

1992

# Legal and Policy Aspects of Home Care Coverage

S. Mitchell Weitzman

*Loyola University Chicago, School of Law*

Follow this and additional works at: <http://lawcommons.luc.edu/annals>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

S. M. Weitzman *Legal and Policy Aspects of Home Care Coverage*, 1 *Annals Health L.* 1 (1992).

Available at: <http://lawcommons.luc.edu/annals/vol1/iss1/3>

This Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in *Annals of Health Law* by an authorized administrator of LAW eCommons. For more information, please contact [law-library@luc.edu](mailto:law-library@luc.edu).

# Legal and Policy Aspects of Home Care Coverage

*S. Mitchell Weitzman\**

## I. INTRODUCTION

“Home care” is a catch-all term that encompasses several distinct industries and services. A clear definition of what home care means is crucial in terms of coverage, reimbursement, and licensure. The underlying policy governing home care services in the United States is fragmented, operationalized through various funding mechanisms, and heavily geared towards acute, medical custodial care, rather than long-term care. Fundamental policy questions regarding eligibility and coverage of home care must be addressed as the debates on health reform intensify and as efforts are made to more efficiently streamline health care delivery.

This article reviews home care coverage and reimbursement by both public and private payors, with particular emphasis on the Medicare and Medicaid programs. In addition, regulation of both the service and product sectors of the home care industry are reviewed. Finally, policy considerations in expanding home care programs are presented.

### *A. Origins of Organized Home Care*

Home care is a century old American tradition. Organized home care began in the late 1880's, a time when even the most seriously ill patients were sick at home. In 1909, Metropolitan Life Insurance Company successfully experimented with the idea of extending the services of visiting nurses to all of its industrial insurance policyholders. Soon, home-based nursing care was provided by a mix of organizations. By 1930, however, this early practice was becoming increasingly marginal when compared to the hospi-

---

\* Mitch Weitzman will receive his LL.M. in Health Law from the Institute for Health Law, Loyola University Chicago School of Law in January of 1993. He is currently a Project Manager in the health care division of State & Federal Associates, a consulting agency that assists pharmaceutical and medical device manufacturers with product coverage and reimbursement issues. Prior to enrollment at the Institute, he served as a staff member of the Pepper Commission and worked with the AARP's Legal Counsel for the Elderly in Washington, D.C. Mr. Weitzman received his J.D. from the George Washington University National Law Center in 1989.

tal-based system that came to dominate American health care.<sup>1</sup> Today, home care is enjoying a resurgence due largely to the enactment of Medicare and Medicaid, to advances in medical technology for the home, and to the recognition that home care is a more benevolent — and perhaps a more cost-efficient — way to provide care.

### B. *The Need for Home Care*

Older Americans suffer from a variety of both acute and chronic conditions that can be cared for in the home.<sup>2</sup> Limitations in activities of daily living (“ADLs”),<sup>3</sup> which include bathing, dressing, moving in and out of a bed or chair, toileting, and eating, make it difficult or impossible for almost one quarter of the nation’s elderly population — seven million people — to manage independently.<sup>4</sup> The vast majority of older Americans who need long-term care live in the community.<sup>5</sup> At the same time, estimates indicate that roughly one-third of nursing home residents do not require institutionalization and could live at home with assistance.<sup>6</sup> Given the choice, most people would chose not to reside in nursing homes.<sup>7</sup>

The greying of the baby boom generation will increase the need for home care. Between 1989 and 2030, the population of those 65 years and older is expected to more than double. By the year 2030, there will be proportionally more elderly than young people in the population. The population aged 85 and older is expected to more

---

1. Karen Buhler-Wilkerson, *Home Care the American Way: An Historical Analysis*, 12 HOME HEALTH SERVICES Q. 6 (1991).

2. This article will focus on the need for home care by the elderly and the services they receive. Note, however, that as many as one million children suffer from chronic illnesses that necessitate long-term care as well. UNITED STATES BIPARTISAN COMM’N ON COMPREHENSIVE HEALTH CARE, A CALL FOR ACTION, FINAL REPORT, 101st Cong., 2d Sess. 90 (1990) [hereinafter PEPPER COMMISSION].

3. The need for long-term care is usually measured by assessing limitations in an individual’s capacity to manage tasks of daily living (called activities of daily living, or ADLs). ADLs also encompass activities necessary to remain independent (known as instrumental activities of daily living, or IADLs). IADLs include housework, meal preparation, transportation, financial management, etc. ADL limitations are usually associated with chronic conditions such as cardiovascular disease or Alzheimer’s disease. *Id.* at 90, 91.

4. *Id.* at 91.

5. *Id.*

6. Carole Cox, *Expanding Social Work’s Role in Home Care: An Ecological Perspective*, 37 SOC. WORK 179 (1992).

7. Raymond J. Hanley & Joshua M. Wiener, *Use of Paid Home Care by the Chronically Disabled Elderly*, 13 RES. ON AGING 310, 311 (1991) [hereinafter *Use of Paid Home Care*].

than triple in size.<sup>8</sup> The growing number of older Americans will increase the number of people with chronic health conditions who will require home care services.<sup>9</sup> Clearly, the nation's health care system must be prepared to meet the challenge of greater utilization and changing needs.

### C. Defining "Home Care"

Defining "home care" is necessary on both a practical and policy level because its connotation is uncertain. Does a home care benefit in an insurance policy, for instance, cover only skilled nursing services in the home? What about changing and washing the linens on that individual's bed? What about the respirator that helps him or her breathe? Are these components of home care as well? Patients may have no idea of what services are covered by their "home care" benefit. By contrast, services covered under a typical "hospital" or "nursing home" benefit are generally universally understood. One would expect, for instance, that linens would be changed in a hospital as part of the hospital benefit.

Many think of home care as a nurse visiting a patient at home. However, the respirator example above illustrates another aspect of home care, home medical equipment. Thus, "home care" consists of both a service and product industry.

Typical home care services include skilled nursing care, physical therapy, and personal care. Typical home care products include home medical equipment and medical supplies. The service side of home care accounts for approximately two-thirds of industry revenue and the product side accounts for one-third.<sup>10</sup>

Further definitional precision of home care is required, however, because of the possible distinction between "home care" and "home health care." To illustrate the problem, consider Sarah, age 75, who needs assistance getting dressed in the morning. While a helper may be giving Sarah help in the home, i.e., home care, is Sarah receiving care that is related to her health, i.e., home *health* care?

As will be discussed in the Medicare coverage section of this

---

8. U.S. SENATE SPECIAL COMMITTEE ON AGING ET AL., *AGING AMERICA: TRENDS AND PROJECTIONS*, xix (1991) [hereinafter *AGING AMERICA*].

9. By the year 2030, 23.5 million older Americans are expected to have a disability. NAT'L ASS'N OF MEDICAL EQUIP. SUPPLIERS, INFORMATION, RESEARCH AND STATISTICS ON HOME CARE AND THE HOME MEDICAL EQUIPMENT SERVICES INDUSTRY: *A HOME CARE DIGEST* 3 (1992 draft) [hereinafter *HOME CARE DIGEST*].

10. AM. HOSP. ASS'N, *HOME CARE: POSITIONING THE HOSPITAL FOR THE FUTURE* 2 (Dan Lerman ed.) (1987) [hereinafter *POSITIONING THE HOSPITAL*].

article (section II.A.1.), Medicare specifically refers to a “home health benefit.”<sup>11</sup> Generally, Medicare will not pay for the services provided by Sarah’s helper unless the service relates to a medical condition.

For policy purposes, the distinction between home care and home health care highlights a key difference between traditional health care and home care. That is, home care users frequently purchase formal in-home services to maintain independence in the community rather than singularly to obtain a state of improved health.<sup>12</sup>

This article will employ a definition of home care that slightly modifies one used by the National Association for Home Care (“NAHC”); “home care” is a service (or provision of medical equipment) to the recovering, disabled, or chronically ill person providing for treatment and/or effective functioning in the home environment.<sup>13</sup> Home medical equipment, home health care, and a range of possible personal or custodial care services are components of this broad definition. As will be evident throughout this article, this definition inherently expands upon the acute illness, medically-oriented model of home care prevalent today.<sup>14</sup> In the future, policy makers will need to more precisely define home care to alleviate confusion and determine how home care programs will grow or change.

#### D. *Players in the Home Care Market*

In light of its tremendous growth, the home care industry has, not surprisingly, seen many new entrants and increased competition. Some of the primary players in the home care market include:

- large health care manufacturers and providers

---

11. 42 U.S.C.A. § 1395x(m) (West 1992).

12. Joshua M. Wiener & Raymond J. Hanley, *Caring for the Disabled Elderly: There’s No Place Like Home*, in THE BAXTER HEALTH POLICY REVIEW, IMPROVING HEALTH POLICY AND MANAGEMENT: NINE CRITICAL RESEARCH ISSUES FOR THE 1990s 81 (Stephen M. Shortell et al. eds., 1992) [hereinafter *Caring*].

13. National Association for Home Care information sheet, *What is Home Care* (1991) (on file with author). The remainder of this article will employ the term “home care” consistent with the definition above unless referring specifically to statutory language such as “home health care benefit” under Medicare.

14. Another component of home care is hospice care, which includes medical, social, psychological, and spiritual care for terminally ill patients and their loved ones. Though recognizing that hospice care is a component of home care, this article will generally not address hospice care benefits.

