards and I think there has to be a national curriculum. A person should not go into the home and provide home care when that person has never had any training in how to lift a person. I mean, that puts everybody at risk. And so there has to be a curriculum developed that says, If you are going to provide personal services in this home environment, regardless of what your reimbursement source is, these are the skills that you have to learn and you have to document the fact that you can perform those skills. Because otherwise you do put—you put families and clients, and actually you even put the provider at a very, very significant risk. And the provider hurts himself or herself in trying to do something for which he or she isn't trained. There are health issues for the provider as well as legal issues. So I mean, I really believe there has to be a standardization of skills that has to be promoted.

Senator BURNS. Bridget, thank you for coming this morning.

**STATEMENT OF BRIDGET MCGREGOR, WEST MONT,
HELENA, MT**

Ms. MCGREGOR. Thank you. Well, as Nancy indicated, my intent is to really cover the training of the paraprofessionals in depth, and also somewhat the professional training that's required of home health agencies.

As far as home aide training I'm speaking from a Medicare-certified home health stance. West Mont holds a Certificate of Need for home care services in seven counties in Montana, and in addition to that they hold the contract for the statewide Medicaid Personal Care Attendant Program. So my intent is to try and give you a little bit of briefing on where the two entities differ significantly when we're really speaking about Federal dollars' expenditures for both.

In 1990 Medicare-certified home health agencies and hospices were required by law to implement a competency evaluation or training and competency evaluation program for homemaker-home health aides to meet OBRA 1987 requirements. Specific requirements for training included 75 hours for nurse aide training plus 16 hours of home health aide training totaling 91 hours. Components for the required training include communication skills; observation, reporting and documentation of patient status and the care or service furnished; reading and recording temperature, pulse and respiration; basic infection control procedures; basic elements of body functioning and changes in body functioning that must be reported to an aide supervisor; maintenance of a clean, safe, and healthy environment; recognizing emergencies and knowledge of emergency procedures; the physical, emotional, and developmental needs of, and ways to work with the populations served by the agency, including the need for respect for the patient, his or her

privacy and his or her property; appropriate and safe techniques in personal hygiene and grooming that include bed bath, sponge, tub or shower bath, shampoo in sink, tub or bath, nail and skin care, oral hygiene, toileting and elimination; safe transfer techniques and ambulation; normal range of motion and positioning; adequate nutrition and fluid intake; and then the catch all of any other tasks that the agency may choose to have the paraprofessional perform.

Instructors that are qualified to complete the aide training must have a minimum of 2 years nursing experience of which at least 1 of those has to be in home care. Now, in addition to the 91 hours of training to get an aide certified to provide home care services, there are 12 hours of annual homemaker-home health aide training that needs to be conducted every year. And then on top of all that, there's an annual performance review of the homemaker-home health aide that's required every year. Added to that, Medicare requires that there be a supervisory visit in the home for Medicare-certified home health aides every 2 weeks to make sure that the care being provided is adequate and appropriate.

In switching to the personal care attendant training, I'm referring to personal care attendants as those persons who are employed to provide personal care and support services through the State social and rehabilitation services department under the Medicaid program. This is an optional Medicaid service that the State of Montana has chosen to provide. PCA's are exempt from Federal legislation which mandates 91 hours of training for homemaker-home health aides. PCA training is further approved by the State department of social and rehabilitative services to include a mere 16 hours before they begin the job. So we're looking at 91 hours of home health aide training as compared to 16 hours of PCA training. And many of the components of their program or training are similar. They're the same as what are provided under the Medicare-mandated program.

In addition, 8 hours of in-service is provided on an annual basis to the PCAs as opposed to 12 hours for the Medicare-certified home health agencies. PCA's are then only supervised every 120 days with recertification of the plan of care which is approved by the patient's physician. Now, it should be noted that OBRA 1990 legislation on a national level is seeking to eliminate RN supervision and physician certification of services all together for the PCA program. Montana has yet to determine what changes, if any, they will be implementing in response to OBRA 1990.

Included in the home health aide, personal care attendant training, every home care organization that is licensed or certified are required to provide training in response to different entities. OSHA, for example, requires training on occupational exposure to blood-borne pathogens upon hire and annually thereafter. Training must include all of the areas of the standard which include agency exposure control plan, universal precaution practices, engineering and work practice controls, protective equipment, handling of regulated waste, hepatitis B vaccine and its administration if requested by the employee, confidential medical evaluation and follow-up following an exposure, and the maintenance of exposure records for 30 years.

OSHA also requires tuberculosis education upon hiring and annually thereafter. Training must include education on the basic concepts of TB transmission, occupational exposure and infection control according to the Center of Disease Control's Draft Guidelines for Preventing the Transmission of TB in Health Care Facilities.

OSHA also requires hazard communication plan education related to the products that staff are exposed to in the work environment upon hiring and annually thereafter.

Education is required by OSHA on the agency's emergency action plan for evacuation in case of a fire, earthquake, or other national disaster upon hire and annually thereafter.

In addition to this, the Health Care Financing Administration (HCFA), has mandated that there be staff education in order to notify patients of their rights of advance directive legislation implementation, and this includes their right to execute a living will or health care durable power of attorney.

HCFA also requires employee proficiency testing for lab tests conducted by agency personnel per the Clinical Laboratory Improvement Act, or CLIA.

The State of Montana has just enacted legislation to require a safety program to be implemented by all agencies. Final rules are still pending, but it is anticipated that formal safety training will be required for all employees.

To reiterate some of the points that Nancy has stressed, there is a dire need to provide uniform requirements and regulations to combine the training of aides, personal care attendants, home-maker-home health aides, and private duty aides, so that we can all have a personnel pool to draw from. As it stands right now, I cannot use a personal care attendant who's trained with a measly 16 hours to provide home health aide services.

Added to that, there is a drastic fluctuation in services that are needed. You may have high, intense services requiring a large pool of personnel and then you may drop down at the blink of an eye to needing very few hours. What this does is provide a burden on the staff person and the agency itself to meet the hours to keep these people employed. You can't cross over your personnel because of the training deficits between each of the programs.

Most of these personal care providers are low income, single family people, and all we're doing is paying them a low wage because a lot of our money is being pushed into the training, the competency evaluation, the supervision of these individuals, thus we are unable to put them back into their wages.

Now, I'm not advocating the elimination of all training. I think that training and supervision are very important elements of providing paraprofessional services in the home. I also believe that without some type of training and supervision we're only going to see our insurance rates escalate. Last year alone West Mont paid over \$1.5 million to the State of Montana for workers' compensation premiums. Our skilled home health program paid \$200,000 in addition to the \$1.5 million.

[The prepared statement of Ms. McGregor follows:]

West MONT

SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING
 "HOME HEALTH CARE & COMMUNITY-BASED SERVICES:
 OVERCOMING BARRIERS TO ACCESS"
 KALISPELL, MONTANA
 MARCH 30, 1994

EDUCATION & TRAINING OF HOME HEALTH CARE PERSONNEL

TERMS: HCFA - Health Care Financing Administration
 CLIA - Clinical Laboratory Improvement Act
 OSHA - Occupational & Safety Health Administration
 OBRA - Omnibus Budget Reconciliation Act

HOME HEALTH AIDE TRAINING: In 1990, Medicare-certified home health and hospice agencies were required by law to implement a competency evaluation or training and competency evaluation program for homemaker-home health aides that met OBRA '87 requirements. Specific requirements for training included 75 hours of nurse aide training plus 16 hours of home health aide training (total = 91 hours). Components of required training includes:

1. communication skills;
2. observation, reporting & documentation of patient status & the care or service furnished;
3. reading & recording temperature, pulse & respiration;
4. basic infection control procedures;
5. basic elements of body functioning & changes in body function that must be reported to an aide's supervisor;
6. maintenance of a clean, safe & healthy environment;
7. recognizing emergencies & knowledge of emergency procedures;
8. the physical, emotional & developmental needs of, & ways to work with, the populations served by the agency, including the need for respect for the patient, his or her privacy & his or her property;
9. appropriate & safe techniques in personal hygiene & grooming that include bed bath; sponge, tub or shower bath; shampoo in sink, tub or bed; nail & skin care; oral hygiene; toileting & elimination;
10. safe transfer techniques & ambulation;
11. normal range of motion & positioning;
12. adequate nutrition & fluid intake; and
13. any other task that the agency may choose to have the homemaker-home health aide perform.

Instructors qualified to complete homemaker-home health aide training must be a registered nurse with a minimum of 2 years nursing experience of which at least 1 year has been completed in the provision of home health care.

12 hours of annual homemaker-home health aide in-service training are required in addition to basic training. An annual performance review of the homemaker-home health aide is also required no less than every 12 months.

PERSONAL CARE ATTENDANT TRAINING: Personal Care Attendants (PCA's) refer to those persons employed to provide personal care and support services through the state Social & Rehabilitation Services department under the Medicaid program. This is an optional Medicaid service provided by Montana. PCA's are exempt from federal legislation mandating 91 hours of training for homemaker-home health aides. PCA training (as approved by SRS) includes 16 hours at date of hire. Topics covered include:

1. basic orientation;
2. patient rights and confidentiality;
3. infection control;
4. observation & documentation;
5. body systems;
6. body mechanics with patient transfers & lifting;
7. personal care;
8. home safety;
9. emergency recognition & responsibilities;
10. nutrition & modified diets;
11. therapeutic communication;
12. housekeeping; and
13. use of adaptive devices & equipment.

8 hours of in-service education is provided on an annual basis in addition to the initial training.

PCA's are supervised every 120 days with recertification of the plan of care as approved by the patient's physician. OBRA '90 legislation on a national level is seeking to eliminate RN supervision and physician certification of PCA services. Montana has yet to determine what changes, if any, will be implemented in response to these restrictions in supervision and certification.

HEALTH CARE ORGANIZATION TRAINING: Several other entities mandate required training for health care personnel. These include:

1. OSHA -
 - a. Occupational Exposure to Blood-borne Pathogens training is required upon hire and annually thereafter. Training must include all areas of the standard; i.e., agency exposure control plan, universal precaution practices, engineering & work practice controls, protective equipment, handling of regulated waste, hepatitis B vaccine administration, confidential medical evaluation & follow-up, & exposure record maintenance.
 - b. Tuberculosis (TB) education is required upon hire and annually thereafter. Training must include education on the basic concepts of TB transmission, occupational exposure, and infection control according to the Center of Disease Control's 'Draft Guidelines for Preventing the Transmission of TB in Health-Care Facilities.'
 - c. Hazard Communication Plan education related to products staff are exposed to in the work environment upon hire and annually thereafter.
 - d. Education on the agency's emergency action plan for evacuation in case of a fire, earthquake, or other national disaster upon hire and annually thereafter.
2. HCFA
 - a. Staff education for patient notification of Advance Directive legislation (living will, healthcare durable power of attorney).
 - b. Employee proficiency testing for lab tests conducted by agency personnel per the Clinical Laboratory Improvement Act (CLIA).
3. State of Montana
 - a. Agency Safety Program mandated by the last legislative session. Final rules are still pending but it is anticipated that formal safety training will be required for all employees.
4. Agency Specific
 - a. West Mont has incorporated mandatory orientation and continuing education programs for all staff. Topics include:
 - i. fire plan/safety;
 - ii. basic home safety;
 - iii. infection control/universal precautions/biohazardous waste disposal;
 - iv. TB update;
 - v. hazard communication plan;
 - vi. transfers/lifting;
 - vii. CPR certification;
 - viii. patient rights & responsibilities / confidentiality;
 - ix. emergency preparedness;
 - x. employee orientation & competency checklists;
 - xi. IV therapy certification & recertification; and
 - xii. One Touch Glucometer certification & recertification.

MISCELLANEOUS INFORMATION: In 1993, West Mont paid \$200,000 in Worker's Compensation premiums for its home health program and \$1.5 million in premiums for the PCA program.

Senator BURNS. Do you know what the rate is now? Because, you know, I'm going back when I served on the Commission and we had a county nursing home and that was one of the factors that entered into why we should privatize the county nursing home because of the escalating cost in workers' compensation. Do you know what your workers' compensation rate is right now?

Ms. MCGREGOR. I don't have that figure for the different programs.

Ms. HEYER. I don't have the rates, but let me also tell you that the way the workmen's compensation program is set up here is that in a hospice program, for example, one of the things that hospice must do is use volunteers and are required to provide at least 5 percent of our total services through volunteers. If we have those volunteers perform any of the functions that Bridget has outlined and talked about in terms of paraprofessional care, workmen's compensation makes us put a dollar value on the services that we would have paid for by volunteers, we end up paying workmen's compensation for volunteers, which does make sense from a workmen's compensation perspective, you'd think what we're trying to do is to save some dollars here, but the financial burden falls on the provider. The rates are extremely high for this category. I know that the paraprofessional category for home care aides is a huge risk category.

Senator BURNS. Just going back and a couple of other questions. The OSHA regulation sounds like we've got two different departments with OSHA taking the lead as far as rules and regulations are concerned in order to provide the service. Is that a wrong assumption on my part?

Ms. MCGREGOR. No, I don't think so. I think that home care agencies—every time we turn around we have a different regulating body telling us something else that we have to add to our program.

Senator BURNS. Ann, I'm interested in the Senior Companion Program. I was fairly familiar with some of the other programs in Yellowstone County. The Senior Companion Program, lay that out for me why it was started and how it operates. Are these volunteers and are they seniors that volunteer for this program?

Ms. COOK. They are technically volunteers. Originally the Senior Companion Program was started in the early 1980's and at that time it was under the supervision of ACTION. Since the merger now it is under the supervision of the Corporation for National and Community Service. Senior companions are low-income seniors so you have to have an income below U.S. poverty standards and you have to be over 60. If you meet those two criteria you can then serve, provide direct support and assistance and companionship to people over 21. In Missoula all of our clients are very elderly, and senior companions provide direct services to those people. They receive a tax-free stipend of \$2.45 an hour.

Senior Companion grants are extremely difficult to acquire. Our Federal funds have been frozen at the same level for over 10 years. When Missoula received a Senior Companion grant in 1984 we were competing with Billings, with other cities in Missoula as well as with six other States in our Region Eight. We were lucky to receive a grant. This kind of a program is important. The Missoula

program provides over 40,000 hours of direct support to homebound elders every year. So it's extremely cost-effective. It provides needed support for companies. The majority of people who work have worked all their lives and find poverty in old age. Senior companions come to us in tears. Their poverty is overriding. They often-times say they can't afford food, they can't afford medicine. They are thrilled to have the opportunity to serve as senior companions and thrilled to be needed and have an opportunity to provide a viable service.

Senator BURNS. Anything we do it seems like there's always—someone falls through the cracks. We just can't cover all the bases it seems. But I was struck by the lady that was only getting the one meal a week until the Senior Companion Program was put in there and she was discovered, this lady.

Ms. COOK. Yes, she was getting a daily meal through the Meals on Wheels, but there was no other food in the home. And the reality is that our service system is fragmented. Especially when you're at that front line of paraprofessional, it is fragmented.

Senator BURNS. At this time in Missoula County, do they have a visiting nurse program?

Ms. COOK. That's Nancy's.

Senator BURNS. That's Nancy's.

Ms. HEYER. Yes, Partners in Home Care—Visiting Nurse Associations are voluntary nursing associations that are home care agencies. The VNA in Billings is what you're familiar with. We are the same. We are private, not for profit. Visiting Nurses Associations are private, not for profit.

Senator BURNS. I have to tell you I used to go out and ride with those nurses. I think they provide a wonderful service. But there was an afternoon you know when your telephone is ringing and everybody is mad at you and you're getting nothing but bad calls, and you go down and you're riding with a visiting nurse to pick up your day. But I'm wondering, in this case of the lady falling through the cracks, wouldn't that have been—Shouldn't that have been discovered?

Ms. COOK. It's very easy to fall through the cracks. She may have been released from the hospital, and the hospital discharge plan might have said, you know, she's going to do all right. She had the cataract surgery but she could figure out how to put her eye drops in her eyes, she'll do all right. How about if they just arrange for Meals on Wheels to bring a meal by everyday? There wasn't the follow-through and the understanding. Looking at her case, and the reality is she's very poor and she doesn't have any way to acquire food and she doesn't have the money to buy food and she probably doesn't have the ability to put the eye drops in her eyes. That's what kind of happens.

Ms. HEYER. But let me say that had the discharge planner, who is either a social worker or a nurse in a hospital, received formalized education and had the ability to ask key questions to people, it's real hard to do a home assessment when a person is in a hospital room. You just can't do that. And they're not forthcoming with the fact that their daughter is breaking her neck to take care of her, that they do need help. I think that does go back to the issue of education and training because all health care providers, even

if they don't work in home health, need to understand home health so that some key things might have been picked up in that case.

Ms. COOK. One of the realities, Senator Burns, especially for a lot of elderly clients we serve is they have a high value on independence and a high value of not asking anyone for a lot of help. I was originally from northern Minnesota and they talk "Minnesotan." You say, "Well, how are things?" And the answer, "Well, could be worse." You never really say, I'm in bad shape and need help. You say, Could be worse.

Senator BURNS. Don't know how, but it could be worse.

Ms. COOK. And that is one of the real realities that we see, especially among frail, elderly who need a wide range of services. They're probably not even able to identify exactly what it is that they need. And if someone says, How are you going to do when you get home? They'll say, Well——

Senator BURNS. Make do.

Ms. COOK. I'll do.

Senator BURNS. And they say, yes, you betcha.

Ms. HEYER. But that person may also not have been homebound, might not have required the skills of a nurse or a therapist. You can't imagine that they might not, but in the sources from HCFA, we have another layer of regulation that we really haven't talked about and I think we will later, the other providers will talk about, major barriers, and that's the interpretation of what's paid for and what's not. So this person may have not been eligible for Medicare-reimbursed services. That would have been the key right there in the minds of the discharge plan that said there are no skilled needs so we're not going to refer them to Partners.

Senator BURNS. That leads me to the question, what sort of incentives do we need to offer to attract the right personnel into this field? Give me some idea on what we should be doing.

Ms. MCGREGOR. Money. Better wages. Most people can go to Hardees and do a lot better and work a lot less hard than they have to work when they're providing personal care. And so you don't attract high quality individuals for a tenure when you're paying them just barely above minimum wage and they're going home to feed a family of three.

Ms. COOK. Home care work is really difficult. We talk about some of the homes some of our senior companions go into, and the commitment it takes to go into these homes where there might not be any plumbing, where there might not be any sanitation, where there has been great poverty. And it is difficult to go into those homes and it takes a high level of commitment. So when you send the lowest paid worker into a home, is it any surprise that 3 months later that person looks for another job?

Senator BURNS. Take a State like Montana. Are we looking at even a more difficult situation when we start talking about rural health?

Ms. COOK. We're looking at the fact we don't have the people to do the job. We're looking at the fact that many of the homes are substandard, certainly not handicapped accessible, and yet much of what happens in home care, so much of what happens is the result of a quick turn of health, hospitalization, something that happens that quickly changes a person's health status so that the person

themselves, the family members, often times the community is not really ready for the occurrence and then everyone's left kind of picking up the pieces.

Senator BURNS. I understand that there are many decisions that could easily be made by a home care nurse and yet it requires physician demands. Tell me what these are and why do home care providers not have this freedom?

Ms. HEYER. I'm not sure I understand. Is that for me?

Senator BURNS. Yes.

Ms. HEYER. I'm not sure I understand the first part of your question.

Senator BURNS. Well, I understand that the decisions that could be easily made by a home care nurse, in other words, some decisions that could be made by a nurse but yet the decision is mandatory by rule and regulation to be made by a physician.

Ms. HEYER. We believe that's the current model. You know, we're talking now about a model which is physician-directed. There are some things under my nursing license that I cannot do unless a physician orders them. That I can live with; that isn't a problem. There are a number of things on the treatment plan, however, such as the decision of how frequently a bath might be given. Two times a week? Seven times a week? It is the nurse, the patient, and the aide who usually know that, but they still have to call the physician for the M.D. order in order for the agency to get reimbursed for the service.

Senator BURNS. Excuse me. That's a physician decision?

Ms. HEYER. I'm not kidding you. That is the way that the plan—

Ms. MCGREGOR. And actually if you provide a shampoo one time a week and it's ordered three times a week, then regulatorywise, we're in violation of the physician's orders.

Ms. HEYER. Exactly. It has to be a doctor's order. And we not only have the reimbursement source saying, "We won't pay you unless you have that order," but then we have the State licensure surveyors who come in and say, "You're not following the plan of care because today that person needed a shampoo and it wasn't on the plan of treatment." In other words, if the doctor doesn't order it, you can't do it. And that is something as minor as a shampoo or even a linen change. If we add that on the treatment plan and expect to get reimbursed for it, a physician's signature has to be there. And physicians are extremely bothered by that. They are up in arms. I know in Kalispell they have some problems here. In Missoula we're having problems, and nationwide physicians are saying, "I should not have to be bothered with that phone call." You can just imagine. Our client load is over 400 clients in Missoula, half of whom receive services from home health aides. When a patient's condition changes and we've got to increase or decrease services, we have to call the physician every single time. Yes, there are problems with that.

Senator BURNS. Now I'm going to expose how naive I am about that. This sounds like a commonsense kind of decision that doesn't really take a highly trained person to tell when somebody needs a bath.

Ms. HEYER. That's correct. And it's generally—

Senator BURNS. Or change the linen.

