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HOME CARE

EXECUTIVE SUMMARY

INTRODUCTION

Concern with long-term care issues has grown in recent years, due largely to the realization that a rapidly increasing elderly and disabled population with a longer life expectancy is resulting in an expansion of a segment of the population with high health and support service needs. With escalating costs of institutional care, particularly within the Medicaid program, and concern over inappropriate placement of individuals into institutional settings, there has been increasing emphasis on placing individuals in appropriate, less intensive and less costly levels of long-term care.

In Minnesota, of the over $400 million spent in the Medicaid program, 65 percent supports nursing home care. Less than 0.4 percent is spent on non-institutional long-term care. Although long-term care encompasses an increasing variety of forms, public resources disproportionately support the institutional types.

Long-term care encompasses a spectrum of services and settings which allows individuals a choice of the type of care which most appropriately fits their needs. This report deals with what is considered the least restrictive setting of the long-term care system - home care.

Home care consists of long-term care services provided in the client's home. It includes services needed by individuals if they are to remain in their own homes including: chore, homemaking, home-delivered meals, transportation, home health aide, attendant/personal care, home nursing, respite care and family subsidies.

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In Minnesota the primary goals of home care have been the prevention of inappropriate or premature institutionalization, the removal of individuals currently in nursing homes who need not be there, the reduction of the cost of long-term care services, and the provision of an option preferred by many persons. However, these goals may not apply to all individuals. There will always be a need for institutionalization in certain cases. An expanded home care system will not close down nursing homes; it may not even remove a large number of people from them. It does attempt to prevent the elderly and disabled from entering institutions or to delay their admissions for months or years. When an individual's impairment level eventually requires an intensive package of home care services, institutionalization may be appropriate. It is also not clear whether home care will be less expensive. Costs will depend on client impairment levels, quality of care, types of care provided, available family support and service utilization. Cost savings may be a long-run phenomenon whereby a number of years are needed before the effect of this preventive approach will be seen.

As a result of the concern over the costs of long-term care and the perceived advantages of home care the 1978 Minnesota Legislature mandated an examination of state home care programs, their current funding sources and an estimate of additional services needed. This report is a response to that mandate.

Section One: An Examination of the Minnesota Home Care System

This section examines all of the programs in Minnesota that fund or provide home care services. Each program is examined in terms of overall program, administration, funding sources, eligibility criteria, home care services offered, current home care expenditures, and number of clients served.

At least $26.7 million is currently spent annually for home care services in Minnesota through public programs. Of this amount, 15 percent represents state expenditures, 43 percent is federal and 32 percent is local and other non-federal funds. In addition, an undetermined amount of private funds, both from agencies and individuals, is spent for home care services.

In Minnesota there are more than 16 sources of funding for home care services which are administered by six federal agencies, three state agencies, over 300 local agencies and uncounted private sector providers. Each program has different eligibility criteria, services and restrictions.

The public programs funding home care services are listed by administrative agency.

Department of Public Welfare

- Medicaid (Title XIX)
- General Assistance Medical Care (GAMC)
- Catastrophic Health Expense Protection Program
- Title XX of the Social Security Act
- Title III of the Older Americans Act
- Title VII of the Older Americans Act
- Mental Retardation Family Subsidy Program
- Title IV-B of the Social Security Act
- Cost of Care

Department of Health

- Community Health Services

Department of Economic Security

- Community Action Program
- Vocational Rehabilitation

Social Security Administration

- Medicare (Title XVIII)

Veterans Administration

- Veterans Administration Home Health Care

ACTION

- Senior Companion

Housing and Urban Development

- Community Development Block Grants

Section Two: An Examination of the Need for Home Care in Minnesota

This section defines the three target population groups for this report - the elderly, the physically disabled and the developmentally disabled - in terms of their numbers and their need for home care services. This section also estimates the number of these individuals who are potentially in need of home care in order to prevent institutionalization and those who could be removed from institutional placement.

Estimation of need for home care is a difficult task because need depends on several factors about which very little information has been collected. The following numbers are ranges of estimates determined by applying needs estimates from the literature and from other states to Minnesota population statistics.

The following table summarizes the current number of people potentially in need of home care services. These figures indicate the number of people who potentially need formal services from either public or private sources. They do not indicate potential demand for these services nor the number of individuals currently served by home care programs.