- dealers in durable medical equipment and surgical supplies
- staffing agencies
- health maintenance organizations (“HMOs”)
- chain pharmacies
- independent drugstores
- retail home care centers
- department stores
- independent practitioners
- mail order houses
- home health agencies<sup>15</sup>

### *E. Major Public and Private Programs Funding Home Care*

Home care is paid for by both public and private sources. Major public programs funding home care include Medicare, Medicaid, and the Older Americans Act.<sup>16</sup> Under Medicare, the largest source of public funding for home care,<sup>17</sup> the patient must be homebound, among other qualifying criteria, and care is usually available only for a limited duration.<sup>18</sup> Medicaid, which is federal and state jointly funded, provides more limited home health services, although under the system of Medicaid waivers, states are able to offer social and personal care services to patients who would otherwise be institutionalized.<sup>19</sup>

## II. HOME CARE COVERAGE BY PUBLIC AND PRIVATE PAYORS

### *A. Public Payors*

#### 1. Medicare

The Medicare program, established by Title XVIII of the Social Security Act,<sup>20</sup> is a system of health insurance for the aged and

15. POSITIONING THE HOSPITAL, *supra* note 10, at 2.

16. Under the Older Americans Act, 42 U.S.C.A. § 3001-3057n (West 1973 & Supp. 1992), demonstration projects may be undertaken to improve or expand supportive or nutrition services or otherwise promote the well-being of older individuals. Special consideration is to be given to projects designed to meet the supportive services needs of elderly victims of Alzheimer's disease and related disorders. Services include home health care, adult day health care, homemaker aides, transportation, and in-home respite care for the families, particularly spouses, of such individuals. 42 U.S.C.A. § 3035a (West Supp. 1992).

17. NAT'L ASS'N FOR HOME CARE, BASIC STATISTICS ABOUT HOME CARE-1992 at 3 [hereinafter BASIC STATISTICS].

18. 42 U.S.C.A. §§ 1395-1395ccc (West 1992 & Supp. 1992).

19. 42 U.S.C.A. §§ 1396-1396u (West 1992 & Supp. 1992).

20. *See generally* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified in scattered sections of 42 U.S.C.A.).

disabled. The Medicare program consists of two basic parts, Part A and Part B. Medicare Part A provides coverage for hospital care and extended care. In addition, most home health benefits are provided under Part A.<sup>21</sup> Medicare Part B is a voluntary program; eligible beneficiaries who pay a monthly premium are entitled to reimbursement for physicians' and other medical services.<sup>22</sup>

Medicare offers home care coverage that is focused on acute care, particularly periods of recovery following hospital and surgical care. To qualify for Medicare home health coverage, a beneficiary must be under the care of a physician, homebound, and in need of intermittent skilled nursing care or physical or speech therapy. Coverage is available for care that is "reasonable and necessary," and is not "custodial."<sup>23</sup> Services must be furnished on a visiting basis in the individual's home or, if it is necessary to use equipment that cannot readily be made available in the home, on an outpatient basis in a hospital, skilled nursing facility, etc.<sup>24</sup>

*a) qualifying for home health services under Medicare Part A*

Eligibility for home health services is predicated on several conditions. First, the beneficiary must need skilled care while "confined to his home."<sup>25</sup> This is commonly known as the "homebound" requirement and has been the source of much controversy. Medicare frequently denies claims based on a beneficiary's not meeting this condition. There has been some confusion, for instance, over whether "homebound" means "bedbound." Medicare has denied coverage when a beneficiary visited an adult day care center on the basis that he is not homebound, even if herculean efforts were needed to transport the patient to the center.<sup>26</sup>

The definition of "homebound" has been clarified and liberalized by the Omnibus Budget Reconciliation Act of 1987,<sup>27</sup> which confers eligibility for home health services to those who, although not bedridden, leave home only with the help of others or supportive devices. The Act states, in part:

[W]hile an individual does not have to be bedridden to be consid-

21. See generally 42 U.S.C.A. §§ 1395c to 1395i-2.

22. See generally 42 U.S.C.A. §§ 1395j-1395w.

23. 42 U.S.C.A. §§ 1395y(a)(1)(A), (a)(9).

24. 42 C.F.R. § 409.42(e) (1991).

25. 42 U.S.C.A. § 1395f(a)(2)(C); 42 C.F.R. § 409.42.

26. Interview with William Dombi, Director of the Center for Health Care Law, National Association for Home Care, in Washington, D.C. (Jan. 15, 1992).

27. Pub. L. No. 100-203, 101 Stat. 1330-73 (codified in scattered sections of U.S.C.A.).

ered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.<sup>28</sup>

Proposed Rules issued on October 7, 1991<sup>29</sup> quantify terms such as "normal inability to leave the home" (limits a beneficiary's absence from the home, other than for medical treatment reasons, to an average number of hours per calendar month) and "infrequent absences" (an average of five absences or fewer per calendar month, except for medical treatment reasons).<sup>30</sup>

The second condition on which eligibility is conditioned requires the establishment of a plan for servicing home health services; a physician must periodically review the plan<sup>31</sup> and services must be furnished under arrangements made by a participating home health agency.<sup>32</sup>

The third condition is that the home health services are needed for intermittent skilled nursing services, physical therapy, in some instances occupational therapy,<sup>33</sup> or speech pathology.<sup>34</sup> If skilled nursing is the qualifying service, it must meet further criteria for coverage.<sup>35</sup> First, there must be a medically predictable recurring need for the service, usually once every 60 days. Second, the need for skilled nursing services must be needed less often than "daily" (five or more days a week). Thus, the duration of care for skilled nursing services must be for a finite and predictable period of time.<sup>36</sup> In practical terms, the issue of whether there is a predictable end to the need for skilled nursing services is a frequent source of conflict between providers and the Health Care Financing Ad-

28. 42 U.S.C.A. § 1395f(a)(8) (West 1992).

29. 56 Fed. Reg. 50,542 (1991) (to be codified at 42 C.F.R. § 409).

30. Medical absences from the home would be limited to absences to receive treatment that cannot be furnished in the home.

31. 42 U.S.C.A. § 1395f(a).

32. 42 C.F.R. § 409.42(g).

33. Occupational therapy is not a qualifying service to start care, but is a qualifying skilled service to continue care when other skilled services have been discontinued.

34. 42 U.S.C.A. § 1395f(a)(2)(C). See generally HEALTH CARE FIN. ADMIN., HEALTH INSURANCE MANUAL-11 § 205.2A-2D (1989) [hereinafter HIM-11]. HIM-11 is a HCFA manual that provides instruction to providers on coverage, billing, and other issues. HIM-13 is a HCFA manual that provides instruction to intermediaries on coverage, billing, and other issues.

35. HIM-11, *supra* note 34, § 205.1C.

36. Thus, if a patient qualifies under a covered therapy, it is not also necessary for the nursing services to meet the intermittent care qualifying criteria; the intermittent care rules do not apply to therapy services.



ministration (“HCFA”), the governmental agency that administers Medicare.<sup>37</sup>

*b) coverage criteria under Medicare Part A*

Once the *qualifying* criteria described above have been met, the beneficiary must also meet the *coverage* criteria embodied in the description of the Medicare home health benefit. The home health benefit under Medicare includes the following items and services: part-time or intermittent nursing care; physical, occupational, or speech therapy; medical social services; part-time or intermittent services of a home health aid; medical supplies (other than drugs and biologicals); and the use of medical appliances.<sup>38</sup> The most confusing and contested of these criteria is the requirement that any skilled nursing or home health aid services be “part-time or intermittent.” These terms are not defined in either the statute or the regulations, and coverage decisions tended to be based on informal sources of policy, such as transmittals and correspondence sent by HCFA to its fiscal intermediaries.

Frequent coverage denials based on the part-time or intermittent requirements resulted in a significant Medicare home care case, *Duggan v. Bowen*.<sup>39</sup> In *Duggan*, HCFA was charged with using an unlawfully narrow definition of “part-time or intermittent care” to deny home health benefits to beneficiaries essentially by defining “part-time” as less than eight hours a day and “intermittent” as care offered less than “daily” (more than four times a week). Thus, HCFA did not cover skilled nursing or home health aid services if they were required more than four days a week — regardless of the number of hours per day the Medicare beneficiary needed such care. In addition, HCFA was charged with requiring a beneficiary to demonstrate a need for both “part-time *and* intermittent care,” requiring Medicare-covered care to be provided four or fewer days a week for less than eight hours a day.

The court concluded that HCFA violated the Medicare statute by requiring care to be both part-time (less than eight hours per day) *and* intermittent (four or less days per week). Both the plain meaning of the statute and its legislative history indicates that Congress intended the “part-time *or* intermittent” home health care provision to entitle Medicare beneficiaries to receive care at

37. Interview with Thomas Galluppi, Vice President of the Finance and Administration/CFO, Visting Nurses Association of Chicago, in Chicago, Illinois (Aug. 14, 1992).

38. 42 U.S.C.A. § 1395x(m).