Ms. HEYER. Correct.

Senator BURNS. I'm going down a track here, and I would say there has to be a reason that this rule or regulation was put in there. Were there abuses that caused this? Because they say for every action there is an opposite and equal reaction.

Ms. HEYER. Well, I can at least provide some historical input since I am considered a dinosaur in home health.

Senator BURNS. You're on an endangered species list too?

Ms. HEYER. I am on the endangered species list. I think again, as I emphasized before, the medical model is what I want to get across to you is the problem with our reimbursement system, particularly for home health. Back in 1966, when I started being a nurse it was an extremely paternalistic physician-directed system. That still is the thread that goes through home care regulations: Physician direction. And that's the point that I was making back a little bit ago when I talked about advanced practice nursing. I can think of a better system where advanced practice nurses who are familiar with adult or pediatric health, nurse practitioners particularly, that could certify treatment plans for home care. My guess is that we would have a lot better quality of service and a lot less cost in shuffling papers back and forth because an agency could have a better line of communication. We're bothering doctors. We're bothering them now, they say so.

Senator BURNS. Then I believe it sounds like to me—and I would invite your comments on this. It sounds like we have to redo the model.

Ms. COOK. We do.

Senator BURNS. It is time it should be redone, Bridget or Ann?

Ms. COOK. I think one thing I said was that it's a new model in some ways, the home-delivered part. When I first started working in the late 1960's and early 1970's I was involved with the DD services and deinstitutionalization. It was this brand new idea to think that you would limit the population of places like nursing homes and hospitals and you would move toward community-based services. And that idea of the deinstitutionalization and moving to community-based services began to impact the elderly when you talked about all these services which should be available in the home. It really wasn't until the mid 1980's when you were really hearing it in great numbers. And so what happened was that the existing model that has been operational in hospitals and nursing homes for years was simply supplanted into the home industry and it said, Well, instead of getting the service in a hospital bed, we'll give it in a home bed. But we'll follow the same protocols. And the reality is your supervision isn't the same and your training isn't the same and your funding sources are different. And so it's unrealistic.

Senator BURNS. So is the environment in the home?

Ms. COOK. And the environment in the home is different. So the ability to say you can just transcend situations and have the same sphere of protocols is very unrealistic.

Senator BURNS. How much flexibility do you have of the rules and regulations that you have to go by now? Do you have any kind

of flexibility at all to make some decisions that would be common-sense decisions and that would put you at risk?

Ms. COOK. Well, I think that's why the Senior Companion Program is an interesting model to investigate. We are free agents in the field. We have fewer regulations than anybody else. We have regulations for orientation, training and for 4 hours a month in-service training. But because we are less regulated than the nurses and the home care attendants, our companions are able to see what's going on in homes. They can report to their work stations and report to their supervisors and they can advocate for changes. And they are not so carefully regulated by so many divergent sources, and I think that helps make the service very, very cost-efficient.

Senator BURNS. I'm finding that the reason we run into a multitude of rules and regulations when they're written is because of reported and found abuses of the system. Like we can reimburse doctors to make a call in Medicare or Medicaid—Medicare. Let's put it that way—that would call on a patient in a nursing home or a skilled—in a skilled environment and in a hospital, but not at home.

Ms. COOK. Right.

Ms. HEYER. Right.

Senator BURNS. That doesn't seem—That doesn't seem right to me because years ago doctors used to make house calls. Was there a perceived or real abuse in that situation why that rule was written? Were there abuses there or—

Ms. HEYER. Doctors can still be reimbursed for house calls. There is a rate. There is a code. They simply do not do it. There are physicians that still do house calls and there is a billing code for them to go home and do it. Obviously their business is their time. This has to be considered—You know, it isn't cost-effective for them to get in their Wagoneer and go up to Nine Mile and see a patient. In one sense that's what home care can do for them is to be an extension of their practice. However, the rules and regulations tend to get in the way.

There is lack of understanding what home care services are. Believe me, physicians could not tell you the difference between a personal care attendant and a home health aide in Missoula, MT and they expect the same service. So we sit there trying to be customer-responsive and say, "We can't do that." And they ask "Why? Why? Why?" We can't do it.

I think we should be an extension of their practice, but they currently are not being reimbursed for the management of the care. We're calling them—I think the national average on a plan of treatment is there are 2.5 changes in the treatment plan every 60 days. Now, if you multiply that by the number of clients that we have, that is several hundred, up to thousands, of phone calls made almost every month to physicians for this kind of direction for some things such as home health aide orders and those things that are common sense things to nurses.

Senator BURNS. In the nursing school, have they changed the curricula to train home health care nurses now?

Ms. HEYER. Almost all bachelor's programs do have a home health rotation as part of the community health. However, what

you have to have when you graduate from nursing school is the clinical, hands-on medical/surgical experience that they need. Most home health agencies will not hire new graduates. If they do, it is under a preceptor type situation, which is very costly because you don't begin to reap the benefits of hiring that person for at least the 6 months to a year.

Senator BURNS. I've got a daughter in medical school. What should I tell her? She wants to be a family physician.

Ms. HEYER. Tell her to make some home visits.

Ms. MCGREGOR. Tell her to be a PT.

Ms. HEYER. Physical therapy is the way to go.

Ms. MCGREGOR. Our professional personnel, if they're entering into the home health field with no home health experience, it's a good 6 months before they are functioning independently. With the reams of paper work that need to be done—

Senator BURNS. By the way, for those who are attending the hearing this morning, this is all the paper work.

Ms. HEYER. That's just initial paper work.

Senator BURNS. That's the initial paper work. That's right. And all of this has to be done. Most of it is very redundant.

Ms. COOK. And can you imagine what it is like to a patient or a client when someone goes into their home and asks question after question after question and somebody else comes back and asks questions and wants more information.

Senator BURNS. It's very intimidating.

Ms. COOK. And then 2 months later you ask the client: "Where are you getting your health care from? Is it coming from Partners in Home Care or is it coming from West Mont?" And they say, I have no idea. That's the reality.

Senator BURNS. I would think, and here's where my thinking is going, and this is very interesting testimony that goes into the Committee and I'm very thankful for that. I think what may be our challenge, and maybe that's part of our job in D.C.—that some changes have to be made. I would be interested in seeing your recommended changes, how we make it—well, we streamline it, how we make it more user-friendly I think is probably the best term you can come up with. And that maybe we should design a model, maybe we should sort of tweak this thing and design a model that applies to Montana. We get into these situations on a national level. We try to write rules and regulations and pass legislation that one size fits all. And sometimes that isn't always the case. And to figure out some way to write into the—to the law where States could have the flexibility to ask for waivers to promote their own program or what works for them. Am I—How far am I wrong here? You tell me if I'm wrong, and I think we should maybe set up a task force or something. I'm thinking about a task force to maybe start to work on this.

Ms. COOK. We need new models. We really do need new models. I mean, there should not be two Senior Companion Programs in the State of Montana. There should be Senior Companion Programs functioning with every community that has home health needs. We do need new models.

Senator BURNS. Bridget.

Ms. MCGREGOR. I agree. I think that the constraints however are still going to be dictated nationally based on the majority of home health, a certified home health business being Medicare. So we're still going to have to deal with the reams of paperwork and the licensure and certification requirements that are placing the education and training burden on certified agencies. So a model in Montana sounds like a great idea to coordinate services. But we're still going to have the same constraints unless there's change on a national level.

Ms. HEYER. On the reimbursement.

Senator BURNS. On the reimbursement. This is not the only area where we run into reimbursement problems as you well now. It happens not only in Medicare, but Medicaid and the delivery of our welfare system. This is what I've said before we start is—I think we have the cart before the horse whenever we start talking about health care reform. I think we have to start talking about something that's just as important, welfare reform, and how we handle these situations, because there are some people falling through the cracks. I know we can't get them all, but nonetheless, we can get a good set of them.

I'll have some more questions, and we're going to leave the record open for you. But I appreciate your testimony here today and I look forward to working with you. As we hear the dialogue, I'm not real sure that will—we've got a lot of work ahead of us to make—times change, and I would imagine, Ann, since the time that you started working in this area you have seen many changes in the demands for the services and even those services change.

Ms. COOK. Programs have changed entirely. The philosophy of program management has changed a great deal.

Senator BURNS. Well, I appreciate that. And thank you for coming today and we appreciate it. Thank you.

I think at this time—How are we doing on time?

Ms. DEUTSCHE. We're a little late, but that's okay.

Senator BURNS. A little late? That's the story of my life, a day late and a dollar short here.

The second panel today will help us examine the availability of cost-effectiveness of home medical equipment. We have with us Linda Iverson, who's manager of the Kalispell Medical Equipment and Vice-president of the Big Sky Medical Equipment Suppliers. Also here today is Bob Grady, owner of Option Care here in Kalispell; and Jerry Stoick, who is owner of Stoick Drug in Kalispell rounds out our panel today. Again I would ask that you might summarize your statements, and your written testimony will be entered in the record for the Congressional record. And I thank you for coming today. We appreciate that very much.

Now, this is a learning experience for me and that's why we have these hearings. It's nice to have them here on the grounds where the rubber meets the road. I'll tell you that. Thank you for coming.

Linda, you may start.

**STATEMENT OF LINDA IVERSON, MANAGER, KALISPELL
MEDICAL EQUIPMENT, KALISPELL, MT**

Ms. IVERSON. Thank you. I get to be first because I'm the only woman sitting here.

Senator BURNS. No. It's because beauty goes before everything else.

Ms. IVERSON. Thank you. I'll vote for you.

Senator BURNS. I didn't say that on that last panel. I didn't want to get in a lot of trouble.

Ms. IVERSON. Well, I'm Linda Iverson. I'm a manager in Kalispell, MT of a local durable medical equipment company. I have been part of the durable medical equipment side of home care for the last 6 years. I've been in the health care field for the past 25 years. I really enjoy the durable medical equipment field. It's been very rewarding to me. About the time that I entered this field, 6 years ago, we started having a lot of cutbacks and problems in our industry.

First of all I would like to address, "What is durable medical equipment?" The category of durable medical equipment is large and it encompasses hospital beds to patient aids to enteral feedings. Most often we think of durable medical equipment as patient lifts, elevating toilet seats, wheelchairs, but under the durable medical label are also products for incontinence, impotence, breast prosthesis, decubitus care and many, many more. It's a very broad category. One thing that all these have in common is that they help in providing home care.

Cost-effectiveness of durable medical equipment for home care. The cost of durable medical equipment used in the home is minimal compared to costs for comparable products used in a medical facility, both acute or long-term care. Many reports have documented the savings that are achieved when home care services and equipment are used versus a structured medical environment. The savings are acknowledged by everyone that has interest in our industry. Yet the barriers to provide the service are such that we have a problem getting these products and services to the people. We as health care providers cannot be expected to continue to cut our costs and assume more and more paper work and to continue to provide the same quality of service.

An example of this is Certificates of Medical Necessity. We heard earlier, in the other people's testimony, about the requests on doctors for more and more paper work to be filled out. Certificates of Medical Necessity are generally referred to as CMNs, and these are to be completed by the physician that is prescribing durable medical equipment or services. These CMNs are to be completed by the physician, even though he's already written out a prescription for a product. Examples I have attached to my narrative and the report that I have given.

An example of a CMN is a 1-page document, but questions on the CMN have to be completed by the physician, or someone that's in the physician's employ. They have to have the diagnosis, date of birth of the patient, date needed, that list—One example is for a bed. Does the patient require traction which can only be attached to a hospital bed? There are 22 questions on that CMN that's pertaining to beds. There are 22 questions on a CMN for wheelchairs. There are 22 questions to be completed—I'm sorry. Not 22 for an oxygen form, but there are many questions on an oxygen Certificate of Medical Necessity that a doctor must fill out. Many times the physician doesn't realize all of this because other people are

providing a lot of that service, respiratory therapy departments and nursing services. But he is required to fill this form out. Needless to say, frustration runs very high when these CMN's need to be completed.

The problem that occurs is when a prescription form is sent to a durable medical or oxygen company, we turn around and request a CMN to be filled out from the physician, and if he makes one mistake on the form, we know we're not going to be paid. It's not going to be reimbursed by Medicare or by one of the government agencies if this is not completed, so it's sent back to him. And by the third time that the doctor has been asked to complete this CMN, he writes out in very bold letters, "Because The Patient Needs It." And that's it. And we know that isn't going to pay the bill and it certainly doesn't help the beneficiary, but that's where we're at with the CMN situation.

What would be a solution? Why could we not use the doctor's prescription as a doctor's order. Not have to turn around and ask them to complete a CMN? Prescriptions work for drug-related items. From one prescription you can go into a pharmacy and receive drugs. You can't from one prescription receive a hospital bed. You have to have a 22-question report, form, filled out to get that.

Senator BURNS. Why do you think that is?

Ms. IVERSON. Well, something I put in the next line here is—why were CMN's put in place? I believe, and probably a good majority of my fellow health care participants would say, that probably it is to prevent fraud and abuse. I don't know any other reason for CMN's to be used. But monitoring of durable medical equipment companies can be done in a different way than doing CMN's. It can be done through our provider numbers. We have to have a provider number to provide services and we have to be able to get a provider number. We have to be a reputable company.

Senator BURNS. With that are you subject then to a yearly audit or is there someone that comes around that—

Ms. IVERSON. Sporadically there are people that come through from the FDA. Sometimes—I guess any time someone could come in from the Medicare division and do an audit. I myself have only been involved in one time where someone from Medicare offices have come in. And they do this, you know, by just walking into the offices spontaneously. So anyone, yes, could be subject to audit. I think that would be a far better way of doing this. They can track what we're doing through our provider numbers. They know how many beds we're putting out. They know how many oxygen units we have out there and they can do that through the provider number.

The same thing could happen with the doctors. If they're afraid the doctors are going to give everybody oxygen, why not track the doctors' records? They do it for c-sections, they do it for appendectomies. They can track how many of these surgery procedures are being done by a physician. So why not track it that way instead of adding to our paper load which bogs everyone down?

If we have to go through the time for a CMN to be completed by a doctor, we may be looking at 90 to 220 days for a reimbursement. And if a doctor refuses to do it all, we throw it back into the

patient's lap or the beneficiary who has to try the whole procedure again.

I realize that this was put in place for some reason, as you asked me. And I do believe it was probably to prevent fraud and abuse. There's other methods of tracking that.

[The prepared statement of Ms. Iverson follows:]

SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING
 "HOME HEALTH CARE AND COMMUNITY-BASED SERVICES"
 OVERCOMING BARRIERS TO ACCESS

Outlaw Inn
 Kalispell Montana
 March 30, 1994

PANEL 2: Durable Medical Equipment -- Cost, Effectiveness, and Availability

WHAT IS DURABLE MEDICAL EQUIPMENT ?

The category of durable medical equipment is large and encompasses hospital beds to patient aids to enteral feedings. Most often we think of durable medical equipment as patient lifts, elevating toilet seats, wheelchairs, etc. but under the durable medical label are also products for incontinence, impotence, breast prosthesis, decubitus care, and many, many more. One thing these have in common is they help in providing Home Care.

COST-EFFECTIVENESS OF DURABLE MEDICAL EQUIPMENT FOR HOME CARE:

The cost of durable medical equipment used in the home is minimal compared to costs for comparable products used in medical facilities, both acute and long term care.

Many reports have documented the savings that are achieved when home care services and equipment are used vs. a structured medical environment.

The savings are acknowledged by everyone that has interest in our industry, yet the barriers to provide the service and products needed have increased.

We, as healthcare providers can not be expected to continue to cut our costs and assume more and more paperwork to provide the products and service.

Example: Certificates of Medical Necessity, referred to as CMN's, are to be completed by the physician prescribing durable medical equipment and services. These CMN's are to be completed by the physician that has written a prescription for the product. Examples attached of the Oxygen, Hospital Bed, and Wheelchair CMN's.

A prescription form from a physician will act as an order for prescription drugs but to order a wheelchair, or any other type of durable medical equipment the physician must complete a complicated document. Frustration is what we receive at the durable medical end from the physicians when we have to send the document back for the second and third time to make sure that all the questions are properly answered. We have received many of these forms back with "BECAUSE THEY NEED IT" written across the form. Of course, this does not help the patient because the claim will not be paid without the completion of the proper forms.

Should the physician have to complete these forms? Medicare states that the physician or someone in his employ must complete the forms. They can not be completed by a supplier of durable medical goods.

Solution: Use the prescription as the doctor's order. If it works for pharmaceutical products it should work for hospital beds, etc. If a physician writes a prescription for a product or service, the patient qualifies for the product or service.

Why were the CMN's put in place? To Prevent Fraud and Abuse. Monitoring Durable Medical Equipment Companies through our provider numbers and using doctors UPIN numbers (Unique Physician Identification Numbers) to monitor the number of referrals for specific products and services would be far less costly than making everyone play the paper game.

Provider numbers and UPIN numbers are used to monitor revenues received and numbers of each service provided. Already, the UPIN numbers have been used to monitor C-Sections and other surgeries provided by that physician.

Example: Medicare sends out a fee schedule every year and we have to accept assignment if we are participating suppliers or we have the option to accept assignment if we are not participating suppliers.

Medicaid and Worker's Compensation approach us with a new budget and say that they must save X number of dollars in the budget year. We are expected to lower our prices but complete the paper work and provide the same quality of service.

Home care is a way to save money. When looking at the budget the government agencies need to be aware of the cost savings in the acute care areas and not look to cutting the budget in the most cost effective avenues of health care -- HOME CARE.

AVAILABILITY OF DURABLE MEDICAL EQUIPMENT FOR HOME CARE

Each area of our country has it's own special needs when it comes to Home Care Products and Services, especially the service. What is a workable solution in New York is not workable for Montana.

Montana, as well as many other Western states, is mostly rural and requires a different approach to delivery of home care equipment and service.

The number of durable medical equipment suppliers that we have in Montana has been sufficient to supply the products and services needed.

The problems that we have had and that have been reported to the agencies in the state are due to the "competitive bidding" process that Medicaid adopted last year. The awarding of a contract to one company for a state or region leads to more problems -- not less. More money spent in lost time due to unhappy people calling the agencies as well as the suppliers. This process was carried out in Montana even though the process had not worked in other states.

Competitive bidding jeopardizes patient choice, compromises the service component of home medical equipment delivery and often leads to expensive rehospitalization.

Durable Medical Equipment and the services provided by Durable Medical Companies can not be compared to any other retail business.

When approaching durable medical suppliers for lower fees when in the budget cutting process some threats have been made that if the cuts were not deep enough that manufacturers would be allowed to bid. This would be a tragic mistake. Equipment would be sent in boxes. Beneficiaries would assemble the equipment as well as educate themselves on the proper usage of the equipment. This could lead to emergency room visits as well as costly hospital stays.

DURABLE MEDICAL SUPPLIERS ARE PROVIDERS OF SERVICE--NOT EQUIPMENT.

One would only need a day to follow an oxygen technician, seating consultant, or home health care provider to see that we are SERVICE not just product.