THE NON-INSTITUTIONALIZED POPULATION

Elderly

Chore	38,000
Transportation	30,600
Homemaking	13,005
Personal Care	7,680

Physically Disabled

Chore	62,816
Transportation	102,696
Homemaking	62,816
Personal Care	50,195

Developmentally Disabled

Chore	1,817-10,250
Transportation	1,817-10,250
Homemaking	1,817-10,250
Personal Care	1,817-10,250

TOTAL

Chore	102,633-111,066
Transportation	135,113-143,546
Homemaking	77,638-86,071
Personal Care	59,692-68,125

The need for home health aide services, home nursing and home-delivered meals is not estimated since it depends primarily on an individual's condition rather than functional limitations. This information is not available. There are an estimated 325,000 families caring for impaired elderly, physically disabled and developmentally disabled individuals. Although not all these families will require formal respite care services, they are the potential population in need.

THE INSTITUTIONALIZED POPULATION

Good Potential for Restoration to Independent Living

Elderly	639
Nonelderly	320
TOTAL	959

Moderate Potential for Restoration to Independent Living

Elderly	1,489
Nonelderly	857
TOTAL	2,346

Section Three: An Analysis of Minnesota's Supply of Home Care Services

This section assesses the adequacy of Minnesota's supply of home care services. Determining the adequacy, however, entails more than identifying which services are and are not available. The adequacy of the supply of services depends upon many factors including the size of the population needing each service (i.e., the client impairment levels and the consequent levels of needed services), the demand for each service, the availability of current programs and services, the eligibility criteria of the various programs and the program restrictions. This section examines these factors and determines how they influence the adequacy of service supply.

The following are prioritized lists of the services which should be expanded in the state. The first list consists of the services which need to be expanded statewide. The second list consists of those services which need expansion in certain areas of the state but may not be needed in others.

Services in Need of Statewide Expansion

1) Attendant/Personal Care
2) Homemaking Services
3) Respite Care
4) Family Subsidies

Services in Need of Expansion in Certain Areas of the State

1) Chore Services
2) Transportation Services
3) Home-Delivered Meals

In addition to the problem of the supply of home care services, the following is a list of other issues of concern regarding Minnesota's home care system.

1) Funding mechanisms make institutionalization a less expensive option for counties. Under current Department of Public Welfare programs, counties pay only four percent of institutional care costs under Title XIX (Medicaid), but from 60-100 percent of home care costs under Title XX.
2) The long-term care system is fragmented making it difficult for individ-

uals to get a package of needed care. The individual with multiple needs seeking assistance may be confronted with an assortment of agencies, each with one or more of the needed services, with an array of eligibility regulations, varying rules of how services are provided, and overlapping jurisdictions. Arranging all needed services may be even more difficult for persons with mental confusion, physical frailty or mobility limitations. Once services are arranged, the agencies may operate independently of each other.

3) There are few viable long-term care options for individuals other than institutionalization. Because of the difficulties in finding and obtaining a needed package of services, and because of current funding mechanisms, institutional placement is often the most viable long-term care option.

4) There is a lack of information about the availability of home care services. This lack of information on the part of individuals, physicians and agencies can result in unnecessary institutionalization.

5) Eligibility criteria frequently are limited to certain population groups, leaving out other needy individuals. Current programs emphasize low-income individuals, making it difficult for middle-income persons to obtain care. Some programs are limited to the elderly, resulting in the exclusion of younger disabled individuals.

6) There is very little regulation or quality assurance for home care agencies, particularly those which do not receive public reimbursement. There are few training requirements for home care workers.

RECOMMENDATIONS

Recommendation: It is recommended that between $5,000,000 and $10,000,000 be appropriated annually by the state legislature to provide the following prioritized services:

1) attendant/personal care,
2) homemaking services,
3) respite care,
4) chore services,
5) home-delivered meals,
6) transportation services,
7) home health aide services, and
8) home nursing.

It is recommended that these funds be used as funds of last resort, i.e., they be used for impaired or chronically ill elderly, physically disabled, or developmentally disabled individuals who are ineligible for other public home care programs or for whom home care services are unavailable in an area. The funds may be used to expand existing home care services or to begin new home care services, including 24-hour care and weekend care. Counties or human service boards must use the funds to provide at least one of the listed services.

Target Population

Services provided through these funds should be limited to individuals with the following characteristics:

1) are impaired or chronically ill elderly, physically disabled, or developmentally disabled,

2) are at risk of institutionalization without supportive services,

3) are ineligible for existing public programs or other programs not available to them due to geographic location or program restrictions,

4) have inadequate or no family assistance with service needs, and

5) are unable to pay for privately provided services.

Financing and Administration

1) The state would provide funds to the county boards or human service boards to be distributed to the county welfare agencies and/or public health nursing agencies.