39. 691 F. Supp. 1487 (D.D.C. 1988).

home as long as they do not require full-time care.<sup>40</sup>

The court also took issue with HCFA's definition of "daily," stating that merely because the business week is made up of five days does not mean that home health care needed five days a week is "daily." "Beneficiaries' medical needs do not take the weekend off," Judge Stanley Sporkin added.<sup>41</sup>

Finally the court noted that HCFA's policy was arbitrary and capricious, illustrating that a beneficiary needing a total of five hours of care per week is denied coverage if the care is needed over the course of five or more days, while a person needing as many as 27 hours of care spread over only four days may qualify for coverage.<sup>42</sup> Following the *Duggan* decision, HCFA revised its home health care manuals to recognize that either part-time *or* intermittent services meet the coverage criteria.<sup>43</sup> In addition:

- "Daily" is now defined as seven days a week for the coverage criteria. (Note, however, that "daily" is five or more days a week to determine if a patient *qualifies* for service but seven days a week to determine if the patient meets *coverage* criteria.)<sup>44</sup>
- "Intermittent" is now defined as skilled nursing or home health aid services provided less than "daily" (seven days a week) when combined for up to 35 hours a week, or up to 56 hours a week provided seven or fewer days a week for a predictable, or finite, period of time (generally three or more weeks).<sup>45</sup>
- "Part-time" is now defined as up to 35 hours a week of skilled nursing or home health services that, when combined, are provided for less than eight hours a day regardless of the number of times per week such services are required.<sup>46</sup>

To illustrate how the qualifying and coverage criteria operate, consider the following scenarios.<sup>47</sup>

Alice needs a skilled nursing visit once a week and home

40. *Id.* at 1491. See H.R. REP. NO. 213, 89th Cong., 1st Sess. 29 (1965) and S. REP. NO. 404, 89th Cong., 1st Sess. 32 (1965), reprinted in 1965 U.S.C.C.A.N. 1943.

41. 691 F. Supp. at 1514.

42. *Id.* at 1513.

43. HIM-11, *supra* note 34, § 206.7.

44. *Id.*

45. *Id.*

46. *Id.*

47. Scenarios were adapted from NAT'L ASS'N FOR HOME CARE, HOMECARE: MEDICARE HOME HEALTH COVERAGE, PART-TIME OR INTERMITTENT CARE EXPLAINED (1991).

health aid services seven days a week. It is expected that she will not require this level of care indefinitely. The nursing visit is less than one hour long and the aid visits are three hours each. Alice meets the *qualifying* test since she needs skilled nursing care on an intermittent basis and has a recurring need at least once every 60 days. Alice meets the *coverage* test because the combination of nursing and aid services represents “part-time” care. Alice receives a combined 22 hours of services, well within the 35 hour standard.

Fred requires skilled nursing care five to seven times per week, physical therapy once a week, and home health aid services seven times a week. Nursing and aid services are required for an indefinite duration. Fred meets the *qualifying* test because of his need for weekly physical therapy, thus eliminating the need to apply the skilled nursing care criteria. The *coverage* test must be applied to the nursing and aid services to determine whether coverage will be limited. If the combination of nursing and aid services is not more than 35 hours a week, full coverage would be available.

*c) home health benefits under Medicare Part B*

Durable medical equipment (“DME”) is covered under Medicare Part B and is defined in the regulations as “equipment which can withstand use; is primarily and customarily used to serve a medical purpose; is generally not useful to a person in the absence of an illness or injury; and is appropriate for use in the home.”<sup>48</sup> Examples of DME described in the statute include iron lungs, oxygen tents, hospital beds, and wheelchairs.<sup>49</sup>

Interestingly, the Medicare statute and regulations continue to employ the term “*durable* medical equipment” while the industry utilizes the term “*home* medical equipment,” reflecting the fact that significant technological advances have occurred since the days of the iron lung. New technologies such as infusion therapy make the term “*durable*” outmoded. In light of the continuing development of new technologies, the statutory examples of durable medical equipment seem restrictive and similarly outmoded. Perhaps the statute should be redrafted to eliminate specific examples and to provide for any “*certifiably effective*” home medical equipment currently available or developed in the future.

---

48. 42 C.F.R. § 405.514(b) (1991).

49. 42 U.S.C.A. § 1395x(n) (West 1992).

*d) fragmented coverage under Medicare*

Medicare pays for home health care only for persons needing skilled nursing care or a therapy. Unless a person needs these services, it generally does not pay for less skilled, nonmedical services, such as housekeeping (which Medicare specifically excludes from coverage).<sup>50</sup> Yet custodial services are the very services disabled persons are most likely to need.<sup>51</sup> As a result of Medicare's restrictive qualifying and coverage rules, most disabled elderly are not eligible for benefits or, if they are eligible, are unlikely to receive benefits of sufficient scope or duration to address their needs.<sup>52</sup>

Also hindering the disabled elderly's efforts to remain at home and out of institutions is Medicare's bias towards institutional coverage. Meal preparation is a covered benefit in an institutional setting, but not necessarily in the home. Drugs and biologicals are covered for hospital inpatients,<sup>53</sup> but not at home.<sup>54</sup> Similarly, new medical technologies may be covered in an institution, but not in the home. Yet it is these services that are most likely to keep individuals out of institutions.

When Medicare was enacted in 1965, it was difficult to foresee the rapid evolution in medical technology that makes home care a practical as well as desirable alternative. Yet Medicare has not yet integrated modern home care practice into its policies, as reflected by language such as "durable" medical equipment. Lack of integration and coordination in Medicare coverage is particularly apparent with regard to home drug infusion therapy ("infusion therapy").

Home infusion therapy began in the early 1980s with intravenous feeding. The development of new drugs and improved infusion technologies have made it possible to administer a wide range of therapies, including antibiotics, chemotherapy, pain therapy, and nutritional therapy, in the home. Some drugs, such as antibiotics, are infused over relatively short periods of time a few times a day; others, such as analgesics to relieve pain, may be administered around the clock.<sup>55</sup>

To date, Medicare has no benefit that explicitly covers home in-

---

50. 42 C.F.R. § 409.41 (1991).

51. 138 CONG. REC. S5234 (April 9, 1992).

52. PEPPER COMMISSION, *supra* note 2, at 96.

53. 42 C.F.R. § 409.13 (1991).

54. 42 U.S.C.A. § 1395x(m).

55. An example of a new therapy is Dobutamine therapy for chronic congestive heart failure, which has traditionally been administered in critical care units of hospitals. Now this can be done at home through the use of a pump that administers a constant minimal

fusion therapy. The Medicare Catastrophic Coverage Act of 1988<sup>56</sup> would have extended coverage to this benefit, but it was repealed before it was ever implemented.<sup>57</sup>

Medicare pays for "medically necessary" services and supplies associated with drug infusion when it takes place in hospitals, outpatient clinics, or physicians' offices. For home care, as noted above, there is no current infusion therapy benefit per se, though Medicare sometimes pays for many of the components of home infusion therapy under existing benefits. Core nursing services used in infusion therapy are often covered under the Medicare Part A home health benefit, and pharmacy services and supplies are sometimes covered under the Part B durable medical equipment benefit, which covers equipment such as infusion pumps.

In a report to Congress released in May, 1992, the Office of Technology Assessment ("OTA") addressed Medicare coverage of infusion therapy,<sup>58</sup> stating that the lack of a coordinated benefits "limits the ability of Medicare to assess, monitor, or influence the safety, quality and effectiveness with which HDIT [home drug infusion therapy] services are delivered."<sup>59</sup> In general, OTA found that Medicare coverage of infusion therapy would "offer opportunities for enhanced quality of life during treatment for many beneficiaries," but may not be cost effective.<sup>60</sup>

The report notes that while home infusion therapy often has been touted as a way of reducing health care costs because it would remove the patient from the hospital setting in the short run, "the addition of this benefit would raise program costs significantly because Medicare cannot immediately recoup the financial benefits of shorter hospital stays."<sup>61</sup> Medicare patients are more likely to have medical conditions that would require a paid caregiver to administer home infusion therapy or provide assistance with daily living activities. "Thus while some Medicare patients are ideal and self-sufficient candidates for home infusion therapy, many would

---

dose of the drug, which lessens the possibility of the patient becoming tolerant to the drug.

56. Pub. L. No. 100-360, 102 Stat. 683.

57. Pub. L. No. 101-234, 103 Stat. 1979.

58. OFFICE OF TECHNOLOGY ASSESSMENT, CONGRESS OF THE UNITED STATES, SUMMARY: HOME DRUG INFUSION THERAPY UNDER MEDICARE (1992) [hereinafter OTA].

59. *Id.* at 10.

60. *Id.*

61. *Id.* at 9. In the long run, any potential program savings would depend on such factors as patient eligibility criteria, drugs covered under the program, and payment methodology (prospective or retrospective).

probably have total home care costs that exceed institutional costs."<sup>62</sup>

The OTA report states that current Medicare coverage of infusion therapy is fragmented and highly variable, noting that some carriers interpret the durable medical equipment benefit to include coverage for antibiotics administered by a gravity drip while others almost never pay for any drug through this benefit. OTA also noted that there are no guidelines under Medicare for who can provide infusion therapy, and no minimum quality standards for such providers.<sup>63</sup>

OTA recommended that, while Medicare costs may not be significantly reduced and may actually rise, covering infusion therapy and placing defined requirements on providers and patients is likely to improve the quality of home care that Medicare patients receive.<sup>64</sup>

## 2. Medicaid

Medicaid, Title XIX of the Social Security Act,<sup>65</sup> is a jointly financed and administered federal-state health insurance program for the poor. States develop their own plans based on federal guidelines. If a state agrees to participate in the Medicaid program, federal law requires that it must provide certain services and grants it the option of providing others.