Respectively submitted,

Linda M. Iverson

Linda M. Iverson
Kalispell Medical Equipment
495 N. Main
Kalispell, Mt. 59901

Effective 10/93

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 01.01

CERTIFICATE OF MEDICAL NECESSITY: HOSPITAL BEDS/SUPPORT SURFACES	
SECTION A CERTIFICATION: <input type="checkbox"/> INITIAL <input type="checkbox"/> REVISED	
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO. _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER _____ NSC _____
PLACE OF SERVICE _____ REPLACEMENT ITEM _____	HCPES CODE(S) WARRANTY LENGTH TYPE
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM): _____ _____ _____	
SECTION B INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE	
DIAGNOSIS (ICD9): _____	DOB: ____/____/____
I LAST EXAMINED THIS PATIENT FOR THIS CONDITION ON: ____/____/____ PT. SEX ____ (M OR F)	DATE NEEDED INITIAL ____/____/____ REVISED ____/____/____ EST. LENGTH OF NEED: # OF MONTHS: ____ 1-99 198 = LIFETIME
ANSWER QUESTIONS 1-7 FOR HOSPITAL BEDS, 12-13 AND 21 FOR ALTERNATING PRESSURE PADS OR MATTRESSES, 13-22 FOR AIR-FLUIDIZED BEDS Use Y - Yes, N - No, or D for Does Not Apply unless otherwise noted.	
<p>1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?</p> <p>2. Reserved for future use.</p> <p>3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?</p> <p>4. Does the patient require the head of the bed to be elevated <u>more than 30 degrees</u> most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?</p> <p>5. Does the patient require traction which can only be attached to a hospital bed?</p> <p>6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?</p> <p>7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?</p> <p>8. Reserved for future use.</p> <p>9. Reserved for future use.</p> <p>10. Reserved for future use.</p> <p>11. Reserved for future use.</p>	<p>13. Are you supervising the use of the device?</p> <p>14. Does the patient have coexisting pulmonary disease?</p> <p>15. Has a conservative treatment program been tried without success?</p> <p>16. Was a comprehensive assessment performed after failure of conservative treatment?</p> <p>17. Is the home electric system sufficient for the anticipated increase in energy consumption?</p> <p>18. Is structural support adequate to support the air-fluidized bed?</p> <p>19. Are open, moist dressings used for the treatment of the patient?</p> <p>20. Is there a trained fulltime caregiver to assist the patient and manage all aspects involved with the use of the bed?</p> <p>21. Provide the stage and size of each pressure area/ulcer necessitating the use of the overlay, mattress or bed. Pressure area/Ulcer #1 #2 #3 Stage: _____ Max Length (cm): _____ Max Width (cm): _____</p> <p>22. Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) remained the same 3) worsened</p>
I certify the medical necessity of these items for this patient. Section B of this form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.	
PHYSICIAN NAME, ADDRESS _____ _____ _____	PHYSICIAN'S SIGNATURE: _____ DATE _____ (A STAMPED SIGNATURE IS NOT ACCEPTABLE) <input type="checkbox"/> Attending <input type="checkbox"/> Consulting <input type="checkbox"/> Other ordering UPIN: _____ TELEPHONE #: (____) _____

Effective 10/93

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 02.01

CERTIFICATE OF MEDICAL NECESSITY: MANUAL/MOTORIZED WHEELCHAIRS

SECTION A CERTIFICATION: <input type="checkbox"/> INITIAL <input type="checkbox"/> REVISED	
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO. _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER _____ NSC _____
PLACE OF SERVICE _____ REPLACEMENT ITEM _____	HCPCS CODE(S) _____ WARRANTY _____ LENGTH _____ TYPE _____
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM): _____ _____ _____	
SECTION B INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE	
DIAGNOSIS (ICDS): _____	PT. HT. _____ (IN.) PT. WT. _____ (LBS) DOB _____ / _____ / _____
I LAST EXAMINED THIS PATIENT FOR THIS CONDITION ON: _____ / _____ / _____ PT SEX _____ (M OR F)	DATE NEEDED INITIAL _____ / _____ / _____ REVISED _____ / _____ / _____ EST. LENGTH OF NEED: # OF MONTHS: _____ 1-99 (99 = LIFETIME)
ANSWER QUESTIONS 1-4 FOR MOTORIZED WHEELCHAIR BASE, 4, 18-22 FOR MANUAL WHEELCHAIR BASE, 4-18 FOR WHEELCHAIR OPTIONS. Use Y - Yes, N - No, or D for Does Not Apply unless otherwise noted.	
<input type="checkbox"/> 1. Does the patient have severe weakness of the upper extremities due to a neurologic or muscular disease/condition?	<input type="checkbox"/> 12. Does patient have weak upper body muscles, upper body instability or muscle spasticity?
<input type="checkbox"/> 2. Is the patient unable to operate a wheelchair manually?	<input type="checkbox"/> 13. Does patient have use of only one hand/arm and the condition is expected to last for 6 months or more?
<input type="checkbox"/> 3. Is the patient capable of safely operating the controls of a power wheelchair?	<input type="checkbox"/> 14. Is there hemiplegia or uncontrolled arm movements?
<input type="checkbox"/> 4. Would the patient be bed or chair confined without the use of a wheelchair?	<input type="checkbox"/> 15. Does patient have a need for arm height different than that available using non-adjustable arms?
<input type="checkbox"/> 5. Does patient have quadriplegia?	<input type="checkbox"/> 16. Does the patient need to rest in a recumbent position two or more times during the day?
<input type="checkbox"/> 6. Does patient have a fixed hip angle?	<input type="checkbox"/> 17. Is transfer between bed and wheelchair very difficult?
<input type="checkbox"/> 7. Does patient have a trunk cast or brace that requires a reclining back feature for positioning?	<input type="checkbox"/> 18. How many hours per day does the patient usually spend in the wheelchair? (round up to next hour, e.g., for 3 1/2 hours, use 4) use 1-24.
<input type="checkbox"/> 8. Does the patient have a cast or brace which prevents 90 degree flexion of the knee?	<input type="checkbox"/> 19. Is the patient able to place his/her feet on the ground for propulsion in a standard wheelchair?
<input type="checkbox"/> 9. Does patient have a musculoskeletal condition that prevents 90 degree flexion at the knee?	<input type="checkbox"/> 20. Is the patient able to self-propel in a standard wheelchair?
<input type="checkbox"/> 10. Does patient have excessive extensor tone of the trunk muscles?	<input type="checkbox"/> 21. Reserved for future use.
<input type="checkbox"/> 11. Does patient have weak neck muscles requiring support?	<input type="checkbox"/> 22. Can/does patient self-propel in a lightweight wheelchair?
I certify the medical necessity of these items for this patient. Section B of this form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.	
PHYSICIAN NAME, ADDRESS _____ _____ _____	PHYSICIAN'S SIGNATURE: _____ DATE _____ (A STAMPED SIGNATURE IS NOT ACCEPTABLE) <input type="checkbox"/> Attending <input type="checkbox"/> Consulting <input type="checkbox"/> Other ordering UPIN: _____ TELEPHONE # (_____) _____ - _____

**ATTENDING PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY FOR
HOME OXYGEN THERAPY (Legible handwritten entries acceptable)**

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFR, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Patient's Name, Address, and HIC No.

Supplier's Name, Address, and Identification No.

Certification: Initial Revised Renewed

INFORMATION BELOW TO BE ENTERED ONLY BY PHYSICIAN OR PHYSICIAN'S EMPLOYEE

1. Pertinent Diagnoses, ICD-9-CM Codes, and Findings - CHECK ALL THAT APPLY:

- | | |
|---|--|
| <input type="checkbox"/> Emphysema (492.8) | <input type="checkbox"/> Chronic Obstructive Bronchitis (491.2) |
| <input type="checkbox"/> COPD (496) | <input type="checkbox"/> Chronic Obstructive Asthma (493.20) |
| <input type="checkbox"/> Cor Pulmonale (418.9) | <input type="checkbox"/> Congestive Heart Failure (428.0) |
| <input type="checkbox"/> Interstitial Disease (515) | <input type="checkbox"/> Secondary Polycythemia (289.0) |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Hematocrit 57% or more Yes <input type="checkbox"/> No <input type="checkbox"/> |
- Specify Code

2.A. I last examined this patient for this condition on:

Month / Day / Year

2.B. Home oxygen prescribed:

Month / Day / Year

2.C. Estimated length of need:

1-3 months 4-12 months Lifetime

3.A. Results of Most Recent Arterial Blood Gas and/or Oxygen Saturation Tests (Patient Breathing Room Air)

	PO2	O2 Saturation	Date
(1) At Rest			
(2) Walking			
(2) Sleeping			
(3) Exercising			
(4) Other			

3.C. Physician/Provider Performing Test(s) (Printed/Typed Name and Address):

3.B. If performed under conditions other than room air, explain:

NOTE: If PO2 Level exceeds 59 mm Hg or the arterial blood saturation exceeds 89% at rest on room air, the claim will be disallowed with compelling medical evidence. Check block if you have attached a separate statement on your letterhead of additional documentation.

4. Oxygen Flow Rate: _____ Liters per minute Continuous (24 hrs/day)

Noncontinuous (Enter hrs/day): _____ Walking _____ Sleeping _____ Exercise Program _____ Other (specify) _____

5. Oxygen Equipment Prescribed If you have prescribed a particular form of delivery, check applicable block(s). Otherwise leave blank.

A. Supply System

- (1) Stationary Source Concentrator Liquid Oxygen Compressed Gas Other _____
- (2) Portable or Ambulatory Source Liquid Oxygen Compressed Gas Other _____

B. Delivery System

- (1) Nasal Cannula (2) O2 Conserving Device Pulse O2 System Reservoir System Other _____
- (3) Transtracheal Catheter (4) Other _____

6. If you have prescribed a portable or ambulatory system, describe activities/exercise that patient regularly pursues which require this syst in the home and which cannot be met by a stationary system (e.g., amount and frequency of ambulation).

CERTIFICATION

THE PATIENT HAS APPROPRIATELY TRIED OTHER TREATMENT MEASURES WITHOUT SUCCESS. OXYGEN THERAPY AND OXYGEN EQUIPMENT AS PRESCRIBED IS MEDICALLY INDICATED AND IS REASONABLE AND NECESSARY FOR THE TREATMENT OF THIS PATIENT. THIS FORM AND ANY STATEMENT ON MY LETTERHEAD ATTACHED HERETO HAS BEEN COMPLETED BY ME, OR BY MY EMPLOYEE AND REVIEWED BY ME. THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Attending Physician's Signature: (A STAMPED SIGNATURE IS NOT ACCEPTABLE)

Date:

Physician's Name, Address, Telephone No., and Identification No.:

Senator BURNS. I would be interested in some more of your testimony as making some recommendations on how we can do that in a more timely fashion and streamline that. We come out and ask a lot of questions and don't get answers to how we deal with it.

Ms. IVERSON. Okay. Other examples of things that are happening in the durable medical field is, like I said, 6 years ago we were—we encountered the six point plan. And since the six point plan we have gone onto every year we're given out a new fee schedule through Medicare. If we are participating providers of the Medicare, we then have to accept assignment as to whatever that fee schedule is. If it's Medicaid or Workers' Compensation, they approach every year now with a proposal that they have to cut X number of dollars from their budget. I realize that they need to make these savings, but we are expected to lower our prices and yet again increase the paper work load and provide the same quality of service.

Home care is a way to save money, and when we're looking at the budget I think that the government has to look at the fact that home care is a big savings. If the money is being saved in an acute care setting in the hospital and so forth, that there's money being saved in that area, then it also needs to be looked at that home care would be given some of that budget money rather than asked to decrease that every year.

Okay. Going onto the availability of durable medical for home care. Each area of our country of course is unique, has its own special needs. When it comes to home care products and services, especially the service, what is the working solution in New York is not going to work in Montana. And we recently again had an opportunity to observe that, and that's in the bidding out of a wheelchair contract. This was done through the Medicaid agency. And even though it has not been a workable solution in other States such as Minnesota, we still went ahead with that competitive bidding process and ended up that one vendor was given—awarded the State contract. It has now been in effect for approximately 11 months and is not working. That contract is going to be over in June, I believe on June 30. Sure some money was saved there because people were not getting the service. And what happened in the Medicaid office was that they were getting anywhere from 30 to 150 calls a month from health care providers, home care agencies, the actual Medicaid recipients, that they were not getting the service that they need. We are a rural community, a one-vendor system does not work, not to give the service.

When we're looking at durable medical equipment, and I know that we are considered retail stores, we can't be compared to any other retail store. When you go in and buy something, say, a waffle iron, or something from a store, and you come in and buy a wheelchair from a durable medical equipment service company, you also are expecting not just that product, but knowledge and education. And you need to have that, or otherwise you walk out of there and end up with more problems because you do not know the proper use of that equipment.

Oxygen concentrators being one of them. When they talked about going out and putting oxygen, say, purchasing oxygen concentrators rather than renting them from an oxygen company, when you

go ahead and do that, what happens is you eliminate the service end of it. Things happen, such as over-medication might happen, and that is that they either don't use the oxygen enough or too little or they're not sure of how to do it and they use their tubing, their cannulas, to a point where it is an unhealthy situation and ends up in an expensive hospitalization.

Durable medical equipment suppliers are providers of service and they're not providers of equipment and I think too often it's seen the other way. One would only have to take a day and follow an oxygen technician or a home health care provider to see that service is our product. Thank you.

Senator BURNS. Thank you. Jerry, thank you for coming this morning. I appreciate that.

**STATEMENT OF JERRY STOICK, REGISTERED PHARMACIST,
STOICK DRUG, KALISPELL, MT**

Mr. STOICK. You're welcome. Thanks a lot, Senator Burns, for having this hearing, and I would like to address the other Committee members and the participants for allowing me to testify. I have been in business in Kalispell for about 30 years, a registered pharmacist, and we deal in—my next paragraph is kind of an advertisement so I won't read it all, but we deal in just about everything that a pharmacy or durable medical equipment or sick room supply needs and so on, so I watched this thing develop for a lot of years.

We include all the services pharmacies usually include and I think there are a number of—and enough government agencies, private individuals, church, charitable, Salvation Army avenues for seniors to access services that they need. I think there are enough agencies. In fact, maybe there are too many. There's one pile on top of another. I do also think that perhaps government in many respects is the least efficient way to handle the needs of people requiring assistance such as we're talking about today. And I think it's inefficient because the payer, in most cases the Federal Government, is too far removed from the receiver of the assistance. There's no closeness in person-to-person between the needy and the person who—and those that authorize the payment of the bill. And that's been alluded to by the other panel and also by Linda.

The judge of what is needed is often the physician, and you've asked how would you change that? I'm not sure how you would change it, but the physician, who is not, and perhaps should not be, fully aware of how the system works, they're kept way too busy with paper work, filling out forms that are required to insure access to the payer system, and they're also busy filling out their own forms to access pay for themselves as well as get the items they need for their patients.

The same situation exists in the three nursing homes that we work with. I see the nursing staff filling out forms and documenting. They're not nursing. So the frustration that Linda has found with the physicians is also very prominent in our neck of the woods.

As a provider with—my biggest problem with the present system, and heaven forbid an even larger government involvement, is the incredibly complex system for reimbursement. The myriad of intermingling and commingling of third-party payers for which we must

interface to receive compensation for our products and services is entirely too complicated. Beginning with private insurance to Medicare to Medicaid, with co-payments, deductibles, percentages, not to mention capped or assigned fees applicable, makes the reimbursement procedure a real jungle. All of these variables may, and often do, play a part in every transaction.

I suggest an independent agent administer the payer system to be run by the efficiency of private enterprise with competitive incentive. The system could be greatly simplified employing a single payer system. The complexity of the present system limits the number of providers willing to participate, decreasing competition available thereby leaves the market to be dominated by so-called preferred providers, eliminating the competitive marketplace. The recent abandonment by Medicaid in Montana of a single provider for wheelchairs due to unsatisfactory performance, as was mentioned by Linda, is a good example.

To best deliver care to the seniors as this hearing is about, I would sum up by saying keep it simple, at the local level, and reduce red tape in bureaucratic involvement. Let private enterprise run the system and require some individual participation financially to prevent abuse. It's really amazing how much more responsible and conservative people can be if their own money is involved. I'm not suggesting a solution to any of these little items, but we all see the abuse of the system. And I'm not just talking about Medicare, but Workers' Compensation and everybody in this room that works with this sort of thing. Whenever you give something for nothing, they're going to overuse it. Many people do, and that's where your problem is.

[The prepared statement of Mr. Stoick follows:]



Phone 755-4103

Stoick DRUG

PERSONALIZED SERVICE
P.O. Box 637
Kalispell, Montana. 59901-0637

H - Plaza Bldg
142 E. Idaho St.

Date March 30, 1994

TO

RE Special Committee on
Aging hearing

Conrad Burns
United States Senate
Washington, DC

Thank you Senator Burns, Committee members, and other hearing participants for the opportunity to testify.

My name is Jerry Stoick, a registered pharmacist-owner for 30 years of a small independent pharmacy located at the edge of downtown Kalispell. Our store location provides off street parking and handicap access. We serve our patrons needs including prescriptions, over-the-counter items, incontinent supplies, sick room aids, wheelchairs, walkers, canes, bathroom accessories, blood pressure and diabetic monitors and supplies.

We include free delivery, charge accounts, emergency services and the usual accommodations for special needs of our customers and the three nursing homes we serve.

I believe that a wide variety of agencies are readily available to the public for community based services through government and private or charitable organizations such as Salvation Army and church groups.

I do believe that (GOVERNMENT (federal, state, and many cases, local) is the least efficient method of handling much of the assistance required by people in need for the following reasons:

The payer is too far removed from the recipient of assistance.

The judge of what is needed is often the physician, who is not (and should not be) fully aware of the way the "system works". They are kept way too busy with paper work and forms required to insure access to the payer system for their patients, as well as themselves, while they should be practicing medicine. The same situation exists in nursing homes where I see nurses doing paper-work and documentation instead of nursing.

The decision on who gets what is made by someone far removed from the actual scene of need and those who know how to access the system (with little or no cost to themselves) can easily abuse the privilege to the exclusion of others (regardless of need) and adding to the cost of an already over-burdened budget.

As a provider my biggest problem with the present system (and heaven forbid) an even larger government involvement is the incredibly complex system for re-imburement.

The myriad of intermingled and co-mingling of third party payers through which we must interface to receive compensation for our product and service is entirely too complicated. Beginning with private insurance to Medicare to Medicaid with co-payments and deductible amounts and percentages not to mention capped or assigned fees applicable makes the re-imburement procedure a real jungle. And all of these variables may, and often do, play a part in every transaction.

I suggest an independent agent to administer the payer system run by the efficiency



Phone 755-4103

Stoick DRUGPERSONALIZED SERVICE
P. O. Box 637
Kalispell, Montana 59903-0637H - Plaza Bldg.
142 E. Idaho St.

Date _____

TO _____

RE: _____

of private enterprise with competitive incentive. The system could be greatly simplified employing a single payer system.

The complexity of the present system limits the number of providers willing to participate, decreasing competitors available thereby leaving the market to be dominated by so called "preferred providers" eliminating the competitive marketplace. The recent abandonment by Medicaid in Montana of a single provider for wheelchairs due to unsatisfactory performance is a good example.

To "best deliver care to our seniors" as this hearing is about-I would sum up by saying-keep it simple, at the local level, reduce red-tape and bureaucratic involvement, let private enterprise run the system, and require some individual participation financially to prevent abuse.

It is really amazing how much more responsible and conservative people are if their money is involved. The most important feature of any program must include an incentive not to over-use, and not to abuse.

Finally, a word about prescription products and services in the Medicare system.

Any future programs to BEST DELIVER MEDICAL CARE TO OUR SENIORS must include medications. It is admitted that the cost of prescription medications for the elderly is a great barrier to proper treatment, especially at home. Not only must the cost of prescriptions be leveled as regards the ingredients, but adequate pharmacist intervention and monitoring must be included. A significant number of hospital admissions are due to improper use of prescribed medications. Any proposed legislation, as admitted by the President, must include outpatient medication.

Enclosures include Medicaid pay sheets illustrating complexity of billing various private and government payers.

Sincerely,

Jerome F. Stoick, RPh.

By _____

BTHC8000-R001 DEPT OF SOCIAL AND REHABILITATION SERVICES
AS OF 03/16/94 HELENA, MT 59604

MEDICAID AND STATE MEDICAL REMITTANCE ADVICE

WARRANT # 69771 STOICK DRUG
PO BOX 637
KALISPELL MT 59901

PROVIDER # 0000560417 REMIT ADVICE # 246072 MMIS REF # 0533210 DATE 03/21/94 PAGE 2

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	EOB CODES
PAID CLAIMS - MEDICARE PART B CROSSOVER								
459230868	7 HALL, MARY K	120595 120595	2	A4253	65.79	6.50	Y	
ICN 29407000799000599	PATIENT NUMBER=3580946	120595 120595	2	A4245	2.19	1.97	Y	
		*** MEDICARE PAYMENT*****				52.63		
		LESS COPAY DEDUCTION**				1.00		
		CLAIM TOTAL**				67.98		
517501742	SEEFELDT, JANICE K	102795 102795	50	A4352	37.22	0.00	Y	024
ICN 09404511716000200	PATIENT NUMBER=5161481	102795 102795	100	W2029	5.25	4.72	Y	
		*** MEDICARE PAYMENT*****				29.78		
		LESS COPAY DEDUCTION**				0.50		
		CLAIM TOTAL**				42.47		
517501742	SEEFELDT, JANICE K	102795 102795	1	A4552	37.22	1.09	Y	
ICN 29407000799001043	PATIENT NUMBER=5161481	102795 102795	2	A4247	5.25	4.72	Y	
		*** MEDICARE PAYMENT*****				6.36		
		LESS COPAY DEDUCTION**				1.00		
		CLAIM TOTAL**				42.47		
531607655	4 THOMAS, MARIE L	092895 092895	1	L0120	8.95	1.79	Y	
ICN 29407000799000388	PATIENT NUMBER=0591847	110895 110895	100	A4259	7.27	0.00		
		*** MEDICARE PAYMENT*****				8.00		
		LESS COPAY DEDUCTION**				5.82		
		CLAIM TOTAL**				34.44		802
PAID CLAIM TOTALS - MEDICARE PART B CROS *NUMBER OF CLAIMS- 4*** 161.87 17.87								
DENIED CLAIMS - MEDICARE PART B CROSSOVER								
459230868	HALL, MARY K	110895 110895	120	A4245	2.19	0.00		
ICN 09404511716000400	PATIENT NUMBER=							

BTHC8000-R001 DEPT OF SOCIAL AND REHABILITATION SERVICES
AS OF 03/16/94 HELENA, MT 59604

MEDICAID AND STATE MEDICAL REMITTANCE ADVICE

WARRANT # 69771 STOICK DRUG
PO BOX 637
KALISPELL MT 59901

PROVIDER # 0000560417 REMIT ADVICE # 246072 MMIS REF # 0533210 DATE 03/21/94 PAGE 3

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	EOB CODES
DENIED CLAIMS - MEDICARE PART B CROSSOVER								
449428654	3 HENDREN, MARGARET N	122195 122195	10	A5123	42.50	0.00		
ICN 29407000799000863	PATIENT NUMBER=5170216	122195 122195	10	A5063	21.90	0.00		
		*** MEDICARE PAYMENT*****				51.12		
		CLAIM TOTAL**				64.20		090
OUR RECORDS INDICATE THAT THE RECIPIENT LISTED ABOVE HAS INSURANCE WITH								
BLUE CROSS/BLUE SHIELD OF MT								
P.O. BOX 4589								
HELENA, MT								
59604								
POLICY #: 315352 GROUP CERT #: SUBSCRIBER INITIAL: H								
SUBSCRIBER NAME: HENDREN SUBSCRIBER SSN: 449-42-8654								
517501742	SEEFELDT, JANICE K	102795 102795	50	A4352	37.22	0.00	Y	001
ICN 29407000799001185	PATIENT NUMBER=5173421	102795 102795	2	A4247	5.25	0.00	Y	001
		*** MEDICARE PAYMENT*****				29.78		
		LESS COPAY DEDUCTION**				0.00		
		CLAIM TOTAL**				42.47		
517501742	SEEFELDT, JANICE K	112495 112495	50	A4352	37.22	0.00	Y	001
ICN 29407000799001044	PATIENT NUMBER=5161481	112495 112495	200	A9270	14.90	0.00	Y	089
		*** MEDICARE PAYMENT*****				29.78		
		LESS COPAY DEDUCTION**				0.00		
		CLAIM TOTAL**				52.12		
DENIED CLAIM TOTALS - MEDICARE PART B CROS *NUMBER OF CLAIMS- 4*** 193.23 0.00								
PAID CLAIMS - MISCELLANEOUS CLAIM								