2) The county board or human service board would be responsible for determining the need for these services in their area and distributing the funds accordingly.

3) The funds would be distributed to the county boards or human service boards using the Title XX social services formula which consists of the following components:

   a) social service caseload,
   b) total population in the county,
   c) county Title XX expenditures, and
   d) the equalization aid formula.

   This distributional formula would be used in order to avoid the development of a new formula. This would further delay the distribution of the funds to the counties due to rulemaking procedures. Using an existing formula would be more expedient.

4) These proposed funds would be available either to provide services directly; to purchase services from a private nonprofit, proprietary or other public agency; or funds could be paid to family members to provide care or directly to individuals to purchase services.

5) To ensure that these funds would not be used to offset current home care expenditures and would be used to expand the supply of home care services, counties receiving this money would be required to maintain the fiscal year 1979 level of service expenditures from all sources of funding for each of the specified home care services.

6) Fees for services on a sliding fee basis would be collected from those individuals with an ability to pay according to their income level.

Cost Analysis

The following is an analysis of the services which may be provided given varying levels of appropriation. The matrix indicates the average number of people who can be served with $1 million increments of funding. It is felt that $5 million should be a minimum annual appropriation since, when divided among counties, a lower appropriation would not provide counties with an adequate level of funding to provide an increased number of services. This maxtrix can be used to determine the appropriation level needed to provide a specific number of services. It should be noted that these are based on average costs and average hours of home care services used by the impaired target populations. The $1 million funding increments may provide more or fewer services depending on the type of individuals served (whether they are more or less impaired than the average clients) and the actual cost of the service.

SERVICE	Average Cost Per Hour	Average Hours/Week Average Hours/Year	# Units of Service Provided Per Year*	# Clients Served/Year
Chore	$3.28	1.5/week 78/year	304,878 hours	3,909
Homemaking	5.94	8/week 415/year	168,350 hours	405
Home-Delivered Meals	1.36 per meal	7days/week 365 days/year	735,394 meals	2,015
Transportation	.15 per mile	----------	6,666,667miles	---------
Home Health Aide	7.37	1.5/week 78/year	135,685 hours	1,740
Home Nursing	23.31	1.8/week 94/year	42,900 hours	456
Attendant/Personal Care	4.50	5.4/week 281/year	222,222 hours	791

* Given $1,000,000 annual expenditures

Recommendation: A pilot pre-admission screening program for current and potential Medicaid recipients should be developed to prevent inappropriate nursing home placement.

Before the costs of institutionalization can be controlled, there must be some control over the rate of admissions to institutions. As reported in this study, 483 Medicaid-eligible individuals currently in intermediate care facilities and skilled nursing facilities have physical and mental conditions which would allow them to maintain independent lives. A pre-admission screening program may have prevented or delayed the admissions of some of these individuals to nursing homes.

The current system of reviewing individuals after they have entered the nursing home is adequate for determining changing in condition and preparing for discharge, but it is not adequate for assessing the appropriateness of admissions. As stated previously, once individuals are placed in a nursing home it is difficult, if not impossible, to discharge them. They may have sold their homes, depleted their financial resources or have few friends or family members remaining to assist them with the transition to independent living. The point at which to assess the appropriateness of placement is prior to admission in order to prevent the individual from becoming dependent upon the institution.

Currently, at least six states -- Connecticut, Montana, New York, Pennsylvania, Utah and Virginia -- use a pre-admission screening program for Medicaid recipients. Some of these states also require the assessment of individuals who will be elibible for Medicaid within 90 days of nursing home admission. Although only fifteen percent of individuals who enter institutions are Medicaid-eligible, the Medicaid program is currently paying all or a portion of the costs of nursing home care for 70 percent of all nursing home residents. As a result of the spend-down provision in the Medicaid program, many individuals enter nursing homes on a private pay basis but in a short time spend all their resources on the cost of nursing home care and become eligible for Medicaid.

Two of the states that have instituted pre-admission screening -- New York and Virginia -- have evaluated the program and found a reduced rate of Medicaid admissions into nursing homes. The evaluations indicate that in the first year of the program in Monroe County, New York, the county decreased its Medicaid admission rate to nursing homes by 28 percent. In Virginia, a statewide program decreased the Medicaid nursing home admission rate by 25 percent in one year.

Administration and Financing

1) It is proposed that this program be mandatory for all Medicaid-eligible individuals and all individuals who would be Medicaid-eligible within 90 days of entering a nursing home. In addition, the screening program would be available on a sliding fee basis to all residents of the state who may be in need of long-term care.