A participating state *must* provide certain services to the "categorically needy," who are qualified pregnant women and children and recipients of Aid to Families with Dependent Children ("AFDC") and Supplemental Security Income ("SSI").<sup>66</sup> These services include hospital services, nursing facility services, and physician services.<sup>67</sup> Participating states have the *option* to provide services to the "optional categorically needy,"<sup>68</sup> which might include, for example, persons eligible for AFDC or SSI who have not applied,<sup>69</sup> or the "medically needy,"<sup>70</sup> persons who fall into one of the categories covered by the state, such as the aged, disabled, or

---

62. *Id.* at 8. OTA estimates that 10-15 percent of current home infusion therapy patients are elderly. It is estimated that 250,000 people per year currently receive drug infusion therapy at home. Most infusion therapy patients tend to be those who require intravenous drug therapy for infections or persons with cancer or AIDS. *Id.* at 2-4.

63. *Id.* at 4.

64. *Id.* at 10.

65. 42 U.S.C.A. § 1396.

66. *Id.* at § 1396a(a)(10)(A)(i).

67. *Id.*

68. *Id.* at § 1396a(A)(ii)(I).

69. U.S. HOUSE OF REPRESENTATIVES COMM. ON ENERGY AND COMMERCE, SUB-

families with dependent children, and whose income is only slightly in excess of the standards for cash assistance.<sup>71</sup>

In terms of home care, a state Medicaid plan must cover certain home health services and supplies for all categorically needy individuals entitled to nursing facility care.<sup>72</sup> Those who are covered under the optional categories must be provided home health services if, under their state plan, they are entitled to nursing facility services.<sup>73</sup> Thus, home care services are mandatory for all persons entitled to nursing facility placement.<sup>74</sup> Medicaid pays for home care in two other ways. First, states have the option of providing personal care services for individuals who are not entitled to nursing home placement.<sup>75</sup> Second, states may provide a variety of home care services under special waiver programs.<sup>76</sup> These are further discussed below.<sup>77</sup>

*a) mandatory services for all persons entitled to nursing facility placement*

Home care services that *must* be provided in a Medicaid plan include part-time or intermittent nursing services provided by a home health agency, home health aid services provided by a home health agency, and medical supplies, equipment, and appliances suitable for use in the home.<sup>78</sup> A state Medicaid plan *may* provide physical therapy, occupational therapy, and speech pathology.<sup>79</sup>

Home health aid services are not defined in the Medicaid statute or regulations, but are defined in the Medicare "conditions of participation"<sup>80</sup> as including the "performance of simple procedures as an extension of therapy services, *personal care*, ambulations and

---

COMMITTEE ON HEALTH AND THE ENVIRONMENT, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (1988) [hereinafter MEDICAID SOURCE BOOK].

70. 42 U.S.C.A. § 1396a(a)(10)(C).

71. MEDICAID SOURCE BOOK, *supra* note 69, at 70.

72. 42 U.S.C.A. § 1396a(a)(10)(A); MEDICAID SOURCE BOOK, *supra* note 69, at 92.

73. 42 U.S.C.A. § 1396a(a)(10)(D).

74. Note that patients do not have to be entitled to "skilled" nursing facility services to be eligible for home care services. The word "skilled" was deleted effective October 1, 1990, in accordance with the Omnibus Reconciliation Act of 1987. Thus, entitlement is to "intermediate care facility services," which is defined as "health related services above the level of room and board . . . ." 42 C.F.R. § 440.1509(a) (1991).

75. 42 U.S.C.A. § 1396d(a)(7); 42 C.F.R. § 440.170 (1991).

76. 42 U.S.C.A. §§ 1396n(c)-(d) (West 1992 & Supp. 1992).

77. For a comprehensive discussion of Medicaid home care, see Ellice Fatoullah, *Medicaid Home Care for the Elderly and Disabled* (Clearinghouse Review, forthcoming 1992).

78. 42 C.F.R. § 440.70 (1991).

79. *Id.*

80. To be a participating provider of services and receive payments from Medicare, a

exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, etc.”<sup>81</sup> Personal care services, in turn, are defined in the Medicaid regulations as services prescribed by a physician, supervised by a registered nurse, and provided by a qualified individual who is not a member of the recipient’s family.<sup>82</sup> Personal care services may include grooming, assistance with food, nutrition and diet, and household services (if related to a medical need) as are essential to patients health and comfort in their homes.<sup>83</sup>

Legislation passed in 1990, effective October 1, 1994, amended the Medicaid section providing for home health care services<sup>84</sup> to include the definition of personal care services cited above,<sup>85</sup> thereby expanding the scope of the Medicaid home health benefit in the future.

*b) optional services for individuals who are not entitled to nursing facility placement*

A state has the option of providing home health or personal care services to those not entitled to nursing facility placement. As part of the Omnibus Budget Reconciliation Act (“OBRA”) of 1990, the Frail Elderly Law was enacted allowing states to cover home and community-based care for functionally disabled elderly individuals.<sup>86</sup> Significantly, the law assesses a patient’s need for home care services on a “functional” basis, rather than the “medical” model generally utilized by Medicaid and Medicare.<sup>87</sup>

An individual is “functionally disabled” if (1) he or she is unable to perform without substantial assistance from another individual at least two of the following three ADLs: toileting, transferring, and eating; or (2) he or she has been diagnosed with Alzheimer’s disease and is unable to perform without substantial human assistance or supervision at least two of five ADLs, or so cognitively impaired as to require supervision because he or she engages in behavior that poses a hazard to oneself or others.<sup>88</sup>

---

home health agency must sign an agreement with HCFA and meet statutory “conditions of participation.”

81. 42 C.F.R. § 484.36(c) (1991) (emphasis added).

82. 42 C.F.R. § 440.170(f).

83. Fatoullah, *supra* note 77, at 11.

84. 42 U.S.C.A. § 1396d(a)(7).

85. See note following 42 U.S.C.A. § 1396d.

86. 42 U.S.C.A. §§ 1396d(a)(23), 1396t.

87. Fatoullah, *supra* note 77, at 20.

88. 42 U.S.C.A. § 1396t(c)(1).



The range of services a state may provide under the law is quite comprehensive, including homemaker/home health aid services, chore services, personal care services, nursing services, respite care, training for family members, and adult day care.<sup>89</sup> The Frail Elderly Law represents an expansion of Medicaid services in that most states fail to include all of these optional services in their state plan; significantly, an individual can receive homemaker services, for instance, when functionally unable to perform them, as opposed to standard Medicaid policy, which covers services directly related to a patient's medical condition or plan of treatment.<sup>90</sup>

A significant problem with the law, however, is the limited federal dollars allocated to the program, perhaps explaining why as of this date, the Frail Elderly option has not been exercised by any state.<sup>91</sup>

### c) *waivered services*

Until OBRA-81<sup>92</sup> was enacted on August 13, 1981, the Medicaid program provided little coverage for long-term care services in a noninstitutional setting. HCFA admitted that many elderly, disabled, and chronically ill persons were living in institutions not for medical reasons, but because of the scarcity of health and social services available to them in their homes and communities. Even when services were available, Medicaid coverage was limited.<sup>93</sup> OBRA-81 authorized the Secretary of Health and Human Services to waive Medicaid statutory requirements in order to establish a home and community-based services waiver, commonly known as a "section 2176 waiver."<sup>94</sup>

What is being "waived" is the "comparability" of services requirement under Medicaid.<sup>95</sup> That is, services offered to the categorically needy and medically needy must ordinarily be comparable in amount, duration, and scope to those available to any other categorically needy or medically needy beneficiary in the state.<sup>96</sup> The package of services made available to waiver participants may include optional Medicaid services that are not available to other Medicaid beneficiaries under the state plan, as well as serv-

---

89. 42 U.S.C.A. § 1396t(a).

90. Fatoullah, *supra* note 77, at 23.

91. *Id.* at 23, 25.

92. Pub. L. No. 97-35, 95 Stat. 357.

93. 57 Fed. Reg. 29,142 (1992).

94. 42 U.S.C.A. § 1396n (West 1992 & Supp. 1992); 42 C.F.R. § 440.250(k) (1991).

95. 42 C.F.R. § 440.240 (1991).

96. MEDICAID SOURCE BOOK, *supra* note 69, at 105.

ices that are not strictly medical in nature and would therefore not qualify for ordinary Medicaid coverage. Optional services that may be included are case management services, homemaker/home health aid and personal care services, adult day care, respite care, and habilitation services that improve the participant's social and adaptive skills.<sup>97</sup>

Generally, in order to obtain a section 2176 waiver, a state must demonstrate that its project will be "budget neutral." The projected average per capita costs for persons receiving services under the waiver may not exceed the costs that would have been incurred for the same individuals had the waiver not been granted. States may exclude from waiver participation individuals for whom the cost of waiver services is likely to exceed the cost of institutionalization.<sup>98</sup>

As of February, 1988, 42 states had a total of 86 regular section 2176 programs. Of that number, 42 served the aged and disabled, 35 the developmentally disabled and mentally retarded, three served both groups, four programs served persons with AIDS and related conditions, one program served chronically ill children, and one served the mentally ill.<sup>99</sup>

OBRA-87 established a home and community-based services waiver that is similar to the section 2176 program but is available only for persons over age 65.<sup>100</sup> In return for this waiver, a state must limit its expenditures for home and community-based waiver services in this age category within an amount determined by principles specified in the statute.<sup>101</sup> To date, only one state, Oregon, has applied for and received this waiver.<sup>102</sup>

#### *d) variation among states*

Because each state designs and administers its own Medicaid program, setting eligibility and coverage standards within broad federal guidelines, there is substantial variation among the states in terms of persons covered and scope of benefits offered.<sup>103</sup> The programs in Pennsylvania, Florida, and the District of Columbia illustrate home care coverage variation among the states.

In addition to the services it is required to provide, the District

---

97. 42 C.F.R. § 440.180 (1991).