BTMC000-R001 DEPT OF SOCIAL AND REHABILITATION SERVICES
AS OF 03/16/94 HELENA, MT 59604

MEDICAID AND STATE MEDICAL REIMBURSEMENT ADVISE

WARRANT # 69771 STOICK DRUG
PO BOX 637
KALISPELL MT 59901

PROVIDER # 000560417 REMIT ADVISE # 246072 MHIS REF # 0533210 DATE 03/21/94 PAGE 6

RECIPIENT ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	EOB CODES
DENIED CLAIMS - MISCELLANEOUS CLAIM								
OUR RECORDS INDICATE THAT THE RECIPIENT LISTED ABOVE HAS INSURANCE WITH								
BLUE CROSS/BLUE SHIELD OF MT P.O. BOX 4309 HELENA, MT 59604 POLICY # : 247717 SUBSCRIBER NAME: HAHN GROUP CERT #: 87-5505 SUBSCRIBER INITIAL: F SUBSCRIBER SSN: 000-00-0000								
531812854	WINES, WINFRED F	122493 122493	1	A4500	14.95	0.00		071
ICN 09406111203000000 PATIENT NUMBER=								
530206655	HOWARD, ELEAN A	022294 022294	1		14.95	0.00		029
ICN 09406111215002900 PATIENT NUMBER=								
DENIED CLAIM TOTALS - MISCELLANEOUS CLAIM					4###	103.79	0.00	
CLAIMS PENDING: MISCELLANEOUS CLAIM								
482065006	MACFARLANE, CHRISTINA	122993 012994	1	E0114	15.00	0.00		901
ICN 09404511205001000 PATIENT NUMBER=								
UNCLAIMED CLAIMS PENDING TOTALS - MISCELLANEOUS CLAIM					1###	15.00	0.00	
PAID CLAIMS - QMB MEDICARE PART B CROSSOVER								
516503784	COMBS, FREDRICKA	110493 110493	1	A4397	4.75	0.81		Y
ICN 09404511710000300 PATIENT NUMBER=								
		110493 110493	10	A5123	32.71	3.26		Y
		110493 110493	10	A5065	23.21	3.60		Y
		*** MEDICARE PAYMENT*****				46.68		
		LESS COPY DEDUCTION**				2.59		
		CLAIM TOTAL**			60.67	6.17		

BTMC000-R001 DEPT OF SOCIAL AND REHABILITATION SERVICES
AS OF 03/16/94 HELENA, MT 59604

MEDICAID AND STATE MEDICAL REIMBURSEMENT ADVISE

WARRANT # 69771 STOICK DRUG
PO BOX 637
KALISPELL MT 59901

PROVIDER # 000560417 REMIT ADVISE # 246072 MHIS REF # 0533210 DATE 03/21/94 PAGE 7

RECIPIENT ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	EOB CODES
PAID CLAIMS - QMB MEDICARE PART B CROSSOVER								
516503784	COMBS, FREDRICKA	120393 120393	1	A4397	5.00	0.30		Y
ICN 29407000799000344 PATIENT NUMBER=3342700								
		120393 120393	5	A5123	32.71	4.35		Y
		*** MEDICARE PAYMENT*****				19.80		
		LESS COPY DEDUCTION**				0.80		
		CLAIM TOTAL**			35.71	3.05		
516503784	COMBS, FREDRICKA	121893 121893	5	A5123	32.71	4.35		Y
ICN 29407000799000344 PATIENT NUMBER=0591847								
		*** MEDICARE PAYMENT*****				17.40		
		LESS COPY DEDUCTION**				0.50		
		CLAIM TOTAL**			32.71	3.85		
516503784	COMBS, FREDRICKA	020294 020294	5	A5123	32.71	4.24		Y
ICN 29407000799000343 PATIENT NUMBER=0121700								
		020294 020294	10	A5065	25.21	2.88		Y
		020294 020294	2	R0158	11.21	1.19		Y
		*** MEDICARE PAYMENT*****				39.71		
		LESS COPY DEDUCTION**				1.50		
		CLAIM TOTAL**			67.13	6.61		
UNPAID CLAIMS TOTALS - QMB MEDICARE PART B					4###	196.22	20.68	
CLAIMS PENDING: QMB MEDICARE PART B CROSSOVER								
516503784	COMBS, FREDRICKA	010494 010494	10	A5065	25.21	0.00		
ICN 29407000799000343 PATIENT NUMBER=0591847								
		010494 010494	5	A5123	32.71	0.00		
		010494 010494	1	A4397	4.75	0.00		
		CLAIM TOTAL**			60.67	0.00		900
530100020	SALINAS, BERTHA C	012194 012194	120	A5061	306.00	0.00		
ICN 29407000799000897 PATIENT NUMBER=3192039								

BIMC000-R001 DEPT OF SOCIAL AND REHABILITATION SERVICES
AS OF 03/16/94 HELENA, MT 59604

MEDICAID AND STATE MEDICAL REMITTANCE ADVICE

WARRANT # 69771 STICK DRUG
PO BOX 637
KALISPELL MT 59901

PROVIDER # 0000560417 REMIT ADVISE # 246072 MMIS REF # 0533210 DATE 03/21/94 PAGE 8

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE HDC	TOTAL CHARGES	ALLOWED	CO- PAY	EOB CODES
CLAIMS PENDING:	QMB MEDICARE PART B CROSSOVER	012194 012194	4	A4402	6.86		0.00	
	*** MEDICARE PAYMENT*****					169.28		
	CLAIM TOTAL**				314.86		0.00	900
CLAIMS PENDING TOTALS -QMB MEDICARE PART B ***NUMBER OF CLAIMS-			2		375.53		0.00	
	TOTAL WARRANT AMOUNT						987.78	

*****THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES THAT APPEAR ABOVE: *****

- 001 THIS CLAIM OR LINE IS BEING DENIED AS A DUPLICATE. YOU HAVE ALREADY BILLED AND BEEN REIMBURSED FOR THIS SERVICE. PLEASE CHECK YOUR RECORDS OR STATEMENTS OF REMITTANCE FOR THE PRIOR PAYMENT.
- 024 DIAGNOSIS CODE IS MISSING. CODE WITH ICD-9-CM DIAGNOSIS CODE AND RESUBMIT THE CLAIM.
- 029 PROCEDURE CODE IS MISSING. CODE WITH CPT-4 OR HCPCS CODE AND RESUBMIT THE CLAIM.
- 056 DATES OF SERVICE MORE THAN TWO YEARS OLD. THE AGE OF THIS CLAIM PRECLUDES SYSTEM ABILITY TO ACCURATELY VERIFY ELIGIBILITY. PLEASE CHECK THE DATES OF SERVICE ON YOUR CLAIM FOR ACCURACY BEFORE CONTACTING CONSULTEC FOR ASSISTANCE.
- 071 DIAGNOSIS CODE INVALID/INCOMPLETE. CORRECT WITH ICD-9-CM DIAGNOSIS CODE AND RESUBMIT.
- 085 FOR MEDICAL CLAIMS: THERE IS NO MEDICAID FEE ON FILE FOR THIS DATE OF SERVICE, OR THE PROCEDURE IS NOT COVERED ON THE DATE OF SERVICE.
FOR PHARMACY CLAIMS: THE DRUG CODE IS NOT COVERED ON THE DATE OF SERVICE.
FOR DENTAL CLAIMS: THE PROCEDURE CODE BILLED IS INVALID. PLEASE REFER TO YOUR CURRENT MEDICAID DENTAL PROVIDER MANUAL FOR PROPER CODE.
- 090 CLAIM DENIED. THIS RECIPIENT HAS THIRD PARTY INSURANCE. SUBMIT THE CLAIM DIRECTLY TO MONTANA MEDICAID WITH DOCUMENTATION FROM THE PRIVATE INSURANCE. PLEASE REFER TO THE CLAIM DENIAL ABOVE FOR DETAILS ON THE OTHER INSURANCE.

BIMC000-R001 DEPT OF SOCIAL AND REHABILITATION SERVICES
AS OF 03/16/94 HELENA, MT 59604

MEDICAID AND STATE MEDICAL REMITTANCE ADVICE

WARRANT # 69771 STICK DRUG
PO BOX 637
KALISPELL MT 59901

PROVIDER # 0000560417 REMIT ADVISE # 246072 MMIS REF # 0533210 DATE 03/21/94 PAGE 9

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE HDC	TOTAL CHARGES	ALLOWED	CD- PAY	EOB CODES
002	THE SIGNATURE DATE ON YOUR CLAIM IS PRIOR TO THE LAST DATE OF SERVICE. PLEASE CORRECT THE SIGNATURE DATE AND RESUBMIT.							
900	THIS CLAIM IS CURRENTLY IN PROCESS WITHIN OUR SYSTEM.							
901	CLAIM SUSPENDED FOR A MAXIMUM OF 30 DAYS PENDING RECEIPT OF RECIPIENT ELIGIBILITY INFORMATION.							

Senator BURNS. Are you saying, Jerry, that in this special place then I guess the word—term might be risk management should be in the private sector than with the government?

Mr. STOICK. I've never seen the government do anything except maybe collect taxes and fight wars that private enterprise couldn't do better. And somehow I really believe, as many of the other panel members have mentioned, take the monkey off the physician's back and put it in the hands of—If the doctor doesn't put down the correct diagnosis codes, and so he's got to look it up in his book—we're talking about a wide variety of everything from colostomy supplies to diapers or incontinence supplies or wheelchairs, walkers or so on, that everything stops—or starts—with the physician. The guy is just swamped with paper work, with complying for—with government regulations to try to access his patients to the system that will pay for our products. And if they come in our place of business and we say, you know, these documents are not right, and it goes back over and over and over. And as many times as the doctor has to fill out the form, we have to submit it to Medicare or whoever, and they have to have somebody read it and return it to us and tell us what's wrong with it. And it goes on and on and puts it at a frustration level that just blows your mind. It just blows your mind.

And it's all put in there to limit the abuse, just as you mentioned. Why do you suppose we have these regulations? Why does it start with the doctor? Because he's the one that's got to order the product. And in that part, all that being just fine, but it's the detail of ordering the product is where the—is where you say the rubber hits the road. That's where the brakes get put on it. The frustration level for the consumer, the patient, and with us as providers, is just tremendous. The bookkeeping involved is outrageous.

And you can't let a pharmacist get on a microphone very long without saying something about prescription products in home health care.

Senator BURNS. I sort of had an idea that that was going to happen, reading the mail everyday, you know.

Mr. STOICK. I'm going to talk about it very briefly. In fact, let's not talk about it at all except to say that I think President Clinton recognizes the fact that prescription costs have to be leveled and there has to be some provision for seniors to access prescription medication because significant number of hospital admissions are due to not only poor care, poor nutrition, but medication errors, overuse, underuse, whatever, and how far the pharmacist should be involved doesn't really matter. If someone who's seeing to it that the people are taking the medication correctly, I think it would go a long ways in the long run to save the system money.

Senator BURNS. Thank you.

Mr. STOICK. Any questions, sir?

Senator BURNS. I'll have a couple here when I get back to you. I want to let Bob Grady. Thank you for coming this morning, Bob. I'm looking forward to your testimony. If you have written testimony, it will be placed in the record. If you want to capsule that, that would be fine too.

**STATEMENT OF ROBERT J. GRADY, REGISTERED
PHARMACIST, OPTION CARE, KALISPELL, MT**

Mr. GRADY. Fine. Thank you very much for having us, Senator Burns. My name is Bob Grady and I'm a pharmacist and one of the owners of Medical Arts Pharmacy and Option Care located here in Kalispell. Medical Arts Pharmacy is the retail prescription drug part of our business which, as Jerry just alluded to you, could have a whole 2 or 3 hours on prescription prices alone, which apparently we're not going to cover today.

Option Care is what I'm here for, which is providing IV therapy to patients in their homes which is what we're concerned with here. Regarding Option Care's participation on this particular panel, DME, the only type of DME products we deal with basically are infusion pumps and IV poles. The majority of our business actually is with compounding and administration of intravenous medication. In reality, we are more closely in line with the providers in the next panel, the home health agencies, because we provide nursing and therapies with the home health agencies in this area to provide these services.

However, I suspect that our participation on this particular panel is due to the fact that we are under the Medicare reimbursement coverage of Part B. Medicare Part B is the part of the plan which addresses coverage for durable or in-home medical equipment. And because home infusion therapy is placed under these rules, which do not adequately cover infusion therapy services, home infusion businesses receive only partial reimbursement for their services, and more importantly, people covered under Medicare cannot receive many of these services in their homes. Instead they must remain in the hospital where it costs them more money, Medicare more money, and the taxpayer more money.

I would like to tell you just a couple of stories about how the home IV therapy works in our current system of the health care and health insurance. First I want to tell you a positive outcome with a patient, an outcome that occurs all the time in home health care when providers and insurers work together to increase care and to reduce costs. The example will also illustrate the services a patient receives from a home IV agency so you'll better understand what we are actually doing here.

I'm going to use a fictional Mr. Jones who probably is about my age, 59 years old, and he's still working.

Senator BURNS. That's a great age, by the way.

Mr. GRADY. Thank you. Goes to see his physician about a recurring problem with his hip. The doctor determines that since his hip joint had deteriorated past the point of healing that Mr. Jones should have his hip replaced. Mr. Jones gets a second opinion and the diagnosis is verified. Mr. Jones is still working and is covered by a national insurance company. The company verifies that they will cover the cost of Mr. Jones' operation and recovery therapy. A week later he goes in to have his hip surgery and it goes well. He remains in the hospital for observations. After a few days in the hospital Mr. Jones develops an infection in the hip area. The doctor prescribes IV antibiotics to treat the infection. He wants him to remain on these antibiotics for 6 weeks. Mr. Jones groans because he doesn't want to really spend 6 weeks in the hospital and the insur-

ance company groans because they don't want to pay for an additional 6 weeks in the hospital.

But there is an alternative for Mr. Jones however. The doctor tells the hospital to discharge Mr. Jones and send him home. The hospital calls a local IV agency such as Option Care, gives the intake nurse the needed information about the patient's medical history and therapy. The insurance company is called by the home IV agency and asked about coverage for home care. The insurance company approves the coverage for Mr. Jones to receive 6 weeks of IV antibiotics.

Later that same day a nurse from the home IV agency visits Mr. Jones in the hospital. She educates him and his wife, the designated caregiver, about the medications he'll be receiving, the dosing levels, the pump he'll be using to receive the medication and what to do and who to call if there's a problem. Mr. Jones begins his home therapy right there in the hospital, receives his first dose, is observed for possible reactions to the medication and then the next day goes home.

In the meantime, our pharmacists mix the medication under sterile conditions, deliver the antibiotics to his home. A nurse from the home IV agency or from one of the area's home health agencies makes visits to Mr. Jones' home at least every 2 to 3 days to monitor his therapy, and also to monitor the condition of his hip. However, if Mr. Jones has a problem with his antibiotic therapy, he can call the nurse or pharmacist because they are available 24 hours a day, 7 days a week, and can be at his home within 30 minutes if needed. Mr. Jones can also be assured that the nurse and pharmacist are regularly talking with the doctor about his therapy and progress.

While he's home, Mr. Jones enjoys playing Scrabble with his neighbor and even goes out to dinner with his wife.

In those cases people who are on IV antibiotics at home and can move around easily can even return to work. Now, that's the positive. That's the way it should go. That's when people are working together for that.

Now, let's say Mr. Jones is now a retired person on Medicare. Same scenario all the way up to the point where the doctor calls the home IV agency to see if he can arrange to send Mr. Jones home. When the home IV agency receives the referral she found out according to Medicare regulations that they do not cover antibiotics under the Part B Medicare regulations. Now he has to decide how he wants to receive his antibiotics. He has a couple choices.

He can travel to the emergency room or doctor's office twice a day to receive his antibiotics infusion. This option is not very appealing to him because he is in pain and cannot get around too well on his hip. Or he can remain in the hospital for 6 weeks, but since his hospital DRGs will be used up, meaning the number of days Medicare will pay for a particular procedure in the hospital, the hospital could very well lose money while he's receiving his 6 weeks of antibiotics, or spend some of that time in a convalescent hospital, or he could pay out of his own pocket to receive the IV antibiotics at home. Hardly a choice for someone on a fixed income.

So you would think that Medicare Part A, the guidelines for hospital coverage, would coordinate with Medicare Part B, the current guidelines for home IV, to get this patient home and reduce the overall costs for Mr. Jones's care. This is not the case. The various parts of the Medicare system do not communicate with one another, nor are they set up actively to reduce costs on a case-by-case basis. In addition, since Medicare Part B guidelines are extremely restrictive regarding any IV antibiotics in the home setting, covering only one kind of antibiotic medication and only if a pump is necessary, a vast majority of the elderly who are on Medicare who could otherwise get their IV antibiotic therapy at home cannot because of the problem with Medicare coverage.

Now, just for one last story, let's put Mr. Jones back on private insurance again as he was in the first scenario. However, this time he recently joined this insurance plan because he changed jobs. He could have very well—well, I place myself in that position. Say I was working for a chain store and filling 150 prescriptions a day and my hip began to bother me and I found I could no longer work in that pharmacy. So maybe I would take a part-time job where I could work maybe 30 hours a week at another pharmacy of some sort. So I would have to get another insurance policy under that particular scenario. So here Mr. Jones is in the situation possibly where he had to change jobs, and again, we're getting back to where they would call the insurance company to verify insurance benefits, the home IV agency would do this, and they were told they would call back with the information, and an hour later they receive a call that, I'm sorry; this is a pre-existing condition and there's no way that we can cover that. And it's very possible that the hospital expenses would not be covered in that case too.

These are not isolated examples. In fact, a form of this last example just happened last week in our particular IV therapy center.

Just a few facts about home infusion services. I'll limit it to basically the antibiotic part of it. But Dr. Fincham, Associate Dean of the School of Pharmacy, Creighton University, looked at 13 studies of 521 patients receiving antibiotic therapy at home and found that the cost savings in comparison to the hospital setting ranged from \$2,121 to \$10,666 per patient course. The average savings was over \$5,000 per case.

Yesterday Phyllis Bogdane, the Director of the Social Work and Discharge Planning at Kalispell Regional Hospital here locally, said that she has at least two to three Medicare patients each month who could go home to receive their IV antibiotics but who remain in the hospital because Medicare will not cover that therapy or the medication at home.

So to summarize, it's clear that Medicare is one of the biggest, if not the biggest, obstacles to the access of home health care, especially for any IV therapies. This outdated and inefficient system does not cover their many home health needs nor does it currently cover prescription medication. Better access to care in the home means changing the way our elderly population is now covered. That means expanding Medicare policies to provide home care and prescription drug coverage while reducing the time, incidence, and costs associated with stays in the hospital. In addition, for those elderly people who do have their own insurance, a way must be

found to assure that insurance companies do not reduce their benefits or preclude coverage for certain conditions as they get older. This is the time of their life they need the full coverage and full benefits the most. Thank you for the opportunity to be here.

[The prepared statement of Mr. Grady follows:]

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**PRESENTATION TO
 SENATE SPECIAL COMMITTEE ON AGING:
 "HOME HEALTH CARE & COMMUNITY BASED SERVICES"**

**ORAL PRESENTATION BY ROBERT J. GRADY, R.PH.
 MARCH 30, 1994**

MY NAME IS BOB GRADY I AM A PHARMACIST AND ONE OF THE OWNERS OF MEDICAL ARTS PHARMACY AND OPTION CARE LOCATED HERE IN KALISPELL. MEDICAL ARTS PHARMACY IS A RETAIL PRESCRIPTION DRUG STORE. OPTION CARE IS AN I.V. PHARMACY AND NURSING SERVICE PROVIDING I.V. THERAPY TO PATIENTS IN THEIR HOMES.

REGARDING OPTION CARE'S PARTICIPATION ON THE PANEL CONCERNED WITH DURABLE MEDICAL EQUIPMENT, THE ONLY TYPE OF D.M.E. WE DEAL WITH ARE INFUSION PUMPS, OR IN RARE CASES, I.V. POLES. THE MAJORITY OF OUR BUSINESS IS WITH COMPOUNDING AND ADMINISTRATION OF INTRAVENOUS MEDICATION. IN REALITY, WE ARE MORE CLOSELY ALIGNED WITH THE PROVIDERS IN THE NEXT PANEL --THE HOME HEALTH AGENCIES-- BECAUSE WE PROVIDE NURSING AND THERAPIES IN THE HOME SETTING. IN FACT, WE HAVE WORKING AGREEMENTS WITH THE HOME HEALTH AGENCIES IN THE AREA TO PROVIDE THESE I.V. THERAPIES.