2) Assessment of the need for nursing home care would be the responsibility of the public health nursing agency in the individual's county and would be performed by a team comprised of a public health nurse, a physician, a social worker from the county welfare agency and possibly the individual's physician, and the individual seeking nursing home placement or a representative. The county welfare agency would administer the program and would reimburse the pbulic health nursing agency for the cost of the assessments.

3) No individual who is eligible for Medicaid or within 90 days of Medicaid eligibility would be admitted to a nursing home without written authorization from the county welfare agency and the public health nursing agency.

4) No individual would be denied admittance to a nursing home if (a) the individual was assessed to need long-term supportive services and (b) supportive services other than nursing home care were not available in that area.

5) The screening program should be conducted initially on a demonstration basis in two or three counties to evaluate its effectiveness and to project the impact of a statewide program.

6) The screening program would be financed primarily through federal Medicaid funds. (Federal reimbursement for pre-admission screening programs is allowed under current regulations). Federal Medicaid funds would reimburse 55.26 percent of the costs of screening the recipients and 75 percent of the cost of administering the program. A state appropriation and county match would fund the remaining 45 percent of the cost of screening the recipients, the remaining 25 percent of the cost of administering the program, and the costs of subsidizing the non-Medicaid recipients who choose to have the screening performed. These non-Medicaid individuals would pay according to a sliding fee scale and the state would fund whatever cost remains after the fee is applied.

7) The agency roles for this program would be as follows:

a) The state Department of Public Welfare would supervise the program, select sites for the demonstration, and establish an evaluation procedure to assess the outcome of the project.

b) the county welfare agencies would assess an individuals's eligibility for the assessment, arrange the assessment with and reimburse the public health nursing agency and collect the client fees.

c) the public health nursing agency would perform the individual screenings and assess individuals' need for long-term care.

d) If nursing home care was found to be inappropriate, clients would use the existing service system to arrange alternative services, if needed.

Cost Analysis

The following analysis of the cost of the program is divided into two components. The first component determines the cost of a mandatory program available only to Medicaid recipients. The second component determines the cost of a program which is mandatory for Medicaid recipients and is available to all other residents of the state who are considering nursing home placement. Due to lack of data, a cost analysis including those within 90 days of Medicaid eligibility upon entering the nursing home is impossible. However, the two components which are discussed give a minimum and maximum cost of the program if implemented on a statewide basis.*

1977 Admissions to Nursing homes and Boarding Care Homes	23,369
1977 Medicaid Admissions to Nursing Homes (SNF and ICF)	4,162
Annual Cost of a Pre-admission Screening Program for All Admissions**	$1,335,295

	Screening Costs	Administrative Costs	Total Costs
Federal Share	$ 126,496	$37,500	$ 163,996
State Share	1,148,544	6,250	1,154,794
County Share	10,255	6,250	16,505

Annual Cost of a Pre-admission Screening Program for Medicaid Recipients Only $ 278,910

	Screening Costs	Administrative Costs	Total Costs
Federal Share	$ 126,496	$ $37,500	$163,996
State Share	92,159	6,250	98,409
County Share	10,255	6,250	16,505

*Based upon a $55 per screening payment to the public health nursing agencies and total administrative costs of $50,000 annually.

**This cost projection assumes that the state will pay for the total screening cost of all non-Medicaid admissions. It does not take into account any county share which might be required or any cost sharing on the part of the client.

Recommendation: The Department of Public Welfare should include homemaker services under the Medicaid attendant/personal care program.

Under current federal Medicaid program regulations, the Medicaid program can pay for certain homemaking tasks when they are provided to clients receiving services through the Medicaid attendant/personal care program. Other states, including New York and New Jersey, either are currently allowing reimbursement for these services or are in the process of changing funding sources from Title XX to Title XIX. This modification in Minnesota's attendant/pers onal care program is recommended for the following reasons.

1) Although the scope of the current attendant care program includes only medically-related services, the disabled recipients need assistance with other activities of daily living. This care is often not available from other sources. If it is available through the Title XX program, it frequently results in the county sending two individuals into the recipient's home to perform tasks which could be completed by one individual. Since without this care independent living may be impossible, counties should assure that these services are available.

2) Providing these services through the Medicaid attendant/personal care program would result in the county sending only one person to complete all of the tasks needed by the disabled individual. Additionally, the state would maximize federal dollars since the federal Medicaid program would contribute over 55 percent to the costs of the providing this service. In addition, this program would make use of an unrestricted funding source rather than using the limited Title XX program, freeing those funds for provision of other Title XX services.

Administration and Financing

This program would be administered under the current Medicaid program in Minnesota.