98. 42 C.F.R. § 441.301(a)(3) (1991).

99. MEDICAID SOURCE BOOK, *supra* note 69, at 159.

100. 42 U.S.C.A. § 1396n(d).

101. MEDICAID SOURCE BOOK, *supra* note 69, at 156.

102. 57 Fed. Reg. 29,153 (1992).

103. MEDICAID SOURCE BOOK, *supra* note 69, at 1.

of Columbia covers physical, occupational, and speech therapy for both categorically needy and medically needy individuals. Home health aid is limited to four hours per visit per day, unless prior authorization is granted. Personal care services are also covered, with no time limitations.<sup>104</sup>

While covering mandatory services, Florida limits optional services such as physical, occupational, and speech therapy to children and Early and Periodic Screening and Diagnosis recipients. Social services, homemaker chore services, and nutritional services are specifically excluded. Florida has obtained a section 2176 waiver to provide home and community-based services, including personal care services.<sup>105</sup>

Pennsylvania covers nursing and home health aid services and physical, speech, and occupational therapy services for both the categorically and medically needy, but does not cover medical equipment and supplies for the medically needy. After 28 days of unlimited visits, visits are limited to 15 per month. Durable medical equipment is not covered unless provided as a home health agency service and payment is limited. Personal care services are not provided to either the categorically or medically needy.<sup>106</sup>

#### *e) fragmented coverage under Medicaid*

In terms of eligibility, Medicaid differs from Medicare because it is a means-tested entitlement program, meaning individuals can qualify for coverage only if their income and resources are sufficiently low. Yet, just like Medicare, Medicaid's eligibility policies and benefit structure have resulted in fragmented coverage.

Medicaid's eligibility policies have tended to favor nursing home care over home and community-based care. For instance, older Americans financially ineligible for Medicaid while living at home could become eligible for nursing home care at higher income levels if they lived in a state using special income standards for persons needing nursing home care.<sup>107</sup> Section 2176 waivers somewhat alleviate this problem by authorizing states to cover home care services for persons eligible for nursing home care under the state's Medicaid plan.<sup>108</sup>

In terms of coverage, nonskilled personal care and custodial

---

104. 3 Medicare & Medicaid Guide (CCH) ¶ 15,570 (1992).

105. *Id.* at ¶ 15,572 (1992).

106. *Id.* at ¶ 15,632 (1991).

107. MEDICAID SOURCE BOOK, *supra* note 69, at 366.

108. *Id.*

services needed by chronically disabled older persons are generally not covered under the Medicaid program, though these services would be routinely covered as part of the nursing home benefit.<sup>109</sup> Again, the waiver programs and Frail Elderly Law may theoretically alleviate these problems, but their limited funding has resulted in relatively few states fully exercising these options and thus providing comprehensive home care.

The complexity and fragmentation of eligibility and coverage criteria under Medicaid and the optional programs can tax even the most seasoned social worker or advocate, let alone an older or disabled individual.

### B. Private Payors

#### 1. Health Maintenance Organizations

Health Maintenance Organizations (“HMOs”) have traditionally provided a home care benefit, although the scope and duration of that benefit has recently been contested by enrollees. One contested point has been the HMOs’ adherence to Medicare-type limitations for home care, such as the part-time or intermittent care requirements.<sup>110</sup>

In an October, 1991, notice from HCFA to federally qualified HMOs,<sup>111</sup> the administration restated and clarified its position on the scope of home health services that must be provided by federally-qualified HMOs. The notice cites Title XIII of the Public Health Service Act,<sup>112</sup> which requires that federally-qualified HMOs provide “basic health services” to their members “without limitations as to time or cost other than those prescribed by or under [Title XIII].”<sup>113</sup> “Basic health services” include home health services.<sup>114</sup> Home health services, in turn, are defined in the Act’s regulations as “health services provided at a member’s home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the HMO.”<sup>115</sup>

The HCFA notice also emphasized that “neither the statutory language nor the regulations permit a federally-qualified HMO to

---

109. *Id.*

110. Interview with William Dombi, *supra* note 26.

111. Notice from William F. Broglio, Director of the Office of Prepaid Health Care Operations and Oversight (Oct. 30, 1991) (on file with author) [hereinafter HCFA notice].

112. 42 U.S.C.A. §§ 300e to 300e-17 (West 1991).

113. 42 U.S.C.A. § 300e(b).

114. 42 U.S.C.A. § 300e-1(1)(G).

115. 42 C.F.R. § 417.101(a)(7) (1991).

place across the board time or cost limitations on medically necessary, prescribed home health services for commercial (non-Medicare/Medicaid) enrollees."<sup>116</sup> Thus, the notice states, "if 24-hour 'private duty nursing' in the home is prescribed, that is what the federally-qualified HMO will be required to provide."<sup>117</sup> Note, however, that enrollees who are Medicare or Medicaid recipients may have their home health coverage limited to Medicare or Medicaid levels without negatively impacting the HMO's federally-qualified status.

While the HCFA notice clearly restricts the ability of federally qualified HMOs to limit the duration or availability of home care services, it also describes those services that are not required to be covered in the home, including custodial or domiciliary care, long-term physical therapy and rehabilitation, and durable medical equipment for home use.<sup>118</sup> Finally, the HCFA notice provided some solace to HMO administrators by stating that an HMO is not required to provide specific services in the home simply because an enrollee requests them.<sup>119</sup>

## 2. Blue Cross and Blue Shield

As of 1985, over 90 percent of Blue Cross and Blue Shield plans included home care under their hospital benefit contracts.<sup>120</sup> The plans typically contain limits on the number of visits and patient eligibility and usually exclude custodial care.

The most common eligibility conditions require the patient to be homebound and under the care of a physician. Other conditions include rehabilitative potential; direct admission to home care after an inpatient stay in a hospital or skilled nursing facility; a need for intermittent, not daily, nursing care; and the presence of a

---

116. See 42 U.S.C.A. § 300e(b); 42 C.F.R. § 417.101(a).

117. HCFA notice, *supra* note 111, at 1.

118. 42 C.F.R. § 417.102(d) (1991).

119. The notice states that

the physician is the proper authority to select an appropriate setting for care. Individuals who enroll in HMOs agree to membership rules that give the HMO and its physicians the right to direct the medical care of the individual as the HMO and its physicians deem appropriate within the limits of the statute, regulations, and subscriber agreement. If a choice can be made among several medically appropriate alternatives or settings, medical case management may include consideration of whether a particular service or setting is cost-effective.

HCFA notice, *supra* note 111, at 2.

120. Harriet E. Shapiro, *Non-Medicare and Medicaid Payment and Coverage Issues for Home Care*, in NATIONAL HEALTH LAWYERS ASSOCIATION CONFERENCE ON HOME CARE LEGAL ISSUES: ACCESS AND ACCOUNTABILITY 1 (1988).

caregiver at home who is responsible for the patient's care.<sup>121</sup>

Covered services typically include skilled nursing care, physical, speech, and occupational therapy, medical social services, home health aid visits, and medical supplies. Some plans cover home medical equipment and high technology therapies.<sup>122</sup>

### 3. Commercial Insurers

With hundreds of policies and dozens of insurers, it is difficult to generalize home care coverage offered by commercial insurers. However, generally, home care provisions in insurance contracts exclude "custodial care" and care that is not "medically necessary."<sup>123</sup> Yet lack of certainty as to what these terms mean has been a point of contention in coverage disputes.

In *O'Connor v. Central Virginia U.F.C.W.*,<sup>124</sup> for instance, the court addressed the issue of what type of home care is medically necessary or custodial for insurance coverage purposes. Eva O'Connor, beneficiary of an employee welfare benefit plan (the "Plan"), required daily doses of medications to control seizures and high blood pressure and was generally confined to her bed as a result of a stroke. She could not dress, eat, or use the bathroom without assistance. After a period of skilled nursing care, she was cared for by a home health aid, her physicians concluding that she needed a companion to stay with her during the day when her husband was unavailable. After a utilization review organization advised the Plan that Mrs. O'Connor's care was considered custodial in nature, the Plan decided to no longer cover the home health aid visits, although they did offer to cover nursing or therapy services.

The district court found that the Plan "unreasonably" denied Mrs. O'Connor "nursing care benefits" under the terms of the Plan and ordered the Plan to cover "in-home nursing care" at a level "commensurate with her immediate medical needs."<sup>125</sup> The court did not specify what this meant, and Mrs. O'Connor assumed this included her home health aid visits.

On appeal, the fourth circuit addressed the issue of what care is considered medically necessary, noting that the relevant Plan provisions limited covered charges to those incurred "for medical

---

121. *Id.* at 1-6.

122. *Id.*

123. Telephone interview with Jim Murray, National Association for Home Care (July, 1992).

124. 945 F.2d 799 (4th Cir. 1991).

125. *Id.* at 800.

care, services and supplies.”<sup>126</sup> The Plan argued that “medical care” does not include custodial care. The court agreed, stating that “although it might, as an ideal matter, be preferable that ‘medical care’ be defined broadly to include all services made necessary by a medical condition, we cannot hold the [Plan’s] view . . . to be an unreasonable one.”<sup>127</sup>

Thus, the court concluded that the Plan is obligated to provide intermittent skilled medical care, but that the services of a companion or attendant in helping with activities of daily living can legitimately be considered to fall outside of the covered medical charges.