HOWEVER, I SUSPECT THAT OUR PARTICIPATION ON THE D.M.E PANEL IS A RESULT OF MEDICARE REIMBURSEMENT COVERAGE WHICH PLACES HOME INFUSION THERAPY UNDER MEDICARE PART B REGULATIONS. MEDICARE PART B IS THE PART OF THE PLAN WHICH ADDRESSES COVERAGE FOR DURABLE OR IN-HOME MEDICAL EQUIPMENT. BECAUSE HOME INFUSION THERAPY IS PLACED UNDER THESE RULES -- WHICH DO NOT ADEQUATELY COVER INFUSION THERAPY SERVICES -- HOME INFUSION BUSINESSES RECEIVE ONLY PARTIAL REIMBURSEMENT FOR THEIR SERVICES AND -- MOST IMPORTANTLY -- PEOPLE COVERED UNDER MEDICARE CANNOT RECEIVE MANY OF THESE SERVICES IN THEIR HOMES. INSTEAD THEY MUST REMAIN IN THE HOSPITAL WHERE IT COSTS THEM MORE MONEY, MEDICARE MORE MONEY AND ULTIMATELY, THE TAX PAYERS MORE MONEY.

I WOULD NOW LIKE TO TELL YOU SOME STORIES ABOUT HOW HOME I.V. THERAPY WORKS IN OUR CURRENT SYSTEM OF HEALTH CARE AND HEALTH INSURANCE. FIRST I WILL TELL YOU ABOUT A POSITIVE OUTCOME WITH A PATIENT, AN OUTCOME THAT OCCURS ALL THE TIME IN HOME HEALTH CARE WHEN PROVIDERS AND INSURERS WORK TOGETHER TO INCREASE CARE AND REDUCE COSTS. THIS EXAMPLE WILL ALSO ILLUSTRATE THE SERVICES A PATIENT RECEIVES FROM A HOME I.V. AGENCY SUCH AS OPTION CARE.

MR. JONES GOES TO SEE HIS PHYSICIAN ABOUT A RECURRING PROBLEM WITH HIS HIP. THE DOCTOR DETERMINES THAT SINCE HIS HIP JOINT HAS DETERIORATED PAST THE POINT OF HEALING, THAT MR. JONES SHOULD HAVE HIS HIP REPLACED. MR. JONES GETS A SECOND OPINION AND THE DIAGNOSIS IS VERIFIED. MR. JONES IS STILL WORKING AND IS COVERED BY A NATIONAL INSURANCE COMPANY. THE COMPANY VERIFIES THEY WILL COVER THE COST OF MR. JONES OPERATION AND RECOVERY THERAPY. A WEEK LATER, MR. JONES GOES IN FOR HIP REPLACEMENT SURGERY, WHICH GOES WELL, AND THEN REMAINS IN THE HOSPITAL FOR OBSERVATION AND TO RECEIVE ORAL PAIN MEDICATION. AFTER A FEW DAYS IN THE HOSPITAL, MR. JONES DEVELOPS AN INFECTION IN THE HIP AREA. THE DOCTOR PRESCRIBES I.V. ANTIBIOTICS TO TREAT THE INFECTION. HE WANTS MR. JONES TO REMAIN ON THE ANTIBIOTICS FOR SIX WEEKS. MR. JONES GROANS BECAUSE HE DOES NOT WANT TO SPEND SIX WEEKS IN THE HOSPITAL AND THE INSURANCE COMPANY GROANS BECAUSE THEY DO NOT WANT TO PAY FOR AN ADDITIONAL SIX WEEKS IN THE HOSPITAL.

THERE IS AN ALTERNATIVE FOR MR. JONES, HOWEVER. THE DOCTOR TELLS THE HOSPITAL TO DISCHARGE MR. JONES AND SEND HIM HOME. THE HOSPITAL CALLS A LOCAL HOME I.V. AGENCY -- SUCH AS OPTION CARE -- AND GIVES THE INTAKE NURSE THE NEEDED INFORMATION ABOUT THE PATIENT'S MEDICAL HISTORY AND THERAPY. THE INSURANCE COMPANY IS CALLED BY THE HOME I.V. AGENCY AND ASKED ABOUT COVERAGE FOR HOME CARE. THE INSURANCE COMPANY APPROVES THE COVERAGE FOR MR. JONES TO RECEIVE SIX WEEKS OF I.V. ANTIBIOTICS AT HOME.

LATER THAT SAME DAY, A NURSE FROM THE HOME I.V. AGENCY VISITS MR. JONES IN THE HOSPITAL. SHE EDUCATES HIM AND HIS WIFE, THE DESIGNATED CAREGIVER, ABOUT THE MEDICATION HE WILL BE RECEIVING, THE DOSING LEVELS, THE PUMP HE WILL BE USING TO RECEIVE THE MEDICATION AND WHAT TO DO, AND WHO TO CALL, IF THERE'S A PROBLEM. MR. JONES BEGINS HIS HOME THERAPY RIGHT THERE IN THE HOSPITAL. HE RECEIVES HIS FIRST DOSE, IS OBSERVED FOR POSSIBLE REACTIONS TO THE MEDICATION AND THEN, THE NEXT DAY, GOES HOME.

IN THE MEANTIME, OUR PHARMACIST MIXES THE MEDICATION UNDER STERILE CONDITIONS AND DELIVERS THE ANTIBIOTICS TO MR. JONES AT HIS HOME. A NURSE, FROM THE HOME I.V. AGENCY OR FROM ONE OF THE AREA'S HOME HEALTH AGENCIES, MAKES VISITS TO MR. JONES HOME AT LEAST EVERY TWO TO THREE DAYS TO MONITOR HIS THERAPY AND CONDITION OF HIS HIP. HOWEVER, IF MR. JONES HAS A PROBLEM WITH HIS ANTIBIOTIC THERAPY, HE CAN CALL THE NURSE OR PHARMACIST BECAUSE THEY ARE AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK AND CAN BE AT MR. JONES' HOUSE WITHIN 30 MINUTES IF NEEDED. MR. JONES CAN ALSO BE ASSURED THAT THE NURSE AND PHARMACIST ARE REGULARLY TALKING WITH HIS DOCTOR ABOUT HIS THERAPY AND PROGRESS.

WHILE AT HOME RECEIVING HIS I.V. ANTIBIOTICS, MR. JONES ENJOYS PLAYING SCRABBLE WITH HIS NEIGHBOR AND EVEN GOES OUT TO DINNER WITH HIS WIFE. IN MOST CASES, PEOPLE WHO ARE ON I.V. ANTIBIOTICS AND ARE ABLE TO MOVE AROUND EASILY, CAN EVEN RETURN TO WORK.

THAT, AS I MENTIONED EARLIER, WAS A TYPICAL EXAMPLE OF A POSITIVE OUTCOME WITH HOME I.V. THERAPY. NOW I WOULD LIKE TO TELL YOU A STORY ABOUT A TYPICAL EXAMPLE OF SOME NOT SO POSITIVE SITUATIONS. EXAMPLES THAT HAVE HAPPENED AND WILL CONTINUE TO HAPPEN WHEN PROVIDERS AND INSURERS DO NOT WORK TOGETHER. LET'S RETURN TO MR. JONES BUT ASSUME THAT THIS TIME HE IS RETIRED AND ON MEDICARE.

WE PICK UP THE STORY AT THIS POINT: THE DOCTOR HAS DISCOVERED MR. JONES HAS DEVELOPED AN INFECTION IN THE HIP AREA AND PRESCRIBES SIX WEEKS OF I.V. ANTIBIOTIC THERAPY; SPECIFICALLY A DRUG CALLED ROCEPHIN TO BE GIVEN TWICE EACH DAY. HE AGAIN TELLS THE HOSPITAL DISCHARGE PLANNER TO CALL THE LOCAL HOME I.V. AGENCY AND ARRANGE FOR THE THERAPY TO BE GIVEN AT MR. JONES' HOME. WHEN THE INTAKE PERSON AT THE HOME I.V. AGENCY RECEIVES THE REFERRAL, SHE FINDS OUT THAT MR. JONES IS ON MEDICARE, WITH NO OTHER INSURANCE EXCEPT A MEDICARE SUPPLEMENT. SHE THEN REVIEWS MEDICARE PART B POLICY, WHICH IS THE CURRENT REIMBURSEMENT GUIDELINES FOR HOME I.V. THERAPY, AND DETERMINES THAT MEDICARE DOES NOT COVER THIS THERAPY AND MEDICATION IN THE HOME SETTING. NOW, MR. JONES MUST DECIDE HOW HE WANTS TO RECEIVE HIS I.V. ANTIBIOTICS. HE HAS A FEW CHOICES:

- 1) HE CAN TRAVEL TO THE EMERGENCY ROOM OR THE DOCTOR'S OFFICE TWICE A DAY TO RECEIVE HIS ANTIBIOTIC INFUSION. THIS OPTION IS NOT VERY APPEALING TO HIM BECAUSE HE IS IN PAIN AND CANNOT GET AROUND TOO WELL ON HIS HIP.
- 2) HE CAN REMAIN IN THE HOSPITAL FOR SIX WEEKS BUT SINCE HIS HOSPITAL D-R-G'S WILL BE USED UP, MEANING THE NUMBER OF DAYS MEDICARE WILL PAY FOR A PARTICULAR PROCEDURE IN THE HOSPITAL, THE HOSPITAL WILL LOSE MONEY WHILE HE IS RECEIVING SIX WEEKS OF I.V. ANTIBIOTICS.
- 3) OR, HE COULD PAY OUT OF HIS OWN POCKET TO RECEIVE THE I.V. ANTIBIOTICS AT HOME; HARDLY A CHOICE FOR SOMEONE ON A FIXED INCOME.

YOU WOULD THINK THAT MEDICARE PART A, THE GUIDELINES FOR HOSPITAL COVERAGE, WOULD COORDINATE WITH MEDICARE PART B, THE CURRENT GUIDELINES FOR HOME I.V., TO GET THIS PATIENT HOME AND REDUCE THE OVERALL COSTS FOR MR. JONES' CARE. THIS IS NOT THE CASE. THE VARIOUS PARTS OF THE MEDICARE SYSTEM DO NOT COMMUNICATE WITH ONE ANOTHER, NOR ARE THEY SET UP TO ACTIVELY REDUCE COSTS ON A CASE BY CASE BASIS. IN ADDITION, SINCE MEDICARE PART B GUIDELINES ARE EXTREMELY RESTRICTIVE REGARDING ANY I.V. ANTIBIOTICS IN THE HOME-SETTING, COVERING ONLY ONE KIND OF ANTIBIOTIC MEDICATION AND ONLY IF A PUMP IS NECESSARY, A VAST MAJORITY OF ELDERLY WHO COULD OTHERWISE GET THEIR I.V. ANTIBIOTIC THERAPY AT HOME, CANNOT BECAUSE OF THE PROBLEMS WITH MEDICARE COVERAGE.

NOW, FOR ONE LAST STORY, LET'S PUT MR. JONES BACK ON PRIVATE INSURANCE, AS HE HAD IN THE FIRST STORY. HOWEVER, THIS TIME, HE ONLY RECENTLY JOINED THIS INSURANCE PLAN BECAUSE HE CHANGED JOBS TO REDUCE THE STRAIN ON HIS BAD HIP.

AGAIN, THE DOCTOR DISCOVERS AN INFECTION IN THE HIP AND PRESCRIBES THE SIX WEEKS OF I.V. ANTIBIOTICS. THE HOSPITAL DISCHARGE PLANNER CALLS THE HOME I.V. AGENCY -- OPTION CARE -- AND MAKES DOCTOR'S REFERRAL FOR MR. JONES TO RECEIVE THE THERAPY AT HIS HOME. THE INTAKE PERSON CALLS THE INSURANCE COMPANY TO VERIFY INSURANCE BENEFITS AND IS TOLD THEY WILL CALL BACK WITH THE INFORMATION. AN HOUR LATER, THE INSURANCE COMPANY CALLS AND SAYS THAT MR. JONES WILL NOT BE COVERED TO RECEIVE HIS THERAPY AT HOME AND IN FACT, WILL NOT BE COVERED AT ALL BECAUSE HIS BAD HIP IS A PRE-EXISTING CONDITION, A CONDITION THAT HE DEVELOPED WHILE WITH HIS PREVIOUS INSURANCE COMPANY.

YOU MAY THINK THIS IS AN ISOLATED OR UNREPRESENTATIVE EXAMPLE, BUT THIS VERY SITUATION HAPPENED TO A PATIENT OF OURS JUST THIS WEEK. OTHER CASES IN WHICH INSURANCE BENEFITS ARE DENIED, FOR ANY NUMBER OF REASONS, OCCUR WEEKLY IN OUR OFFICE.

NOW I WOULD LIKE TO GIVE YOU A FEW FACTS ABOUT THE HOME INFUSION SERVICES.

DR. FINCHAM, ASSOCIATE DEAN OF THE SCHOOL OF PHARMACY AT CREIGHTON UNIVERSITY, LOOKED AT 13 STUDIES OF 521 PATIENTS RECEIVING ANTIBIOTIC THERAPY AT HOME AND FOUND THAT COST SAVINGS, IN COMPARISON TO THE HOSPITAL SETTING, RANGED FROM \$2,121.00 TO \$10,666 PER PATIENT COURSE. THE AVERAGE SAVINGS WAS OVER \$5,000.

FOR PATIENTS WHO RECEIVED INTRAVENOUS INFUSIONS OF NUTRITIONAL SOLUTIONS, WHAT WE REFER TO AS T-P-N OR TOTAL PARENTAL NUTRITION, DR. FINCHAM FOUND AN AVERAGE COST SAVINGS OF ALMOST TWO HUNDRED TWENTY FIVE THOUSAND DOLLARS (\$225,000.00) COMPARED TO THE COST OF RECEIVING THIS THERAPY IN THE HOSPITAL.

YESTERDAY, PHYLLIS BOGDANE, DIRECTOR OF SOCIAL WORK AND DISCHARGE PLANNING AT KALISPELL REGIONAL HOSPITAL SAID THAT SHE HAS AT LEAST TWO TO THREE MEDICARE PATIENTS EACH MONTH WHO COULD GO HOME TO RECEIVE THEIR I.V. ANTIBIOTICS, BUT WHO REMAIN IN THE HOSPITAL BECAUSE MEDICARE WILL NOT COVER THAT THERAPY OR MEDICATION IN THE HOME.

IT'S CLEAR THAT MEDICARE IS ONE OF THE BIGGEST, IF NOT THE BIGGEST, OBSTACLES TO THE ACCESS OF HOME HEALTH CARE, ESPECIALLY FOR ANY I.V. THERAPIES. THIS OUTDATED AND INEFFICIENT SYSTEM DOES NOT COVER THEIR MANY HOME HEALTH NEEDS NOR DOES IT CURRENTLY COVER PRESCRIPTION MEDICATIONS. BETTER ACCESS TO CARE IN THE HOME MEANS CHANGING THE WAY OUR ELDERLY POPULATION IS NOW COVERED -- THAT MEANS EXPANDING MEDICARE POLICIES TO PROVIDE HOME CARE AND PRESCRIPTION DRUG COVERAGE WHILE REDUCING THE TIME, INCIDENCE AND COSTS ASSOCIATED WITH STAYS IN THE HOSPITAL. IN ADDITION, FOR THOSE ELDERLY PEOPLE WHO DO HAVE THEIR OWN INSURANCE, A WAY MUST BE FOUND TO ASSURE THAT INSURANCE COMPANIES DO NOT REDUCE THEIR BENEFITS OR PRECLUDE COVERAGE FOR CERTAIN CONDITIONS AS THEY GET OLDER. THIS IS THE TIME OF THEIR LIFE THEY NEED FULL COVERAGE AND FULL BENEFITS THE MOST!!!!

THANK YOU FOR YOUR TIME AND THE OPPORTUNITY TO PRESENT HERE TODAY.

Senator BURNS. Thank you, Bob. Most of you in your testimony have answered about the first three questions that I have, although I have some notes here.

We had some hearings—in fact, two of them in DC, that wonderful area of logic-free environment—with regard to the issues often raised when talking about durable medical equipment is a few suppliers who can conduct their business fraudulently, pushing medical equipment onto unsuspecting seniors telling them that it won't cost them a penny because Medicare pays for it. Most of this comes from telemarketers. And we had some cases where maybe a patient would need something but it comes in a package that offers a whole bunch of stuff with it, and in those instances, but mostly about fraudulent people who operate through telemarketing. And we really heard some bad stories. How prevalent is that in, let's say, in your market area, and what do you suggest that we can do to combat this? Or do you have any suggestions on how we handle that?

Ms. IVERSON. Well, I do believe that the durable medical industry has gotten a bad name over the years. I agree with you. There's a lot of things that have gotten—that have happened recently, and I think they're taking care of that. So anyway, what can we do about our image? I think that's our first goal, and I think we are addressing that. As State associations we are addressing the fact and monitoring ourselves to give ourselves better images.

There are little stores opened everywhere just out of maybe back garages and wherever else, and, yes, there was a lot of telemarketing abuse. We've heard the horror stories too about having a Tupperware party and, Everybody drop your Medicare card in a hat and we'll at the end of it pull one out and someone will win this beautiful Tupperware prize. And instead, everybody got incontinence on their door step the next week. Those types of things did happen. Are they real prevalent here? I don't think so. There has been some fraud and abuse everywhere, even in the State of Montana. But I still believe that the way to monitor it would be to use provider numbers, use UPIN numbers, and monitor this.

I have an instance too where my elderly aunt lives in San Pedro, CA, and I happened to visit her last year. She's 82 years old and she took me to one of her closets and she said, Linda, I'm getting a package in the mail every month. And she said, I don't know what to do about it. She said, I just got all these things piled up in my closet. Well, I went to her closet and she's getting from a company a set of electrodes for a TENS unit. And these electrodes are being billed to Medicare at a rate of a hundred and some dollars a month, and her supplementary insurance is picking up the balance. She does use her TENS unit occasionally, but she doesn't use it enough to use all the electrodes that are being sent to her. Okay, so if the government is picking up some \$90 a month for this person that's got a stack of electrodes in her closet and I say, Aunt Evelyn, call the company and tell them to quit sending you these electrodes. And she said, well, I'm afraid if I tell them I'm not using it all the time they're going to take the TENS unit away from me and then I won't be able to use it at all. But, if this was being monitored, if this company was being monitored, they could say,

gee, this company is sending out an awful lot of electrodes here. They're certainly not sending them out on an as-needed or as-ordered basis. Am I answering your question?

Senator BURNS. Yes, you are. But we hear these stories all the time and we just don't have a way of attacking this problem. Now, nobody promotes telecommunications more than I do. You probably know, but—and I think it's wonderful too, except between 6 and 7 o'clock in the evening. They always call at supper time, if you know what I mean. But there are just some horror stories out there. And, Jerry, do you want to comment on that? Do you want to comment on that? How do we reach this thing? Do we require some way or another that the use of local suppliers is the only one that will be reimbursed, or how do we do that? I don't know how to attack this.

Mr. STOICK. Well, first of all, Linda said there were some unscrupulous suppliers. But I don't think anybody at this table is guilty of that in any way, shape or form. The only two instances that I can really think of where the government really got took, and there are others and Linda just mentioned them, when they first came out with electric lift chairs, pick you up so you could stand, and you had your knees or your hips operated on, they went telemarketing with that. Okay. The reason the physician is the wrong guy to be filling out the form and making the request—now, he should order the item, but the companies that were successful at marketing these things new exactly what to send the physician so that he could sign it. And who would keep—what doctor would keep this lovely old lady patient from having an electric lift chair that cost \$1,200 or \$2,000?

And so being an expert at accessing the person who pays is what's wrong with this system right now. It isn't that the people don't need it. It's that those who—every time the government comes up with a plan, someone will come up with a way to beat it. And I don't care how many restrictions or regulations or rules or time consuming forms you put in, somebody—there's going to be a way to beat this thing, as it is with the electrodes for the TENS unit, as it is for the electric lift chairs, as it is for the hospital beds that went on TV, and, you know, you could float in and all that kind of stuff. Can you imagine the government—Medicare actually paid for a whole bunch of that stuff.

So my suggestions were keep it as local as you can, have someone independent of the physician and the nurse, the people that are totally overburdened with the medical delivery system, keep them from having to do so much paper work.

Senator BURNS. You agree? Then you agree with Linda then on these Certificates of Medical Necessity, that that should be handled just like a prescription, whenever a doctor sends you up a prescription to be filled for your customer?

Mr. STOICK. I think it could be simplified a great deal. I don't know exactly—since the government—you write up a prescription for a wheelchair, and maybe it's just the doctor does it, maybe it's just because the patient has said, boy, when I go shopping on Sunday I get tired walking through the mall with my walker. I wish I had a wheelchair to use when I go on weekends to the mall. Well, a physician may write a prescription for that. I'm not totally sure that if that was the patient's money they would buy a wheelchair

to use to go to the mall because they got tired once a week or once a month. We rent a lot of chairs during fair time. Sure, people go out and they do get tired. When you make it available, and I guess that's—I don't know how else you're going to do it. It's taken advantage of and people take advantage of it. The doctor will write for pert' near anything to get the patients off their back. And if that doctor doesn't write for it, he'll get another doctor to write for it. Honestly, I don't know what the answer is. It's a shame.

Ms. IVERSON. May I insert something here?

Mr. STOICK. What's the answer?

Senator BURNS. What is the answer, Linda?

Ms. IVERSON. Well, I still believe that they can be monitored just like c-sections are monitored in a patient. If a doctor does too many c-sections, they're looked at closely. If a doctor is prescribing because everybody is asking for a wheelchair and they prescribed 30 wheelchairs in a month, they also will be looked at. If you're monitoring something, you're not making everyone go through the laborious paper work all the time on every specific thing, but monitoring every 10th or every 20th, I still think we will accomplish the same need.

Senator BURNS. Again I'll show my—how naive I am in this area, but I have a vision out there that electronic transfer of information and payment is on the horizon. In other words, when you punch it into your computer, your modem is going to send it to the agency it's supposed to and you're going to get reimbursed right back through electronic transfer. I have that vision. I would hope we would be working that way not only to take care of paper work, but the whole record comes up all at once and—am I being naive when I say that this is the direction we should be heading?

Ms. IVERSON. It is the direction we've headed and it's EMC billing. And it is happening, except right now it's not happening very well for us because of the fact that we went regional for Medicare reimbursement. The United States has been split into four regions and we're being paid out of a region along with California and appropriately 12 other States. In the last 3 or 4 months our cash flow has dwindled down to probably a third of what it has been before. Hopefully, because the Big Sky Medical Equipment Suppliers did meet in Great Falls last week and talked to some of the decision-making people in Cigna, which is our reimbursement center, this cash flow problem will decrease. Supposedly EMC problems are getting fixed. But, yes, EMC billing is there and there is such a thing as putting Certificates of Medical Necessity in the billing process. But in addition, there are a lot of problems with that.

Senator BURNS. Thank you for coming today. We're running a little bit late here. You always get the high sign from staff that says speed it up. But there's a lot of questions. Again, we will leave the record open. I appreciate your testimony today and, again, this goes into the record. And I would like to think that we would like to be a part of this solution rather than part of the problem, and with your help I think we can be. So thank you very much for coming today. I appreciate that.

Mr. STOICK. Thank you.

Ms. IVERSON. Thank you.

Senator BURNS. Our next panel and last panel will look at barriers in delivery of home health care services. These folks deal with the paper work, the reimbursement issues as we were talking about while ago, and the physicians who order the care, and to give us their insight.

To give us their insight in that area we have Casey Blumenthal, a nurse and Home Health Care Coordinator for the Flathead County Home Health Care Agency here in Kalispell. Judy Graham is here, Administrative Manager of Kalispell Regional Home Care and Chief at Flathead Hospice. And to give us a State perspective and advice on Medicaid is Joyce DeCunzo, Human Services Manager with Home and Community Services Division of Medicaid in Montana. And I want to thank you for coming today. You made quite a trip, Joyce, and we appreciate it very much and we're looking forward to your testimony. And again, your written testimony will be a part of the record, and if you want to summarize your testimony, that would be fine too.

Joyce, we might start with you.

STATEMENT OF JOYCE DeCUNZO, SUPERVISOR, HOME AND COMMUNITY SERVICES SECTION, MONTANA MEDICAID SERVICES DIVISION

Ms. DECUNZO. Okay. I usually don't have any problem with people hearing me. I hope that's okay.

Senator BURNS. Pull it right up there. I can tell you a hearing story now but I'll tell that later.

Ms. DECUNZO. Okay. It's a little strange being here having listened to everyone else because I too am from the government and so you watch my back. I'm not exactly sure of what—

Senator BURNS. You always get the feeling that there's some truth about this—how the phrase goes, I'm from the government and I'm here to help you.

Ms. DECUNZO. Absolutely. I'm here to tell you about that right now.

Senator BURNS. Okay.

Ms. DECUNZO. Interestingly, a lot of the things that I have to say have turned out to be a summary of some of the things that have been brought up already this morning. And none of us talked to each other, so I think that says something for us in this particular State, that while we have a lot of rural problems, we also are close enough to each other to actually be able to talk to each other and know what people do, and I think that's real important.

Medicaid in Montana has been in the forefront of a lot of home care services. In fact, there's been an ongoing argument about whether we were the second or third State in the Nation to take advantage of the home and community-based services waiver. But at any rate, it was in 1981, and so we were in the very beginning. We had a lot of programs under that particular waiver program, and I'm going to spend some time today making some suggestions on how that can be changed to make it better, or what we consider to be better.

We implemented a personal care program in 1977 which was very early on, and we have quite an extensive personal care program in this State compared to others. And in the unit that I am

administratively responsible for in addition to personal care in the waiver, I also deal with the home health agency services and with hospice and with dialysis attendant services. So all of the home health care services are kind of collective I guess with the exception of the D & D home health care programs.

We notice barriers all the time, and if we don't notice it someone will surely bring it to our attention. It's an interesting place to be in the State agency and in Medicaid because we're the bridge between the Federal regulatory agencies, and for us mainly the Health Care Financing Administration, referred to as HCFA usually, and with the providers of the services because we pay them, and with the users of the services because they want us to do something else often times other than what is being paid for. And then of course some place in there is our State legislature. So working in the State agency is an interesting place to be, and we often times will think that we have handled some barrier only to learn that we didn't. Maybe we handled it for one of those people that we work with and not for another.

I'm not going to read my testimony. I do want to go over it very quickly in terms of what we have identified as some of the barriers. In some cases we have suggestions and in some not.

One of the biggest barriers we have determined in providing home care has to do with what we have labeled as institutional bias. In fact, one of my staff people when I was preparing this said, Why don't you call it the dragons of institutional bias? That was kind of an interesting thing. Because Medicaid in fact has been developed on a medical model, and that has been discussed some this morning. Everything that we do is very medically oriented. So what's happened just in the growth of Medicaid over all the years since 1965 when it was put in the Social Security Act is that we've always been able to pay for institutional services. But somehow if you moved out of the institution and you were in your own home, then you must not be very sick, which is an attitudinal barrier that I will address a little bit.

For us though the institutional bias continues when Congress established the home and community-based services waiver in 1981. One of the main goals of that program was to get out of the institutional bias. You may remember that Katie Becket was a child who lived in a hospital, not because her parents did not want her at home, but because when she went home she lost her Medicaid reimbursement because she could get that as long as she was in the hospital. She lost her Medicaid reimbursement, but her problems were so expensive to handle that her parents didn't have enough income to take care of her, but she had no insurance and they could not have Medicaid. So a little child by the name of Katie Becket, who, by the way, is alive and her mother is a strong advocate for home care programs. She was the one that started this. We thought of the way we could get out of the institutional bias. Institutional services continued to be a mandatory service under Medicaid payments to several home care services. Almost all home care services continue to be what are labeled as optional services under Medicaid payment. So when there are budget crunches, guess who loses? If you have to pay for hospital care and if you have to pay for nursing home care, then—but you do not have to under Federal

regulations pay for home care, then there is a definite disadvantage. Institutions and nursing homes are part of the institutional payment system.

The Medicaid waiver program has what is not fondly referred to as a cold bed policy. What that says is for every individual that we serve in the waiver program in their own home, that we have to be able to prove to—to HCFA—that there is an empty bed in a nursing home waiting for them. Well, if we're going to save money, if that's the concern that we're going to save money on the Medicaid waiver, then we should be really pushing for those beds to be filled with people in their own homes rather than to say that we can't serve them in their own home because our nursing homes are full. There's no justification to that policy. We're told that that policy will be abandoned by HCFA, but we don't know that yet and we haven't seen it yet. So I encourage you to do what you can to make that happen.

On the home care programs, there's a prohibition on payment for room and board. If a person is in a hospital, if a person is in a nursing home and Medicaid is paying for their care, we are in fact paying for their room and board in many instances. Many times people give over their money when they're in a nursing home, they give over whatever income they have, and if that's not enough to pay for their care, then Medicaid pays the rest. But there are some people who have no income, in which case Medicaid pays for it all. So we're paying for room and board, but we're not allowed to deal with those issues in the home care setting.

Another one is that we are not allowed by Medicaid law to pay for packaged services in a community setting. Again, while hospitals do certainly bill for every little thing they do, a nursing facility is a packaged service, we're not able to do that in the community. We want to develop as one example assisted living. It's the thing that is being developed all over the Nation. Again, we're not as first as we were in the waiver, but we're close in wanting to do that. The only way we can do that is under our Medicaid waiver. We cannot make it a service that is available to all Medicaid individuals. That is a disincentive because people need that service. They want to live someplace that's in their home town with friends and relatives and where they know Joe down at the corner grocery, but they can't. They have to go someplace else, to a institutional setting, because we can't pay for that service here on our regular Medicaid.

Residential services by itself is one of the biggest barriers that we have to home care. People cannot afford accessible housing. They don't have the money. We have no affordable and no accessible housing. No is too strong a word.

Senator BURNS. Stop right there. Is this the impact of what's happening in Montana that we can't reach our fair rent value now in our subsidized housing? Is that really becoming a big problem for you too?

Ms. DECUNZO. I don't know the answer to that.

Senator BURNS. Well, we're having people move out because our rents are going up and our subsidized housing, what we have set on our survey, has set how much rent we will pay for subsidized housing and is forcing some of these people into really housing that

is so substandard and so bad that we have to do something in that respect because of a housing shortage here in Montana. Is that a correct assumption on my part?

Ms. DECUNZO. I believe it is. There's a definite housing problem. I'm sure you're aware of all the issues regarding taxing, where people who have lived in their homes all their lives but they are being taxed out of their homes. They cannot afford to keep their homes even when they no longer have a house payment, a mortgage payment, to make because they can't—yes, the Flathead here is a particular problem, and Bozeman, Missoula. It gets really spreading. So what we have are people that are living on an SSI amount of money. There's not the subsidized housing, as you said, available to them. They can't afford any other housing and so, since we are not able to do anything regarding room and board payments, these folks end up going into a nursing home. So affordable and accessible housing is a tremendous problem.

Accessible public transportation. Only our largest cities—and having moved here from Dallas, TX many moons ago, it still always tickles me when I talk about our larger cities because the population in the State of Montana doesn't meet large city status in the United States. We have no transportation at all. If you don't have a neighbor who can take you someplace or if you're not Medicaid-eligible where perhaps we can pay for your medical transportation, then you're in a world of hurt, so to speak, because you can't get where you need to get. You have to move to a larger city to be able to access medical care if you have no transportation. Much less the more everyday issues like groceries and those kinds of things.

Health care insurance is a major problem that has already been brought up this morning, particularly with the disabled individuals that we work with. If they do get a job and make money, they lose their Medicaid. Now, they probably will not be able to get a job that is going to handle all of their medical need expenses, but let's assume they could. Well, now they go to a new company, they make enough money to buy insurance, but no insurance company will cover them. We can't transport their insurance from one place to another. That is a major issue for the whole world of young disabled individuals who are trying to be in the work force. They literally cannot. It is a life saving issue for them to have their Medicaid available to them.

A lack of medical providers. I can't compare that to all other States, but we certainly do have some issues with that here in Montana where medical providers will not sign up as a Medicaid provider. I don't know what that issue is in Medicare. Others could speak more to that. But we have some places in the State that it's been a pretty drastic problem. Lewistown has been a big issue. I understand that Kalispell, again, this area, Flathead, we have a lot of difficulty getting providers. The fees are low for many services. In fact, we have seen that when we are in a position to increase the fees, we increase provider participation.

And we have a lack of State resources. Our budget is going crazy. Medicaid is a huge spender. Every legislative session, everyone is just outraged at the cost of Medicaid, and our revenue growth is not keeping up. There are real issues there. You know, it's almost a schizophrenic world sometimes because on the one hand we say

we have to be able to have higher fees; we must pay personal care attendants more to have more reliable personal care attendants. But then all the taxpayers are telling us that, the people who need these services are telling us that, but then of course when it comes time for a legislative session everyone is incensed at the rate in the Medicaid budget. So something has to be done regarding those issues in the budget.

[The prepared statement of Ms. DeCunzo follows:]

TESTIMONY FOR SENATE SPECIAL COMMITTEE ON AGING
Kalispell, MT
March 30, 1994

Presented by: Joyce De Cunzo, Supervisor
Home and Community Services Section
Montana Medicaid Services Division

Senator Burns: I am pleased to be a part of this discussion today. Montana Medicaid has been involved in the development of home care programs since 1977, when we began paying for personal care attendant services in people's homes. We implemented a home and community based services waiver program (1915(c) of the Social Security Act) in 1981, which made us a leader of the nation in terms of taking advantage of this new program allowed by Congress. I have been asked to address the issue of "barriers to home care", so offer the following information for you and the committee.

Some barriers are very specific and include:

1. **Institutional bias:** There has been and continues to be an institutional bias in publicly funded programs. That is, we tend to pay for care offered in institutional settings - nursing facilities, hospitals - but are not willing to put our resources into people's homes. The regulations for the waiver program - Medicaid's most promising program to allow comprehensive services in an individual's home - have these biases:
 - * The waiver program's cold bed policy means we must be able to prove an empty institutional bed is available for every person enrolled in the waiver. We have been told this policy will be abandoned but have not yet received word from HCFA about this issue.
 - * The waiver program needs to be made a state plan service. We spend inordinate amounts of administrative time to prove that this program, in place now for 13 years, is cost effective.
 - * There is a prohibition on payment for room and board for a person in the waiver. However, Medicaid payment is allowed for room and board costs in nursing facilities and hospitals.
 - * Medicaid may not pay for "packaged" services in community settings, while institutional services are reimbursed as a package of services. For example, assisted living facilities can offer several services in one facility but is not allowed under current Medicaid law except as part of a waiver service, which is not available to all Medicaid recipients.
2. **Residential services:** We have a tremendous lack of accessible and affordable housing. Over and over again we see people entering nursing facilities because they cannot obtain or keep housing which they can afford and which allows them to move about, both within and outside their homes.
3. **Accessible public transportation:** This is available only in our largest cities and even there is usually not sufficient. Most rural communities do not have transportation systems at all.
4. **Health care insurance:** People must be impoverished to access Medicaid but it often is the only medical insurance available to them. If they work, they may lose their Medicaid but still not be able to make enough to buy private insurance. Even when they can buy insurance, they are often permanently excluded from coverage for their disability. For many, it is a life-saving mechanism to stay on Medicaid.

5. **Lack of medical providers:** Medicaid fees are low for many services. Some parts of our state have no or very few physicians who are willing to serve Medicaid clients. Since all home care services require a physician's order, this is a definite barrier.
6. **Lack of state resources:** The Medicaid budget is spiraling upward and the state's revenue growth is not keeping up. We must pay for mandatory services, which includes nursing facility and hospital services, but most home care services are optional. When cuts have to be made to stay within state budgets, home care often is the first to go.

There are other barriers which are harder to describe. There is an attitude that elderly and disabled individuals are sick. This leads us to develop programs on a medical model rather than a model that supports people in their lifestyles. My favorite aunt, at a frail age 89, told me: "I can't sleep - not sick - don't hurt - just can't sleep". If anyone had told her she should see a doctor about that she would have been astounded. However, if a person has simply become frail, slowed down and needs frequent help with everyday activities, we think we must serve them only under a physician's order. The young disabled people we serve are outraged that they must endure medical services such as routine nursing visits to receive their care. To them, they don't need payment for medical services, they need supportive in-home services to get on with their everyday activities and that meet their own needs for choice making.

Finally, a major barrier to providing home based services deals with **cost and quality of life** - what are we willing to pay to allow personal decision-making about the quality of one's life. I know for a fact that, at age 50, I do not want to go to a nursing facility for the rest of my life if I'm in an accident tomorrow. In fact, of the hundreds of people I've talked to about this in my age group, I haven't met one person who said "Gee, I'll be happy when I get to leave my home and go live in a nursing home." At the same time, somebody has to pay for this care, whether it's in the home or in the institution. We are forced into an artificial comparison, based on costs, about which road we should follow when public funds are used. In other words, we must limit the amount we spend in community settings to what we would have paid in the institution. What we don't see in terms of cost is what this causes that also costs money. For people who are forced to receive care in a place they don't want to be results in other hidden costs: we spend money on mental health services; we see secondary illnesses in unhappy residents that costs more to treat; and there is no price we can attach to the dependence this system creates when we do not allow people to receive services in a place of their choosing.

Again, thank you for this opportunity to comment on this important issue.

Senator BURNS. It's actually driving the State budget?

Ms. DECUNZO. Yes, Medicaid is driving at this point the State budget. And for those of us who work in State government, we used to talk about the last legislative session. Now we talk about the last regular legislative session because our budget issues are certainly something.

There are two other things that are much harder to point. One of them is attitude. It's an attitude that says, If you're old or if you're—if you have a disability, that you must be sick. It's not an attitude that says that at some point we are all going to get old and become more frail and need some supportive services that are available around us at the time that we need them, or that we all stand a chance of being in an automobile accident tomorrow and our lives change, and while we will need a great deal of medical support for some period of time, we'll probably not need that medical support for the rest of our lives.

I had a very, very dear and favorite aunt who's 89 years old, and she wrote to me last Christmas and said, I can't sleep, honey. I'm not sick, I don't hurt. I just can't sleep. She needs supportive services around her. But if I said to her, Well, have you talked to your doctor? Well, I don't hurt, I'm not sick. Why on earth would I talk to my doctor? I just—You know. So this is an attitude that we have that when people require some help and some services that they must be sick. And you've already heard a lot about that this morning in terms of that mix and the interplay of, do we need a nurse supervisor or no? Do we need the doctor's signature to wash hair or no? Those are issues that we have to deal with.

And then the last one that I wanted to just very briefly touch on, and that is the cost and quality of life. And here again is where as taxpayers we hear this all the time at the State level. People don't want the costs to go up, but when it comes their turn to need the services that they can't pay for, they want them, they expect them. We expect in the United States of America to be able to have health care that is available to us, and if we can't afford it, we don't expect to have to say, oh, well, I guess I just don't get any health care. Now, we know that happens to people.

But we are constantly being placed in the position of having to determine how much health care and what is adequate in health care and what is right in health care and what should we be doing in health care, and using that as comparison under cost basis. So as an example, if we are always going to say that home care services as a whole have to be compared to the cost of institutional care, then we're losing and we're going to continue to lose because if you collect 50 people in one building, yes, you can provide their care less expensively than if you go to them in the place where they live and the place where they're comfortable.

What we do not consider in those cost comparisons are all the secondary disabilities that come out of that, the depression. Depression is on the rise in the United States. It's a fact that if people can receive their care in a place where they're comfortable, they heal quicker and they are healthier than if they have to be in a place that they don't want to be. And I see it every day, particularly with young disabled individuals who are going to nursing homes because they are not able to prove this cost-effective factor

that we ought to be serving them in their homes, but we can't do it for less than a nursing home, and that's where they go. They're 30, 35 years old; their life span will be every bit as long as yours and mine, because while they are disabled, they're not sick, and they're looking at living in a nursing home for many years to come. Those are the issues that come to us.

And I do certainly have some suggestions regarding decreasing some Federal regulations. Those things have been mentioned this morning that we need to more localize some of these things, and we are working on some coordinating models because it is terrible to go into someone's home and they don't begin to know whichever caregiver, whatever agency that caregiver belongs to. They know that Jane comes and John comes and Joe comes, but they don't know who those employees are and what the name is.

In the Federal level there needs to be some consolidation and standardization, if you will, regarding some of the rules, and I'll give you one perfect example. If you're trying to be eligible for Medicaid as an elderly individual you have to be age 65. However, you can be eligible for the Aging Fund when you're 60. And so are you old at 60 or are you old at 65? Why should we have this kind—I'm 50, and there are days I think I'm old. But there's some very basic issues like that where we have people who are age 60 and they need the services of Medicaid, and we get referral from the aging community for that, but, you know, they're elderly for purposes of that Federal program and not considered—

Senator BURNS. I will cite the example of my dad. He died at age 86. At age 85 he didn't need anything, you know. So you can't go—well, we would be interested in hearing some of your solutions on that and put them in form, and we'll put them in the record and I'll review them and we will be—we want to tell you we take seriously your recommendation.

Casey, thank you for coming this morning. We're interested in what you have to say.

STATEMENT OF CASEY BLUMENTHAL, DIRECTOR, FLATHEAD COUNTY HOME HEALTH AGENCY, KALISPELL, MT

Ms. BLUMENTHAL. Thank you, Senator Burns. My name is Casey Blumenthal. I've been the Director of Flathead County Home Health Agency here in Kalispell for about the last 4 years. Judy Graham and I, who's sitting to my left, have worked together on a joint testimony. I'll present the beginning part and she'll finish out the rest of it. Many of the things we are going to address have been discussed this morning already so I won't elaborate on them certainly, unless you have any questions, but I will mention them again because I feel they're important enough to mention more than once.

We are going to address the barriers to access that we have identified as home health providers in our community. As Medicare/Medicaid certified and State-licensed agencies, we both deliver skilled nursing, physical therapy, speech therapy, occupational therapy, home health aide and medical social services to the homebound residents of all Flathead County.