The case of *Tompkins v. RCA Plan for Health*<sup>128</sup> represents another instance in which a court was confronted with the issue of when home care is custodial as opposed to medically necessary. Brainard Tompkins, a participant of RCA corporation’s welfare benefit plan, received home nursing services on an around-the-clock basis until coverage was scaled back. Tompkins’ estate sought to recover funds paid for home nursing care not reimbursed by RCA. Under the RCA plan, services had to be prescribed by a physician for a medical condition, be medically appropriate and necessary for a recuperative or rehabilitative treatment program designed to return the patient to normal daily functioning, and *not be custodial in nature*. Custodial care was defined in the RCA plan as care designed essentially to assist an individual to meet the activities of daily living.

The court was therefore confronted with the issue of whether his care was custodial in nature. RCA moved for summary judgment, contending that it was. Tompkins’ estate argued that he received medical care during the home health visits and that any custodial services were ancillary and provided as a matter of courtesy. According to Mrs. Tomkins’ testimony, nurses bathed and changed Mr. Tomkins, assisted him in brushing his teeth, prepared some of his food, and helped him to and from the toilet. The court noted that “these are services which fall within the parameters of [RCA’s] definition of custodial care.”<sup>129</sup> Mrs. Tompkins also testified that nurses regularly checked her husband’s vital signs and monitored and assisted with his medical equipment. The estate argued that a certain amount of custodial care is inherently present in skilled nursing care. The court denied RCA’s motion for sum-

---

126. *Id.* at 801.

127. *Id.*

128. No. 88-4601 (CSF), 1990 U.S. Dist. LEXIS 582 (D. N.J. DATE, 1990).

129. *Id.* at \*5.

mary judgment, holding that a “reasonable jury could conclude that Mr. Tompkins had a medical need for home care and that [his] services . . . are compensable because they were of a medical nature, although there was supplemental custodial care.”<sup>130</sup>

Like *O'Connor*, the *Tompkins* case demonstrates the difficulty in determining what care is home *health* care and what care is personal or custodial care. The court’s decision may have been different if Mr. Tompkins only received assistance with brushing his teeth and not more “medically” oriented help such as checking his vital signs. One could argue that teeth brushing and other personal care services such as meal preparation *are* related to health care. Still, since policy makers have yet to clarify the issue, one would expect the courts to have a difficult time as well.

As the cases discussed above illustrate, the issue of what home care is “medically necessary” is crucial in terms of coverage. Noting inconsistencies between institutional and home care coverage, one author observes that insurers deny coverage for personal or custodial care on the basis of the caregiver’s qualifications; the personnel needed to provide such care need not have a medical background, and therefore the care is not medically necessary. Yet, insurers routinely cover the costs of nonmedical hospital personnel who transport patients, bathe them, or prepare their meals.<sup>131</sup>

### C. Conclusion

In many instances, “home care” coverage is not clearly defined, undoubtedly leaving many insureds confused as to what care is covered. HMO enrollees only recently have had the issue specifically addressed by HCFA. Other home care patients may know what care they are entitled to, but face public and private payor biases towards acute/medical coverage as opposed to chronic/custodial coverage. The result is fragmentation of home care coverage.

Fragmentation of coverage occurs, in part, due to public and private payor bias in favor of institutional care. For example, home infusion therapy is widely recognized as a potential breakthrough in home care, yet Medicare covers only limited portions of infusion therapy in the home through its existing benefits while fully covering infusion therapy in institutional settings. Medicaid long-term care benefits, meanwhile, are heavily geared towards

---

130. *Id.* at \*8, \*9.

131. Lachlan Forrow, *Commentary: When is Home Care Medically Necessary?*, 21 HASTINGS CENTER REP. 36-37 (1991).



nursing home care. Financing of nursing home care accounted for more than two-thirds of total Medicaid spending for the elderly in 1989; home health services accounted for only 7.8 percent of Medicaid expenditures for the elderly.<sup>132</sup>

Medicaid is also inherently fragmented due its structure as a federal-state program. Currently, there are no federal standards regarding the minimum frequency and duration of either the mandatory or optional home health services. As a result, state Medicaid programs have implemented the home health benefit to restrict coverage to as little as 12 visits annually (Oklahoma) to an unlimited number of visits (Massachusetts).<sup>133</sup>

Fragmentation of coverage also occurs because of public and private payor bias in favor of acute/medical coverage as opposed to chronic/long-term custodial coverage. When Medicare was enacted in 1965, home health was specifically referred to as a post-hospital benefit. In fact, prior to July, 1981, Medicare Part A paid for home health services only if they were furnished to a beneficiary who had received inpatient care in a participating hospital or skilled nursing facility.<sup>134</sup> While this requirement has been repealed, Medicare home care continues to focus on treatment of acute rather than chronic illness. The United States Bipartisan Commission on Comprehensive Health Care, also known as the "Pepper Commission," stated that the "Medicare home-care benefit is characterized more appropriately as an extended health or acute care benefit than as long-term assistance for those who are chronically disabled."<sup>135</sup>

In theory, the waiver and Frail Elderly programs expand Medicaid coverage and eligibility beyond the acute/medical model. But in practice, limited funding and waiver expenditure limits represent only incremental expansion.

There are those who believe that public and private payor bias towards acute/medical coverage is proper, arguing that the social sector should be responsible for providing custodial care. "In the current climate of 'read-my-lips' morality, social welfare agencies are poorly funded and hard-put to carry out their mandate. As a result, they try to pass the buck of their responsibility elsewhere —

---

132. AGING AMERICA, *supra* note 8, at 138.

133. National Association for Home Care 1992 Blueprint for Action 62 (1992) (on file with author).

134. 42 C.F.R. § 409.42(c) n.1.

135. PEPPER COMMISSION, *supra* note 2, at 97.

e.g., to the health care sector.”<sup>136</sup>

“Read-my lips” morality has a lot to do with the fragmented coverage of home care. Soaring health care costs is now a well-known national crisis. The Medicaid program is already swallowing up a good portion of many states’ budgets. Meanwhile, the tensions reflected in the OTA report with regard to the potential for expanding and improving Medicare home care with a home infusion therapy benefit balanced against its potentially increased costs represents a fundamental home care — if not health care — issue. As a society, we want the most comprehensive, technologically advanced medical care in the most comfortable setting. The question is, how will we pay for it?

### III. REIMBURSEMENT

#### A. Medicare

Medicare Part A home health benefits are reimbursed on a reasonable cost basis, one of the few remaining Medicare services that is not reimbursed in accordance with the prospective payment system.<sup>137</sup> There is, however, serious consideration being given to reimbursing the Part A home health benefit on a prospective basis as well.<sup>138</sup>

Part B home health benefits, such as medical supplies, are generally reimbursed on a “reasonable charge” basis.<sup>139</sup> This was true of durable medical equipment (“DME”) until OBRA-87 was passed; as of January 1, 1989, DME is reimbursed on the basis of fee schedules.<sup>140</sup> Payment is limited to the lower of the actual charge for the equipment or the fee schedule rate. DME is now classified into six categories, with a separate fee schedule for each. These categories are: (1) inexpensive and all other routinely purchased DME; (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; (5) other covered items (other than DME); and (6) other items of DME.<sup>141</sup>

---

136. Norman Daniels & James E. Sabin, *Commentary: When Is Home Care Medically Necessary*, 21 HASTINGS CENTER REP. 37-38 (1991).

137. In 1983, Medicare began paying for inpatient hospital services based on a system where a hospital is paid a fixed amount for each Medicare discharge. The amount paid is based on a diagnosis-related group, into which a discharge is classified regardless of the number of services or length of the patient’s stay. Medicare Explained (CCH) ¶ 151 (1991).

138. Interview with William Dombi, *supra* note 26.

139. Medicare Explained, *supra* note 137, at 152.

140. 42 U.S.C.A. § 1395m(a).

141. *Id.* at §§ 1395 (a)(2)-(7), (9).

According to the legislative history, change was needed due to dissatisfaction on the part of suppliers, carriers, and patients. HCFA was concerned about rapidly increasing outlays. Suppliers complained about the frequency of change in the payment rules, the lack of consistency and predictability in the application of policies, and the long delays in payment. Carriers expressed concern about the complexity of the rules and the difficulty of making rent/purchase determinations. Patients complained about the confusing rules and delays in payment, which sometimes impaired access to these items.<sup>142</sup>

The extent to which OBRA-87 solved these problems is debatable. According to the home medical equipment industry, the new reimbursement methodology has steadily lowered reimbursement rates. A study prepared for the industry revealed that low oxygen reimbursement amounts under Medicare have limited access to oxygen services in some areas of the country, where national home medical equipment dealers have closed branches due to low reimbursement rates.<sup>143</sup> In an effort to make rates more uniform around the country, recent changes in the fee schedule foreclose regional variation up to 15 percent and generally establish national upper and lower fee limits.<sup>144</sup>

### B. Medicaid

Under Medicaid law, states have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services. Only a few basic statutory requirements apply to all types of service, including a requirement that providers accept Medicaid reimbursement as payment in full and that "methods and procedures" for making payments must be such as to assure that payments will be "consistent with efficiency, economy, and quality of care."<sup>145</sup> Most states reimburse home care services in accordance with a fee schedule, and rates vary widely from state to state.

A frequent complaint about the Medicaid program is its inadequate reimbursement rates and slow processing of payment. For example, at the time of this article, Illinois' fixed reimbursement

---

142. H.R. REP. NO. 100-391(I), 100th Cong., 1st Sess. 390 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-210.

143. THE HOME AND MEDICAL EQUIPMENT INDUSTRY: AN EXAMINATION OF THE INDUSTRY'S EXPENSE STRUCTURE (prepared by Lewin/ICF for the Health Industry Distributors Association), July 1990, at 9 [hereinafter EQUIPMENT INDUSTRY].