I'll first discuss the barriers that we've identified related to patients, and certainly some of these cross intermittently with some

of the other categories. While most of our patients do have Medicare or Medicaid coverage, there are always those who fall through the cracks which we've alluded to earlier, and have no health care coverage. While we provide services to these people, after extended periods of time that can be quite a drain on our resources. Certainly having some sort of universal coverage that includes home care would assist in this area.

To be eligible for State or Federal reimbursement for home health services, a patient must meet four eligibility requirements. While they're more involved than I'll say here, I will just enumerate them. First they must have a skilled need for the service; they must have a physician's order; they must have part-time or intermittent need rather than a 24-hour need; and they must be homebound.

We find that there's a major need not only in our community but it appears statewide and nationwide that we need to deliver services to people who may be only borderline eligible or not really even eligible. For instance, perhaps their acutely skilled need period is over, they've healed from whatever primary problem they have, but they still need help with their medication so that they can kind of stay on the clock, or just a checkup once in awhile by a nurse, a little checking in. We have a lot of little old ladies and little old men who would do really well to benefit from someone calling on them once a week, once a month even, to make sure they're eating well, make sure they're taking their medications right. That's not considered a skilled need so we cannot continue to provide services to them unless they can afford to pay out-of-pocket, which virtually none of them can. Often times that's all they need to keep out of a health care crisis and keep out of an institution. But since it isn't considered skilled, we can't do it.

Or on the other hand, we may have a patient that has a skilled need but is not completely homebound by the Federal definitions. Although it may be easier and less costly if home health were provided, it won't be allowed because of that.

I think by relaxing some of these definitions or requirements in the legislation and in the definitions would allow a lot more people to receive the minimum amount of skilled care that they do need so they could remain safely in their homes.

Another problem that Joyce just described was that of transportation, especially in the rural areas of the State. It's very difficult for those who live out of town, even for those who do live in town, if they don't have family or friends. Although we do have some public transportation, if it's pretty difficult for them to get in and out of the home to their doctors appointment or whatever, they just can't do it. And this can extend from acquiring medication to groceries to being unable to make their medical appointments. This is not a covered service for home health agencies even if it were available, and there are few viable alternatives for the more rural and less well-to-do patients.

Another problem we have encountered with patients is just general education. We certainly are working on this all the time, but it always amazes us how many residents of the county do not know what is available or they don't know when or who to call for help. We would like of course everyone to know, and also for people who

have elderly neighbors or relatives to kind of know what the red flags are so that they can utilize our services.

The next barriers are related to physicians. Nancy talked about it earlier. The big problem with doctors is that they're not currently reimbursed for any time directly related to home health. We discussed the huge amounts of paper work and phone calls that are required because of the regulations and that we cannot do anything that is not ordered by a physician. So we do bother them a lot, but we have to do that. Our national association has been working with physicians on this issue, and I don't know if they'll ever arrive at anything as far as HCFA is concerned, but I think that would be a really great way to go to make it a more regular thing that physicians will feel comfortable in ordering home health. They'll know that they'll get some of their services paid for.

Many physicians went through their medical school training without much emphasis on diagnosis and treatment of the geriatric patients. Whereas it's important for the nursing schools to incorporate this into their curricula, it's also important for the physicians to have this in the medical schools. More in-depth education of the medical community in these areas would probably enable these services to be delivered more appropriately and with greater understanding of the aging process. As Joyce just said, you find it common among those who are not geriatric-specialized that they do believe if you're old, you're also sick, or you should be. My personal philosophy is that they do not need to go hand in hand, but that's the way it's generally treated. I think that that's an attitudinal thing that needs to be addressed, and education that would help that.

Here again our education in the communities is something we work on on a regular basis, but there's always new people coming in who are not understanding of the services available or when to order what, and the more they know the better the services are utilized.

We have a lot of barriers related to staffing our agencies. Some of these have also been discussed. A major problem for both of us has been receiving rural reimbursement rates when required to pay urban-equivalent salaries to retain staff. This is especially true with the therapists, physical therapists in particular. I've been trying to locate a staff therapist for a year and a half, and it's been extremely difficult. We have had to make do with temporary traveling therapists which are extremely expensive and not cost-effective at all. But we want to provide the service so we do what we have to do. Therapy visits can be very costly due to increased travel times and mileage in large rural areas. Their productivity goes down and the cost per visit is high, and they don't always get paid what their cost per visit is.

Due to an increasing acuity of patients at home, that means they're sicker at home than they used to be, it is important to maintain a clinically competent staff of nurses and aides and therapists. It's expensive to provide training for continuing education. We have discussed what's involved in the ongoing education for home health aides, and if you want your staff to be able to deliver the kinds of services that are necessary, they have to be up to date on everything. And sometimes this costs a lot of money. If you don't

have the services available in your community, you have to bring someone in to educate them, or send them out to conferences and whatever. And also because we're busier and people are sicker at home, there are more evening and weekend visits that just have to be done and we have to pay differentials for those times to get people to work them, and so agencies can have pretty high staffing costs.

We talked about the Medicare requirement of every 2 weeks supervision of home health aides by a nurse or therapist. This is on an aide that is very well trained. Last year—when we were putting this together yesterday Judy had one of her office people check on how many supervisory nursing visits her agency did, and there were over 500 non-reimbursed only. So you can imagine what an expense that is to an agency to go out every 2 weeks on a patient to do a supervisory visit, not to do any nursing procedures.

Senator BURNS. This was just this county, 500?

Ms. BLUMENTHAL. And that was just her agency. Didn't include mine. I'm sure my numbers are similar. You have to pay the nurse the time and mileage to go out to the home. She has to document the visit that was done. While that's not as lengthy as a regular visit, it includes time and has to be covered but we cannot bill it as a nursing visit. It's an administrative expense that's covered by Medicare and it's very costly.

Another issue is being able to aggregate costs, something currently we are allowed to do. This is essential to maintain home health agencies due to the high cost of certain disciplines, especially the therapies and social services, and many agencies will have the cost of providing the service exceed the limits imposed on them by regs. And if that happens, then they're unable to provide that service if the costs are not continued to be aggregated. There has been legislation to try and do away with aggregated costs. So far our national association has been able to stand that off, but I'm sure it will come back and it won't work for rural agencies. They need to be aggregated.

Another local thing we encounter is due to the more evening visits, driving in rural areas after dark can be a problem. If you can't find anything—the landmarks are usually, "the mailbox is on the left."

Senator BURNS. Break you into the rural ways.

Ms. BLUMENTHAL. Well, our staff does amazingly well when there are no lights out there.

Senator BURNS. That is true.

Ms. BLUMENTHAL. But they get lost and sometimes you have to pay them for an hour driving around and they have to find a phone. It's one of those things.

Various barriers to delivery of special services due to having a larger service area. Services such as a laboratory, for example, are not available in outlying regions, so for that region the nurses go out and draw a blood sample on someone and bring it back into the lab and they have to go back out, and in and out and in and out, depending on how long the specimen can sit. But you have a lot of mileage on travel costs to and from laboratories.

Certain therapies also can be very expensive to deliver at home and also can be unsafe. When Bob Grady was talking about deliv-

ering IV therapy at home, sometimes you may not want to do that if the patient does not have a telephone, and maybe they're getting some morphine or something and there's a problem with that, or they have an IV line that has an immediate problem and there's no way to access the professional to come out and assist them. And there's trouble in some of these immediate areas. People cannot afford telephones and it prohibits delivery and home care to them in a safe manner. Same thing if they happen to be on a ventilator, you need to have emergency service accessible to them at all times.

Those are the various items I'm addressing, and I'll turn it over to Judy Graham and she'll discuss some other categories.

[The prepared statement of Ms. Blumenthal and Ms. Graham follows:]

SENATE SPECIAL COMMITTEE ON AGING FIELD HEARING
"HOME HEALTH CARE AND COMMUNITY-BASED SERVICES:
 OVERCOMING BARRIERS TO ACCESS"

Kalispell, Montana
 March 30, 1994

My name is Casey Blumenthal. I am the Director of Flathead County Home Health Agency here in Kalispell. I plan to present the beginning part of a joint testimony along with Judy Graham, Manager of Kalispell Regional Hospital Home Care and Flathead Hospice. We will address the barriers to access we have identified as home health providers. As Medicare/Medicaid certified and state-licensed agencies, we both deliver skilled nursing, physical therapy, speech therapy, occupational therapy, home health aide, and medical social services to the homebound residents of Flathead County.

Barriers related to Patients

1. While most of our patients do have Medicare or Medicaid benefits to cover home health services, there are oftentimes patients who "fall through the cracks", and have no health care coverage. We do provide services to anyone who needs them, but after an extended period of time this can provide a financial drain to our resources.
2. To be eligible for federal or state reimbursement of home health services, a patient must meet four eligibility requirements: 1) they must have a skilled need for service; 2) they must have a physician's order for care; 3) they must have a part-time or intermittent need (rather than a 24 hour need); 4) they must be homebound. We find that there is a major need to deliver services to people who are only "borderline" eligible. For instance, perhaps their acutely skilled need period is over, but they still require assistance with taking their medications, or need ongoing check-ups by the RN for a "mini-assessment" to make sure they're continuing to be safe in their home, can manage their personal care, are eating properly, etc. Although this is often enough to keep someone from experiencing a health crisis and ending up in the hospital, it is not considered a "skilled" need and is not covered. Or, we may have a patient who requires skilled care, but is not completely homebound -- though it may be easier and less costly for everyone if home health is provided, it would not be allowed because of this.
3. Another patient-related problem in our community is available transportation; this is especially difficult for those who live in outlying areas, or who do not have family or friends to rely on. Transportation problems can range from difficulty acquiring medications or groceries to inability to get to physician appointments. This is not a covered service for home health agencies, and there are few viable alternatives for the more rural and less well-to-do patient.
4. Although it seems like we have spread the word to everyone we know, it always amazes us how many residents of this county do not know about available services. Especially since our target group is those who might be homebound, it is even more difficult for them to become educated about their options. There are also many other service providers who are not aware of what's out there; they need to know too, so they can pass the word on. We would like everyone to know; and also what the red flags are (that might indicate calling home health) for their elderly neighbors or relatives.

Barriers related to Physicians

1. Physicians are not currently reimbursed for any time directly related to Home Health -- e.g. paperwork, phone calls, etc. Since our regulations require that patients be treated per a Plan of Care signed by the physician, and any change to this plan must have a written order also signed by the physician -- the amount of paperwork and time involved can be substantial. This can make some physicians reluctant to order Home Health services.

2. Many physicians went through their medical school training without much emphasis on diagnosis and treatment of the geriatric patient, and how to incorporate their treatment with home and community based services. More in-depth education of the medical community in these areas would probably enable these services to be delivered more frequently and with greater understanding of the aging process.
3. Again, although we have done much education to the physician community, there always seems to be somewhat of a lack of understanding about exactly what is available, or whom to call for which circumstances for their patients. The more they know, the better the services are utilized.

Barriers related to Staffing

1. A major problem for both agencies has been receiving rural reimbursement rates when required to pay urban equivalent salaries to retain staff -- especially with physical therapists. My agency has been trying to recruit a staff therapist for 1 1/2 years, and KRH has also had ongoing difficulty. We have had to resort to using temporary traveling therapists, which is extremely expensive and not cost effective. Therapy visits can also be very costly due to increased travel times and mileage in large rural areas -- their productivity goes down, and cost per visit is high.
2. Due to increasing acuity of patients at home, it is important to maintain a clinically competent staff of nurses, aides, and therapists. It is expensive to provide training for continuing education, especially if resources have to be brought in from outside the community. This can be prohibitive for small, rural agencies. It has also become more expensive to staff all around, as evening and weekend differentials are needed on a regular basis.
3. Medicare requires every two week supervision of home health aides by a nurse or therapist as long as services are provided. If the nurse does not happen to need to see the patient when a supervisory visit is due, the visit is not reimbursed and must be an administrative loss to the agency. Our agencies do over 500 non-reimbursed nursing visits for supervisory purposes per year -- and this is for aides who are already certified with the State, have 16 hours of home health training in addition to their nurse aide training, and must have 12 hours of ongoing education per year.
4. Being able to aggregate costs is essential for home health agencies; due to the high cost of certain disciplines (especially therapies and social workers), many agencies will have the cost of providing the service exceed the cost limits for that discipline and would be unable to afford the delivery.
5. Due to more evening visits, driving in rural areas after dark can be difficult and hazardous -- roads and landmarks are not well-lit, locating patients can be time consuming.

Barriers to Delivery of Special Services

1. Due to a large service area, many services such as a clinical lab are not available in outlying regions. For example, nurses must make frequent trips to and from the laboratory to deliver blood samples, driving up mileage and travel costs.
2. Certain therapies can be very expensive to deliver at home, and may also be unsafe -- for example, infusion therapy with narcotics is not feasible if there is not a phone available for emergency use, or there is not a caretaker in the home.
3. Also, delivering services to patients on ventilators may be difficult if respiratory therapy services not available for equipment, emergency access, etc.

This testimony will continue with the other home health provider in Flathead County.

My name is Judy Graham and I am the Manager of Kalispell Regional Hospital Home Care. I will be presenting the barriers that we see relating to reimbursement and to the non-skilled in home services.

Barriers related to Reimbursement

A. Medicare

1. Currently covers most skilled care needs but not all.
2. In order to qualify for the Medicare benefit, the patient must be "homebound". Although recent legislation clarified that homebound does not mean bedbound, the standard is fairly strict. Greater flexibility is needed in the application of the homebound standard to address the special needs in delivering care in the rural areas.
3. Still requires an excessive amount of regulatory paperwork.
4. Every little change on the established patient Plan of Care must have a physician's order. For example, if the patient needs the home health aide to give a bath more often than currently ordered, an order must be written for the physician to sign. Another example involves the regulation requiring a physician order for all supplies/dressings. If even a minor change occurs in the type of dressing needed, there must be an MD order for that particular supply.
5. Cost limits for home health do not adequately reflect the higher cost of providing service in rural areas, particularly with regard to therapy services.
(Note: it is very important that home health agencies continue to submit costs in the aggregate rather than by discipline).
6. Proposed co-insurance and/or deductible payments would be a definite barrier for those patients who could not/or would choose not to pay.
7. Prospective pay could be a major barrier depending on how it develops.

B. Medicaid

1. Cost of care not completely covered.
2. "Spend down" very confusing for many people. One month home health services are covered, the next month they may not be covered and so on.
3. Many fall through the every growing cracks.

C. Private Insurance

1. Many coverage issues - some are not realistic or logical. Many are very limited.
2. Lack of understanding by insurance personnel of what home health is and is not.
3. Consumer often believes they have more coverage than they actually do.
4. Often still perceived as qualifying service only if in lieu of hospitalization (not always appropriate in today's health care environment).
5. Increasing number of non-insured people. Agencies providing more charity care which in turn increases agency costs.

Barriers to other in-home services (Homemaker, respite, personal care)

1. Medicaid patients have some access.
2. Majority of people have no third party coverage. Cost of service can be as little as \$32 per week up to \$150 per day.
3. Minimal private insurance coverage but often only through home health agency and only in lieu of hospitalization. These can both create problems for the consumer and for the agency.
4. Sandwich Generation (working age citizens with family responsibilities and elderly to care for). The elderly parent is living with the active two generation family and respite care is needed while family members are at work and school.
5. The typical elderly person living by self, may be relatively safe but needs some assistance with medications. This cannot be legally provided by a paid person unless that person is an RN or LPN.
6. Most people/families cannot afford to pay for private services. The cost of all other services have increased e.g. food, prescriptions, rent and utilities, health care, transportation, etc. Usually there is no money left in personal budget to pay for private services.
7. Often home health agencies find a patient ready for discharge according to skilled regulations but the patient is in need of non-skilled in home services. This is always a dilemma because usually they cannot afford to pay for them.

Hospice

This is a whole new issue to discuss perhaps at another time. Patients would have some of the same barriers and some altogether new ones. In consideration of the time factor of this hearing, I will not go into detail but will be happy to answer any questions and/or concerns.

In review,

The Rural Home Care Provider
and
The Rural Health Care Consumer

are faced with several specific barriers including:

1. accessibility
2. isolation
3. transportation
4. limited reimbursement sources
5. lack of universal reimbursement coverage
6. homebound requirements
7. agency increased costs due to mileage and travel time resulting in lowered productivity
8. agency increased costs due to necessary staff education and training.
9. overall education needed for physicians, consumers and payors.
10. staff recruitment problems
11. excessive and duplicative Medicare paperwork

Thank you for allowing us the opportunity to provide our input and concerns. We will be happy to answer any questions.

Casey Blumenthal
Director
Flathead County Home Health

Judy Graham
Administrative Manager
KRH Home Care Agency

STATEMENT OF JUDY GRAHAM, HEALTH CARE PROVIDER

Ms. GRAHAM. Thank you. Up front I would like to say that I was invited here as a provider, but I would like to think that we're all here also as citizens. Most of us have worked in other areas of health care. I personally have been a discharge planner and hospital social worker. I've worked in homemaking programs, community health and school nursing. Our concerns are really not just as a provider. We're here because we're real concerned for all the things that have happened and the many changes that we feel need to be made in health care.

I would like to thank you, Senator Burns, for allowing us to come here. I think you've already figured out that each one of us could have taken a full day of your time. We need to talk very fast, have a lot to say and we cannot say it all today.

I've been in home health since the first year it was created and have seen so many changes that we feel like we're shouting, "Is anybody out there? Does anybody care? Is anybody listening? Are you the only one in the government who really wants to listen?" Or how many times we have somebody listen to us and then we watch the outcome be just bizarre. And maybe one thing is solved, but we end up with 10 more regulations, many of which you've been hearing about all morning. So that's kind of the dilemma that we're in.

Much of what I'm going to say has been either alluded to or mentioned today. I'm going to leave some of my talk out in honor of limited time, but if I repeat what has already been said, you will know that it's very important. Some things I'm going to say for about the third and fourth time and you're going to know that's extremely important to us.

Senator BURNS. I'm seeing the same things surface. It's starting to take a pattern here.

Ms. GRAHAM. Casey and I got together on that because we are in the same field and in the same location. She gave more of the heart part of it. I'm going to talk more about the money part. That also is something that we have seen happen in our field. Most of us remember the time the nurses were all heart and you didn't have to think about the money. And we've seen a major big change in that. So I would like to think that most of us in our field are concerned. We aren't just asking for the government to pay for everything or somebody else to pay for everything. As a consumer we're real concerned, and I feel the largest majority of us do take very, very good care of the resources that are given us.

I'm going to talk mostly about home health. I do want to save a little bit of time to talk about something we haven't talked about too much, and that's the in-home personal care services not reimbursed by Medicare. But first I'll talk about home health as we know it. And of course Medicare is our main provider. Most of us have somewhere from 65 to 85 percent of our patients covered by Medicare. Joyce has already talked about Medicaid. I want to spend a little bit of time on private insurance, but mostly we're going to talk about the home health services reimbursed by Medicare.

With home health we are talking about skilled care. There's so much confusion among providers, among even health care providers and among physicians as to what home health is and what it

is not. And it is a very structured—you've seen some of the paper work. We are a regulated industry and must justify the skilled care provided in home. Coverage is limited though in many cases. Sometimes the diagnosis "isn't correct." Sometimes the patient is getting a medication that's only covered under certain diagnoses, and so that won't be paid for. So it isn't as simple as, "This patient has Medicare; this patient needs skilled care, and automatically home health is covered." There are many barriers. Often the diagnosis is not acceptable or the patient is not making progress. The regulations change all the time. Sometimes the treatment that is needed is either more or not acceptable under the regulations.

Very often the frequency that a patient needs is a barrier—what we're seeing now are so many patients that are really not sick enough to be in the hospital, but borderline too sick to be at home. That has changed greatly in the last few years for home health care providers.

The length of time that a patient can be on home health is often a barrier. Many, many times we've reached a point where reimbursement sources and regulations are saying it's time for us to discharge this patient, and yet we see so many people who still need some care and have no other way for it to be provided. We're kind of like the tail end, and there are many needed services unaffordable to most senior citizens. They go from hospital and nursing homes and home health and then the gap from home health to personal care services is humongous. And we could spend another afternoon talking about that.

In home health we have to be documenting progress. It's a problem if we have a patient who isn't making progress or if we have a patient who is noncompliant. For example, it would take a lot longer for them to really understand and to start being compliant with their diabetic care, than the average. But if we're not able to document progress, we need to be discharging that patient. And that is a major big barrier for us lots and lots of times. We've talked about cracks, and I think crack almost is not a good word any more. Many of the cracks are canyons, big, black holes.

Senator BURNS. As in bottomless.

Ms. GRAHAM. You bet. And they're getting bigger and darker and we are starting to wonder if we will ever have the answers. We see a lot of elderly disabled who aren't making regular progress and they're not getting better, but they need care. You've heard a number of those scenarios today. There are some services such as public health and so on, but there's still just many, many, many, many patients who don't have the services available to them, and home health can't always be the answer. And a lot of times we're called upon to be the answer. "Why can't you be the answer?" we are asked. And our regulations will not allow us to do that.

Casey talked about homebound. In today's world is anyone homebound? You know, the dialysis patient packs up equipment in his van and goes off on a vacation. HCFA has spent some time redefining homebound. But I still feel that it's a long ways from being current. Maybe even the word needs to be changed, because people are not truly homebound any more. And that's a real barrier often times trying to define whether or not we can see a patient or not.

You've heard much about home health regulations. We are an expert in regulations. We've got them coming and going. Like Bridget said, they're coming from everywhere any more. We are definitely at the forefront. And interpreting these regulations and having them enforced just increases paper work, paper work, paper work, increases our time and increases the cost. And somehow in the midst of all of this the purpose generally seems to be that we're increasing quality but what we see is increased frustration and cost.

It is stated that the regulations are needed to prevent abuse. I think there may be one or very few abuse situations in many, many care situations. Suddenly we've got this big new regulation that's got to come down for everybody. I don't think we're really very logical. Abuse situations are not realistically addressed. We just change the regulations for everybody and don't stop to think about what we're creating, the domino effect, the paper work, the time and the cost. And I hear "quality" mixed in there, but I'm not sure we're really addressing quality care. I think there are a lot of us who give and would continue to give quality care without all of these regulations.

The one thing I'm going to mention a third time because this is so important is the fact that we have to get an M.D. order for every little thing we do. We've talked about the home health aide. We have an order on the plan of care for the aide to go out twice a week to give a bath, and suddenly the patient needs the aide to go three times a week. You have an order for the aide to go five times a week and Aunt Suzie comes from California and the patient doesn't need aide visits for a week. Every little change has to have a phone call to the doctor and signed. We have to have an order for every little dressing supply. If we're providing wound care and we've put on the plan of care that we're going to use six BD's and now we need to use a different dressing, we have to get M.D. orders for those. We have completely gone backwards in this area I feel. Nurses' discretion has just gone out the window as far as some of those smaller things that we have to get orders for. That is we feel very, very much a barrier.

It is a vicious cycle with providing care, but also raising the overall cost, when we cannot afford to pay for all the care. We cannot afford to pay for room and board for the people at home on Medicaid, we will not be able to pay for the home health care at all if cost continues to rise because of regulations. I think we've created some of that problem ourselves but we all need to work together.

You mentioned a Montana model. We would all love to do that. I think you will find all of us would give you lots of time and effort put into that, if it were possible. But most of the problems that we have in home health are Federal guidelines. You know, OSHA even wanted to establish a rule that mandated that a home health agency manager prove and make sure that all of his or her staff wore seat belts. Somebody "up there," spent salary dollars discussing and planning and didn't stop to think about the fact that there are some States that don't even have a seat belt law. There are really a lot of bizarre things that people spend some time on trying to understand what we're supposed to be doing providing home care. I think the Federal Government stands in the way of us providing

efficient care. I'm not sure a lot of wisdom or reality is used. I loved your comments about Washington, D.C.

Senator BURNS. There are people that are buried deep in the bounds of those buildings there that never see the sun but about twice a year and they think up these things, and they stay out of sight of us because if we solve them, we fire them.

Ms. GRAHAM. And that's sad.

Senator BURNS. We can't pray to get them out. We can't do anything. They're just there. They're worse than termites. I'm serious. Folks think that I don't pay attention to what I'm doing. I've got to develop—you've got to keep everything in perspective, and a sense of humor allows us to do that. But they're there, and they're funny looking little folks.

Ms. GRAHAM. Well, to talk about HCFA for just a few more minutes. I feel like we have been attacking HCFA all day, but I would like to think that we are all HCFA. We're the taxpayers and we're the government.

There are just a couple other areas that I would like to address this morning. Private insurance is a major barrier for many, many people who receive home health. Coverages are still very limited in many cases. There's still very much a lack of understanding by insurance companies. This is getting better, but it's very slow.

Many insurance people do not understand what home health really is. Oftentimes as a hospice and home health manager, and I find insurance companies haven't figured out the difference between hospice and home health yet. There's a lot of confusion, and that can be a real barrier.

We find a lot of older people who have a policy that they think covers many things that it does not. They think they have it all, "I've got insurance coverage and it's going to pay for everything." And oftentimes it doesn't. It's very, very limited. There's still a tendency on insurance policies to want to have the service be in lieu of hospitalization, which I think is no longer even appropriate for our world. Before DRGs, yes, it was. Now, it's not.

We provide maternal/child care in our agency too and we run into a lot of situations where we have moms who are on strict bed rest before the babies are born, and insurance companies will still say that's not in lieu of hospitalization and disallow the care.

We find particularly in the Flathead an increasing number of people who are not insured, and that's part of the biggest canyons that there are.

I would like to just address personal care services. When I talk about in-home personal care I'm talking about homemaking services, respite care, aide services. You've heard it addressed somewhat earlier this morning in the area of education. The point that I really want to make is to say that this is not reimbursed at this time by anybody. Medicaid has a program that pays for it partly. Occasionally you will have insurance coverage. But for the most part, this is a service that people must pay for themselves. And the cost can be anywhere from a few dollars a day to as high as \$150 a day if somebody needs to have a personal care attendant or a homemaker in order to stay out of a nursing home.

We run into a lot of problems seeing the elderly. You have the sandwich generation. You have the working mom and dad who are

raising their children and you have Grandma at home with them also. They all need to go to work and go to school, and Grandma is not quite healthy enough or mentally clear enough to stay at home so then what do they do? How do they pay for that? There's some adult care. But there's lots and lots of cracks and canyons there also. There are many, many of them.

We also see a great many elderly who will live alone in this community. I'll give you a quick example, one we just had a couple weeks ago which is pretty typical of the Flathead. An elderly gentleman who is not married. He worked in the Forest Service for many, many years. He lives in what some people would perceive to be a shack. It's his home. It's way out in the middle of nowhere. He has a couple of friends who check on him once a week. He's still mentally clear at age 95 but borderline. He's starting to forget a little bit, but he also wants to stay there at home by himself with his dog. He doesn't really need skilled care any more, and yet close to our discharge time, one of our physical therapists went into his home and found a dishpan of dishes on the stove; the pan was fiery red; the dishes had melted. The patient couldn't smell it. The therapist got there just in time to save a fire. We see these kinds of things all the time. And I don't know if anybody really has the answer for all these people, but we do run into a lot of times when it's time for us to discharge patients.

Hospice we haven't even addressed. I am a hospice manager such as is Nancy Heyer.

Senator BURNS. You're an angel. I really believe in that program.

Ms. GRAHAM. And we don't have time today to go into hospice. Hospice is a little different. Some of the barriers are the same, but there's a lot of barriers that are different. Much of it is a lack of understanding. Pain management is very, very expensive. There's no respite care, someone is dying at home, wants to die at home, and the family is getting very exhausted and they need someone to stay with them at night. The cost of paying that person is very high. And the other problem that we have in this State is it's against the law for a paid caregiver to help with medication. That is a real barrier at this point. If you're paying someone to come into your home and they cannot help you with the medicine, that is a major problem with hospice patients, as it is with home care.

To close, I was going to review but time is running out and I want to give you a chance to ask some questions. The main barrier for the consumer seems to be cost, paying for services. The main barrier for the provider seems to be heavily burdened with regulations and people telling us how to run our business and what's quality and what isn't quality. Personally I do not expect the government to pay for everybody and all services. I don't think most of us do. We have seen some progress, but it seems like every time we take a step forward we've taken several steps backwards. I think we all want to spend our government dollars wisely, but we want to see the American people get the care that they need. And we appreciate your efforts this morning in inviting us to come here. Thank you.

Senator BURNS. I'm going to ask a couple of questions and then go through this whole discussion. And Joyce, you know I love—in Washington we always have the people from the administration or

the administrators of a program testify first. They make their testimony and then they get up and leave, but they don't ever listen to the stories of the people who have to deliver the services and this type of thing. We see it all the time. I like this kind of arrangement because I think you should sit through and hear some of those things. And I think it's very—I think it helps us.

In some of these problems that we have talked about this morning, how many changes have got to be made at the Federal level and how many—that I can't change—and how many changes need to be made at the State level? If we could ferret those out—do you understand where I'm coming from?

Ms. BLUMENTHAL. Well, I would just say that in thinking over all that we've discussed this morning, the majority of our barriers seem to be federally related since our primary payer is a Federal payer and it's ruled by the Health Care Financing Administration. Generally those rules—or oftentimes a lot of our State rules and regulations are the same as the Federal ones. They haven't re-written them except of course with—probably with Medicaid administration and some of those things might be different. But primarily it would have to start with dialogue between the Federal payer and the people who are providing the services.

Senator BURNS. Now I'll ask anybody. I want to say we hear almost the same stories in just about every State we go about HCFA. Why is it so hard to change what they're doing? Have we got a turf war going on here? Everybody's nodding yes. Yes?

Ms. HEYER. We have a nickname for HCFA. It's called Here Comes Further Aggravation.

Senator BURNS. I'll write that down.

Ms. HEYER. I wanted to comment, Joyce will be happy to hear this. I think as home care providers, we have found the Medicaid program in Montana to bend over backwards as far as it can go within its limits to get home care to recipients. I believe it has been fantastic within the limits, but we do read the papers and we know what their constraints are. The relationship and the efforts to get care that has been the least barrier in delivering care. It's a lot easier to provide home care to a Medicaid client than it is to a Medicare client. I can say that in Montana we are unique. I've been active on the national level, and to hear the stories from other home care providers in other States where the Medicaid programs have had to cut and cut, that isn't the case here.

Senator BURNS. That's good to hear.

Ms. GRAHAM. Can I just make one more comment? On the State level the things that we're able to do on the local levels do work. Your aging council, your senior companions. We could list a lot of things that we do. If we had to spend less time fighting HCFA, we would have a lot more time to work on solving some of the problems we have at home.

Senator BURNS. Well, we thank you for coming this morning and, sir, we're not going to take any questions. I tell you what I have to do. I'm constrained on time, but I don't want to get this started because there's no place to turn it off whenever we start. Do you have a question though? Is it for the panel?

Mr. EASTMAN. I just wanted to make a statement how these problems can be stopped. It's the State government and the Federal

Government that are responsible for this. Because no one in State and Federal Government has the backbone to bring on severe iron fist laws to all this medical fraudulence. What is being talked about here this morning is really a very minute cost that can be taken care of real easy. We can well afford it if the Federal and State government will put their foot down and punish these fraudulent people from the doctor right on through. And also just like on 48 Hours, this one medical institute, doctors were sending patients to this place and they were running them through all—they would get to bill through all kinds of problems that never even existed. They fined this outfit over \$100 million. Can you imagine the money that outfit was making before that? One month later—they redid their medical bills. One month later they were doing the same thing. And what did the government do? Nothing. These people should be put away forever and these problems here, like I say, costwise are very incidental, and it can be well taken care of.

And the same way with this business of making people live on surviving equipment, that these people are dead. It's terrible. There should be a law everyone should have to have a death will, something—just like this last gorgeous ballet dancer because she was famous, they kept her on a life-suspended equipment at Temple University. And they showed a picture of her and it looked like some zombie that was taken out of a grave from a hundred years ago. And they question the doctor in charge of the hospital—what is this costing us? He says, It's well over \$1 million already. She's been dead a long time ago. It's the machines that are keeping her working. This is where our costs are. They're fraudulent.

And the same way with all the people coming into this country from other countries being taken care of because it's a Federal law. They come in here and have their children. Why should I have to pay for this? It's wrong.

Senator BURNS. That's true.

Mr. EASTMAN. It should be stopped, and our Federal Government and our State government doesn't have the guts to stand up and say, Hey, this has got to stop right now.

Senator BURNS. We thank you for those comments.

Mr. EASTMAN. They interviewed a doctor in charge of a hospital why these people were coming in, and he said, I want to let you people know. This isn't costing millions. This is into the billions.

Senator BURNS. I'm not going to make any excuses for that. But this is not the only water where that goes on. And in the private sector as well. So there's some people that won't stand up. Right now we're in a position, as far as law and order is concerned, we're in a catch and release situation anyway, and that only works up here on the river.

But I thank you for your comments. I thank the panels here who have testified. All of this will be entered into the record and we appreciate that, and this hearing and proceeding is closed. Thank you for coming.

[Whereupon, at 12 noon, the Committee adjourned, to reconvene at the call of the Chair.]

APPENDIX



Flathead County Area IX Agency on Aging

Courthouse East, 723 5th Ave. East
Kalispell, Montana 59901
Phone 756-5640

To: Senate Special Committee on Aging
From: Jim Atkinson, Director, Area IX Agency on Aging
Re: Field Hearing Testimony
Date: March 30, 1994

Dear Committee Members,

Thank you for the opportunity to submit testimony relative to the most pressing issues we experience on the front lines. I have discussed the issues with aging services directors across our state and the director of the state unit on aging, Charlie Rehbein. We would like to express some concerns and offer some suggestions that would allow us to continue serving the aging population in the most efficient and economical manner possible.

There are several positive aspects about the Older Americans Act that allow us to reach our clientele. One aspect is the absence of means tests for eligibility. We have just received the State Performance Reporting Requirements for FY 95, and income status reporting is included in the requirements. I realize that the federal government is asking for the data strictly to assess delivery patterns and that, at this time, income is not a determining factor as to whether or not a senior citizen will receive services. Allow me to enlighten you on the effects the means test will have on my clientele:

Seniors are very sensitive about accepting welfare, and any perception of receiving welfare tends to make them shy away from the services.

We are able to serve many who are just above poverty levels and who, if they did not receive our services, would no longer be able to stay in their homes. The alternative would be to spend down their assets and add to the Medicaid burden we already see in this state. If Aging Services becomes another program for the poor, those struggling to stay independent will sink.

Statewide, much of our work is done by volunteers. Most will put up with the paperwork in order to provide the human services work for which they volunteered. Increased paperwork, especially of such a personal nature, could have an adverse effect on the recruitment of volunteers.

If the objective of means testing is to reduce the number of seniors that will take advantages of the services available through the Older Americans Act, I believe it will succeed. However, if the objective is to identify the makeup of the population that is receiving services through Aging Services, let me suggest another way in which that could be accomplished.

The Older Americans Act requires us to coordinate services with other agencies (another positive aspect of the Act). However, other agencies are not required to coordinate services with us. Social Rehabilitative Services must ascertain the means of it's clients. If we were allowed to cross reference our clients with theirs, we could provide the poverty data desired by the federal government without putting our entire population through the rigors and embarrassment of a means test.

Another positive aspect of the Older Americans Act is the ability we have to tailor the funds to the needs of our clientele. Our area is able to utilize funds for an expanded transportation program, for example, that other areas cannot implement due to sparse population and distance. I would encourage the committee to continue to allow flexibility in delivery of services by maintaining a liberal fund transfer policy.

I received from the Area II Agency on Aging in Roundup a copy of a letter that highlights the need for support of care givers of the Alzheimer patients we have in Montana. The letter and responses that I have attached to this document will give you an idea of the dire need we have to support the selfless people that work with all dementia related victims.

A final comment I would like to offer is a request to recognize the need for Adult Protective Services in this state. Adult Protective Services is not mandated by the federal government and is underfunded by the state government. I can personally relate several horror stories that my staff and other support services have experienced in intervening for seniors. We could only go so far, though, before and entity with authority of guardianship needed to be brought in. Without APS, the client could not get help and continues to be a hazard to himself and others. Though we do not administer the APS program, we certainly want to advocate for it because of the great gap it fills in the continuum of services needed by our senior population.

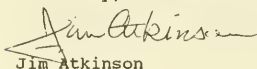
The Older Americans Act has several dignified aspects that serve our seniors well. The absence of means tests, the ability to design the program to fit the needs of the area and the impetus to coordinate with other agencies to meet the needs of our clients are all parts of the act you should strive to keep intact.

The onset of means testing would make us just another welfare program and destroy the intent of the Older Americans Act. We feel there is another way to get the data needed without resorting to means tests.

We would also encourage you to take a special look at services for our at risk seniors (those caretaking Alzheimer clients and those who are being abused or neglected and need Adult Protective Services). Funding for these intervention programs is vital for us to provide the continuum of care that the senior population needs.

Thank you for your audience and your interest in the well being of our older population.

Sincerely,



Jim Atkinson
Director
Area IX Agency on Aging

Rec.
January 11, 1994

Dorothy Bradley
State Capitol
Helena Mt 59620

Dear Mrs. Bradley:

My husband, Don A. Lacy, 56 years of age, was diagnosed with Alzheimer's Disease two years ago this month. He was employed with the Billings Public School system as a custodian at Will James Junior High School until his diagnosis two years ago. He is on Social Security disability and PERS retirement disability. He will not be eligible for Medicare until August 1, 1994. He served two years active duty in the U.S. Army from September 1960 - September 1962, (peacetime).

We have had Don on the experimental and now approved medication Cognex since August 1993. I feel it has not helped his condition at all. His condition has deteriorated in the last two months to the point that I have had to seek Adult Day Care provisions for him at St. Johns Lutheran Center. I am a secretary at West High School and I have to work to keep our health insurance and for my income to help pay the bills.

Adult Day Care at St. Johns costs \$25.00 per day. I have checked into financial help with this type of care and I cannot find any program that helps with day care. I have checked into Medicaid and they have informed me that he will not qualify until he is a full-time resident for one month and then they take his social security disability check and his PERS retirement disability check to pay for part of the long term care. My take home pay is approximately \$700.00. This is not enough money to pay our bills.

Do you know of any assistance that we might qualify for? I would appreciate any type of information that you might be able to help us with. Also, please help us by seeing that long-term care is a must in the health care reform package. Also adult day care.

Thank you for taking the time to consider my request for information.

Sincerely,



Patty Lacy
2946 Belvedere Drive
Billings, MT 59102
406-655-3101 (work)
406-656-1966

February 9, 1994

Mrs. Patty Lacy
2946 Belvedere Drive
Billings, MT 59102

Dear Mrs. Lacy:

Thank you for your letter regarding health care reform.

I am sorry for all your struggles with the health of your husband. Your situation is urgent and I wish I had an immediate solution to offer. The best I can suggest is that I will forward your letter to the Governor's Advocate in hopes that they can suggest some avenue that you have not thought of yet.

As to your recommendations about including long-term care in any plan that the Montana Health Care Authority proposes to the 1995 Legislature, I can assure you that it is an area we are paying great attention to. We are just completing a grant application that will go to the Robert Wood Johnson Foundation to fund an in-depth study of this very important element of health care reform.

I wish you the very best. Thank you for your time and interest.

Sincerely,

Dorothy Bradley
Chair

OFFICE OF THE GOVERNOR
STATE OF MONTANAMARC RACICOT
GOVERNORSTATE CAPITOL
HELENA, MONTANA 59620-0801

February 15, 1994

Mrs. Patty Lacy
2946 Belvedere Drive
Billings, Montana 59102

Dear Mrs. Lacy:

Your letter addressed to Ms. Dorothy Bradley was forwarded to my office for reply/referral.

I am sending copies of your correspondence to Mr. Brian LaMoure, Office on Aging, in the Department of Family Services. Mr. LaMoure is very knowledgeable in the area of Alzheimer's and will be able to offer advice as to what is available to you.

I sincerely hope services can be found to help ease your burden.

Sincerely,

A handwritten signature in cursive script, appearing to read "Myrna Omholt-Mason".

Myrna Omholt-Mason
Citizens' Advocate
Office of the Governor
Room 213, Capitol Station
Helena, Montana 59620

cc: Brian LaMoure

OFFICE ON AGING
DEPARTMENT OF FAMILY SERVICES



MARC RACICOT, GOVERNOR

(406) 444-5900

STATE OF MONTANA

PO BOX 8005
HELENA, MONTANA 59604-8005

February 22, 1994

Mrs Patty Lacy
2946 Belvedere Drive
Billings Mt 59102

Re: 1-11-94 letter to Dorothy Bradley on Long-Term and Adult Day Care.

Dear Mrs Lacy:

Your letter to Dorothy Bradley was forwarded to me from the Citizens Advocate, Myrna Omholt-Mason. I have made some inquiries into your situation and it was mentioned that Kathy Wise of SRS's Billings Medicaid Wavier team has been in contact with you, and apparently some Wavier services are being provided.

Enclosed is a brochure describing services available to Montanan's age sixty plus, these services are provided by local Area Agencies on Aging and Senior Centers through Federal Older American Act (OAA) funding. Unfortunately, Long-Term and Adult Day care are not programs funded under the OAA and in light of their cost, most likely it will not be. However, we do have some local contact people who may be able to assist you with the services in the brochure, they are:

✓ Karen Erdie, Director Area II Agency on Aging 323-1320 Roundup	Bea Ann Melicar Yellowstone Council on Aging 259-9666 Billings
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The Office on Aging also has an individual hired for Alzheimer's issues and she is presently managing a grant for outreach and respite programs on the Crow reservation, you may want to contact Ann Johnson in Bozeman at 586-3071, as the purpose of the grant is to expand these programs off of the reservation eventually.

In the Billings area there is an Alzheimer's Association Chapter which provides information and organizes support groups for caregivers. It has been shown that belonging to a support group is a tremendous help to caregivers. The Billings Chapter is through St. Vincent's Hospital and they can be reached at 657-7759.

Unfortunately, Long-Term and Adult Day Care alternatives are both limited and expensive, they are however becoming important issues in the discussions for the need of a changing health care plan and delivery system. The Montana Office on Aging is taking an active role in advocating for the elderly on these issues and we have been exploring alternatives to the present Nursing Home or nothing situation.

In summary, Mrs Lacy, there are no existing programs which offer the services you need outside of either the Medicaid or Medicare programs. There is a definite need for the services you have identified and the system is starting to look into and to debate the alternatives, but none of the alternatives are here today. I encourage you to keep the decision makers informed of the need for a changed health care delivery system for the benefit of both patients and caregivers.

Sincerely

Brian LaMoure
Office on Aging

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