144. See OBRA-90, 42 U.S.C.A. § 1395m.

145. MEDICAID SOURCE BOOK, *supra* note 69, at 121, 123.

rate of \$41 for a typical home health visit did not cover a home health agency's cost.<sup>146</sup> Similar complaints were voiced by those in the home medical equipment industry, citing reimbursement rates below cost and resulting difficulties on the part of Medicaid beneficiaries to find a supplier willing to accept Medicaid.<sup>147</sup>

### C. Physician Reimbursement

Most reimbursable services under both Medicare and Medicaid are conditioned by physician involvement and supervision of a patient's home care program. Medicare conditions of participation for home health agencies require "a written plan of care established and periodically reviewed by a [physician]."<sup>148</sup> Despite this requirement of physician participation, however, "meaningful physician involvement in home care services is mediocre at best, with the physician's signature often representing little more than a tacit accommodation to permit third party reimbursement of the agency."<sup>149</sup>

One of the major reasons physicians fail to get more involved in home care cases is poor reimbursement.<sup>150</sup> Physicians are not reimbursed for telephone consultations or other monitoring services performed on behalf of home care patients. Recently the Office of Inspector General investigated kickbacks at Caremark Inc., a home care subsidiary of Baxter International Inc. On a weekly basis, Caremark paid doctors who monitored the progress of patients receiving home infusion therapy. Caremark maintained that the doctors earned these payments, having read blood tests, reviewed records, and prescribed drug dosages.<sup>151</sup> Most insurers, including Medicare, do not reimburse for this work, requiring that the doctor have face-to-face contact with the patient in a hospital, office, or home.<sup>152</sup>

### D. Conclusion

Reimbursement policies add to the fragmentation of home care

---

146. Interview with Thomas Galluppi, *supra* note 37.

147. Telephone interview with Cara Bacheneimer, Director of Government Affairs, Health Industry Distributors Association (Aug., 1992).

148. 42 C.F.R. § 484.18 (1991).

149. AMY MARIE HADDAD & MARSHALL B. KAPP, *ETHICAL AND LEGAL ISSUES IN HOME HEALTH CARE* 158 (1991).

150. Council on Scientific Affairs, *Educating Physicians in Home Health Care*, 265 *JAMA* 769 (1991).

151. Michael Abramowitz, *Paying the Price for Home Care*, *WASH. POST*, Oct. 6, 1991, at H1.

152. *Id.* at H5.

in the United States. First, reimbursement is obviously tied into the discussion of coverage issues above because third party payors will not reimburse what they do not cover. Second, reimbursement policies may impede access to home care. The industry contends that decreased reimbursement rates for home medical equipment have had such an impact, particularly in rural areas. Medicaid's frequently abysmal reimbursement rates have resulted in fewer and fewer home health agencies eager to participate in the Medicaid program and accept Medicaid patients. Finally, failure by most payors to reimburse physicians for home care consultations is a disincentive for physicians to discharge qualified patients to home care under the current system.

#### IV. REGULATION AND ACCREDITATION

##### A. Regulation

Like coverage and reimbursement, the regulation of the quality of home care is fragmented and piecemeal.<sup>153</sup> One problem might be the issue of defining home care as discussed above. Until recently, if states regulated home care at all, they regulated home health agencies. Overlooked as a component of home care — and thus not a target of regulation — has been the home medical equipment industry.

##### 1. Home Health Agencies

States vary greatly in their approaches to home care. Some do not even license home health agencies ("agencies"), while others provide an elaborate regulatory framework.<sup>154</sup> There are approximately 12,000 agencies in the United States.<sup>155</sup> Some agencies are regulated via their Medicare certification, but approximately half of all agencies are not Medicare certified and are thus subject to far less regulation. Most of these agencies provide only homemaker or companion services. Of the 39 states that licensed home care providers in 1989, only nine states gave licenses to agencies other than those that delivered skilled home health services.<sup>156</sup> The statutes of those states that do license agencies closely resemble the federal Medicare conditions of participation, although several (including New York, Connecticut, and the District of Columbia) have en-

---

153. *Caring*, *supra* note 12, at 75, 97. The National Association for Home Care is currently compiling an abstract of state licensure laws.

154. PETER J. STRAUSS ET AL., *AGING AND THE LAW* 556 (1990).

155. *BASIC STATISTICS*, *supra* note 17, at 1.

156. *Caring*, *supra* note 12, at 98.

acted more stringent provisions.<sup>157</sup>

## 2. Home Medical Equipment Industry

Currently, there are about 8,000 to 10,000 home medical equipment ("HME") suppliers.<sup>158</sup> As noted above, the HME industry has generally been lightly regulated. Still, suppliers are subject to varying requirements from state to state. Some states require that suppliers employ credentialed medical professionals in order to be licensed. For example, California requires that a physician medical director and registered respiratory therapists be on-staff as part of state licensure requirements.<sup>159</sup>

On the federal level, light regulation of the HME industry may soon be a thing of the past. HCFA issued regulations on June 18, 1992, aimed at curbing perceived fraud and abuse and streamlining reimbursement.<sup>160</sup> The regulations establish four regional Medicare carriers for HME claims instead of the current 34, effective October 1, 1993. In addition, the regulations require that HME claims be submitted to the Medicare carrier serving the area in which the beneficiary resides and not necessarily where the sale is made. This is intended to end the practice of "forum shopping" in which unscrupulous HME suppliers submit Medicare claims to carriers with the highest reimbursement rates and most lenient coverage practices.<sup>161</sup> Pending legislation in Congress includes the Federal Program Improvement Act of 1991,<sup>162</sup> which requires the establishment of standards for the certification of suppliers of durable medical equipment, and directs the Secretary of Health and Human Services to develop standardized certificates of medical necessity for such equipment and services, and to establish uniform national coverage and utilization review criteria for selected items.

### B. Accreditation

Home health agencies participate in the Medicare program in accordance with a provider agreement. In order to enter into such

---

157. HADDAD & KAPP, *supra* note 149, at 123. In the District of Columbia, for example, home care is regulated by the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, D.C. CODE ANN. § 32-1301 (1981). Proposed regulations for "home care agencies" set forth enough standards to fill 60 pages. 37 D.C. Reg. 8010 (1990).

158. HOME CARE DIGEST, *supra* note 9, at 1.

159. EQUIPMENT INDUSTRY, *supra* note 143, at 5.

160. 57 Fed. Reg. 27,290 (1992).

161. HOME CARE DIGEST, *supra* note 9, at 25.

162. H.R. REP. NO. 3837, 102d Cong., 1st Sess. (1991).

an agreement, an agency must first be certified by a state survey agency as complying with federal laws and regulations. A home health agency may be “deemed” as meeting the Medicare conditions of participation, and therefore exempt from the state survey, if the provider is accredited by a recognized national accrediting organization.<sup>163</sup> The recognized national accrediting organizations for home care are the Joint Commission on Accreditation of Healthcare Organizations, whose application to HCFA for deemed status is currently under review,<sup>164</sup> and the National League for Nursing, whose Community Health Accreditation Program recently received deemed status.<sup>165</sup>

## V. POLICY

### A. *Home Care and Long-Term Care on the Health Reform Agenda*

Long-time home care advocate Representative Claude Pepper (D-FL), in introducing his Medicare Long-Term Home Care Catastrophic Protection Act of 1988,<sup>166</sup> said to his colleagues: “I ask you, my colleagues, when you go home tonight and you close your eyes and you sleep and you ask: ‘What have I done today to lighten the burden upon those who suffer,’ at least you could say, ‘I helped a little bit today; I voted to help those who needed help.’”<sup>167</sup> Despite the stirring oratory, the bill was defeated.<sup>168</sup> However, legislation was subsequently enacted as part of the Medicare Catastrophic Coverage Act of 1988<sup>169</sup> to create a bipartisan commission to study the matter further. Claude Pepper was named as its first chairman. Upon Pepper’s death in 1989, the Commission was named in his honor and Senator John D. “Jay” Rockefeller IV (D-WV) assumed the chairmanship. The Pepper Commission’s charge was to make specific recommendations to Congress needed to assure the availability of comprehensive health care and long-term care services for all Americans.<sup>170</sup> Since the release of the Pepper Commission’s recommendations, several

---

163. 42 U.S.C.A. § 1395bb.

164. 57 Fed. Reg. 4044 (1992).

165. 57 Fed. Reg. 22,773 (1992).

166. H.R. REP. NO. 3436, 100th Cong., 2d Sess. (1988).

167. 134 CONG. REC. H4046 (June 8, 1988).

168. Opponents of the bill cited as reasons for the defeat its failure to include nursing home coverage and failure to use a means-test for benefits.

169. Pub. L. No. 100-360, 102 Stat. 683.

170. 102 Stat. at 765.

health reform bills have been introduced that incorporate long-term care and home care reforms.

Home care now ranks high on the health policy agenda. Presented below are some of the policy issues being addressed with regard to expanding home care coverage and eligibility.

### *B. Expanding Home Care Coverage*

#### 1. Policy Arguments in Support of Expanding Home Care Benefits

##### *a) Older Americans strongly desire and need expanded home care benefits*

Most older Americans desire home care, which allows them to live independently, keep from burdening relatives, and avoid institutionalization. A 1988 nationwide poll by Louis Harris found that 87 percent of the people polled favored a "federal long-term home care program for the chronically ill and disabled elderly."<sup>171</sup>

Older Americans also need home care benefits that expand upon the acute, medical model prevalent today. The pattern of illness has changed in the past 80 years. Whereas acute conditions were once predominant, chronic conditions are now the more prevalent health problem for elderly people. More than four out of five people age 65 and older have at least one chronic condition.<sup>172</sup> Of older Americans age 65 and older with activity limitations who live alone, 74 percent receive no assistance with daily tasks.<sup>173</sup> About 291,000 people age 65 and older who live alone are unable to perform at least one activity of daily living. By the year 2020, that number will grow to 506,000 people.<sup>174</sup>

##### *b) expanded benefits can reduce financial burdens on the elderly and their families*

In 1988, the nation spent \$53 billion on long-term care. Only 18 percent of those expenditures went to home care, despite the fact that most disabled persons live at home.<sup>175</sup> With public programs providing relatively little help for home care, as much as one-third of the amount annually spent on home care is financed out-of-pocket.<sup>176</sup> This results in only a minority of the chronically dis-

---

171. *Use of Paid Home Care*, *supra* note 7, at 311.

172. AGING AMERICA, *supra* note 8, at 112.

173. *Id.* at 229.

174. *Id.* at xxvi.

175. PEPPER COMMISSION, *supra* note 2, at 92.

176. AGING AMERICA, *supra* note 8, at 174.



abled elderly receiving any formal home care services.<sup>177</sup>

Expanded formal home care services would also relieve the physical, financial, and emotional burden of family and friends who act as informal caregivers. Eight out of 10 caregivers provide unpaid assistance an average of four hours a day, seven days a week.<sup>178</sup> Many caregivers are themselves vulnerable, in poor health, or financially struggling. In some cases, caregivers forgo employment opportunities to provide care.<sup>179</sup>

*c) home care is cost-effective*

In the past, cost-effectiveness has frequently been cited as a reason to expand home care coverage and programs. Yet recent data make this proposition debatable. While the issue is still inconclusive, studies have generally not found that in the aggregate, home care produces significant cost savings for society through reduced institutionalization.<sup>180</sup>

While the cost-effectiveness of home care in the aggregate is debatable, specific examples of cost effectiveness abound. For instance, the cost of home care for a patient requiring respiratory support in 1987 was \$9,267 as compared to \$24,715 for hospital care.<sup>181</sup> According to the National Association of Medical Equipment Suppliers, for the 250,000 patients who suffer hip fractures every year, home care can produce cost savings to society of \$2,300 per episode for an annual savings of \$575,000,000.<sup>182</sup>

While specific examples of cost effective home care can possibly be attributed to dollars saved by avoiding per diem costs of institutional beds, it is easy to see how the home care price tag can add up when a physician or home health agency determines that 24-hour skilled nursing care is needed at home.

If the cost effectiveness of home care is debatable, is it still good policy to expand home care programs? Perhaps, as one author posits, "we should abandon hope of cost savings and render such

177. *Use of Paid Home Care*, *supra* note 7, at 328.

178. PEPPER COMMISSION, *supra* note 2, at 93.

179. *Id.* at 93-94.

180. Any cost savings that are realized generally occur when a home care patient would have had to otherwise enter a nursing home for a long stay. For a comprehensive review of these studies, see William G. Weissert et al., *The Past and Future of Home and Community-based Long Term Care*, 66 MILBANK Q. 309, 324-369 (1988) [hereinafter *Community-based Care*].

181. BASIC STATISTICS, *supra* note 17, at 7.

182. ECONOMIC ANALYSIS OF HOME MEDICAL EQUIPMENT SERVICES (prepared by Lewin/ICF for Health Industry Distributors Association, National Association of Medical Equipment Suppliers), 1992, at ES-2.

care simply because it raises contentment of patients and caregivers."<sup>183</sup>

## 2. Policy Arguments Against Expanding Home Care Benefits

### a) *expansion of paid home care will erode informal support*

Policy makers fear that an expansion of paid home care programs will cause friends and relatives who are now providing informal care to stop doing so. The concern is that the public would be paying the bill for services that otherwise are provided for free, escalating health care costs that are already out of control.<sup>184</sup> Studies suggest, however, that an increase in paid home care will not erode informal support. Rather, formal care increases the overall amount of care provided and thus should result in fewer unmet needs among the disabled elderly.<sup>185</sup>

### b) *home care expenditures will soar out of control*

Home care is already among the fastest growing categories of Medicaid expenses<sup>186</sup> and Medicare expenditures have soared from \$46 million in 1967 to \$2.3 billion in 1987 to \$3.8 billion in 1991.<sup>187</sup>

Yet, as noted above, current benefits do not meet the elderly's desire and need for non-skilled home care or personal care. "The inherent desirability of [such care] means that their use is likely to increase substantially if covered by public or private programs. Who, after all, would not want a homemaker to help clean the house and prepare meals?"<sup>188</sup> Methods to control expenditures such as cost sharing, case management, restricted eligibility, and budget caps may be utilized,<sup>189</sup> but may or may not be enough to control expenditures.

## 3. Basis for Determining Home Care Eligibility

Determining eligibility for expanded home care programs is crucial since it dictates the size and composition of the population that will receive benefits, as well as how much it will cost.<sup>190</sup>

As discussed throughout this article, home care eligibility is

183. *Community-based Care*, *supra* note 180, at 367.

184. *Caring*, *supra* note 12, at 88.

185. Raymond J. Hanley et al., *Will Paid Home Care Erode Informal Support*, 13 J. HEALTH POL., POL'Y & L. 507, 516 (1991).

186. AGING AMERICA, *supra* note 8, at 138.

187. National Association for Home Care Statistics (1991) (on file with author).

188. *Caring*, *supra* note 12, at 93.

189. *Id.*

190. *Id.* at 77.

largely based on a medical model that requires a specific diagnosis and a physician's order for services. One of the issues policy makers must address is whether there is a more appropriate basis for eligibility. In Canada, eligibility is sometimes based on the presence or absence of informal supports.<sup>191</sup>

Increasingly, policy makers and private insurers in this country are using the activities of daily living ("ADLs") and cognitive impairment standards to measure the elderly's ability to function in the community and thus to determine their eligibility for home care.<sup>192</sup> This approach is used in pending legislation embodying the Pepper Commission recommendations on long-term care, the Long-Term Family Security Act of 1992 (the "Act"),<sup>193</sup> introduced on April 9, 1992. The Act provides for eligibility for home and community-based care (regardless of age, income, or employment status) if an individual can demonstrate any of the following: (1) a need for human assistance (including supervision) with three or more ADLs; (2) a need for substantial supervision due to cognitive or mental impairment and at least one ADL limitation or a need for assistance managing his or her medications; or (3) a need for substantial supervision due to behaviors that are dangerous (to themselves or others), disruptive, or difficult to manage.<sup>194</sup>

Benefits under the Act are more expansive than those under Medicare and include both skilled and unskilled home care services, medical social services, and home medical equipment.<sup>195</sup> Benefits would vary with the degree of impairment. Thus, eligible persons with limitations in fewer than four ADLs ("moderately disabled") would be entitled to 52 hours of service per month; those with limitations in four or more ADLs ("severely disabled") would be entitled to 88 hours of service per month; and additional hours could be made available to individuals with greater needs from pooled benefit hours.

To contain costs, benefits would be subject to 20 percent cost-sharing requirements, adjusted by sliding-scale low-income assistance. In addition, the Act specifies that payment be based on a fee schedule or prospective payment system and that expenditures for home and community-based services may not exceed costs of entitlement hours, plus pooled benefit hours. The preliminary Con-

---

191. Cox, *supra* note 6, at 180.

192. *Caring, supra* note 12, at 77.

193. S. 2571, 102d Cong., 2d Sess. (1992).

194. 138 CONG. REC. S5265 (April 9, 1992).

195. The Act retains, however, the Medicare exclusion of drugs and biologicals in the home.

gressional Budget Office cost estimate for the public program for the first full year of implementation is \$45 billion (\$25 billion for just home and community-based care) to be funded by an increase in payroll taxes and a long-term care tax.<sup>196</sup>

## VI. CONCLUSION

Though physicians have generally stopped making house calls, there is an increasing amount of home care activity taking place. Some home care involves skilled nursing care, while some involves home medical equipment, but not all of it is strictly health care. In many instances, home care is assistance with dressing, bathing, or ambulating. In this author's opinion, all of these activities are components of "home care."

In reviewing home care coverage by public and private payors, bias towards institutional care for acute medical conditions and against custodial care for chronic conditions is evident. As some of the cited case law demonstrates, however, it is not always easy to differentiate between medically necessary and custodial care. Is helping an older person move from her bed to her living room *health care*? If it is something other than health care, i.e., personal or custodial care, should home care programs fund it?

The focus of health care reform has, in recent months, shifted away from access to care issues and towards an all-out assault on health care costs. Discussion of expanding home care programs seems ludicrous in today's economic environment of cost containment. Cost containment is at odds with medical breakthroughs that can bring new technology into the home, and at odds with mandating new custodial or personal care benefits.

Can we afford to improve and expand on currently fragmented home care services? The answer must be that we cannot afford not to. Surely a risk-spreading mechanism can be employed to fund comprehensive home care. Most of us will develop chronic conditions that in some instances will threaten our independence. Few of us voluntarily want to be institutionalized. Home care may or may not represent sound cost containment policy or be cost-effective, but it is a more humane, benevolent manner of caring for our elderly and disabled.

---

196. 138 CONG REC. S5266 (April 9, 1992).