Cost Analysis

Based on the current caseload of 67 individuals in the Medicaid attendant/personal care program, and given an average number of hours of homemaking services of 5.6 per week at $.50 per hour (which is the current salary level for Medicaid attendants), the additional cost to the Medicaid program would be $87,797 annually. The federal government would reimburse $48,727 of this expenditure, the state government would pay an additional $35,119, and the county could pay the remaining $3,951. For each additional individual entering the program, an average of $1,310 per year would be added to the cost of the program. It should be noted that only those individuals who qualify under the Medicaid attendant/personal care program would be eligible to receive the homemaking services under this program.

Recommendation: The legislature should make the following modifications to the Mental Retardation Family Subsidy Program:

1) that the MR-FSP be established as a permanent department program rather than a pilot,
2) that there be no maximum limit on the number of children in the program,
3) that the maximum monthly subsidy payment of $250 be waived in cases of extraordinary need, not to exceed 50 percent of the potential average institutional costs for the child,
4) that the subsidy be granted on a per child basis rather than on a per family basis, and
5) that the legislature appropriate $1,200,000 for the biennium to the Mental Retardation Family Subsidy Program.

The Mental Retardation Family Subsidy Program has been a pilot program for four years. Evaluations have indicated its effectiveness in reducing the financial burden on families with mentally retarded children. For this reason, the program should become a permanent department program.

The 50-family limit has resulted in the return of money to the general fund every year, at the expense of serving additional families within the legislative allocation. In fiscal year 1978, the 50-family ceiling prevented, at a minimum, an additional 14 families from being served. In fiscal year 1978, $43,817 (25.6%) was returned to the general fund; $20,142 (13.2%) was returned in fiscal year 1977.

The individual needs of families vary due to the uniqueness of each situation. Seventeen (34%) of the participating families have documented needs above the $250 per month maximum. In addition, 22 (44%) families are currently receiving less than the maximum monthly subsidy. However, according to law, the unused funds (a) cannot be directed to those families requiring additional assistance in excess of the $250 limit, or (b) cannot be used to place additional families on the program.

Two families in the program each had two retarded children, but were limited to $250 for both children. Both families had eligible expenses as a result of providing for their two children in excess of the $250 limit.

Cost Analysis

The request for an appropriation of $1,200,000 is based on a documented need for a minimum of 200 children at $250 per child. There should be no legislative limit to the number of children in the program. Within this budget, it is estimated that the Department of Public Welfare should have the ability to fund more than 200 families.

Recommendation: The legislature should establish a pilot family subsidy program modeled after the Mental Retardation Family Subsidy Program for families who are providing or will provide care for their developmentally disabled, physically disabled or impaired elderly members within the same household.

As has been shown in the evaluation of the Mental Retardation Family Subsidy Program, family subsidies are an effective means of providing financial assistance to families with disabled members. These families are particularly burdened with extraordinary expenses due to the presence of the disabled member and in certain cases this results in institutionalization which may have been prevented if financial assistance had been made available. For these reasons, other impaired population groups should have access to family subsidies. This recommendation would make family subsidies available to the other target population groups of this study -- the developmentally disabled (other than the mentally retarded), the physically disabled and the impaired elderly.

Administration and Financing

The eligibility for this family subsidy program would be based upon the presence of a severely disabled family member residing in the family's home, who is ineligible for other family subsidy programs and needs special care which is not ordinarily provided in a family setting. In addition, the family must be unable to privately purchase or provide the needed care. An assessment would be completed which would determine whether a family meets these criteria. Once a family is determined to eligible for the program, the amount of the subsidy (not to exeed $250 per disabled member) would be based on extraordinary expenses incurred by the family due to the presence of the impaired individual in the home and the family's and/or individual's income. This subsidy program would be reserved for the most severely disabled individuals in Minnesota, i.e., those who would be unable to live independently. Without assistance by the family, the individual must need institutional placement.

Cost Analysis

An annual appropriation of $450,000 is recommended for this pilot program. These funds would provide family subsidies for at least 50 families with elderly members, 50 families with physically disabled members and 25 families with developmentally disabled members. In addition, $50,000 would be needed for program administration and evaluation.

Recommendation: The Departments of Health and Public Welfare should be directed to examine the various types of home care regulation and make recommendations to the 1980 Minnesota legislature regarding action that should be taken.

Concern has been expressed by the home care advisory committee and various providers regarding the lack of quality assurance and regulation for home care services. These services are provided to an impaired and vulnerable population with little direct supervision. This can result in a potential for abuse and neglect if agencies do not provide quality services. Regulation of this industry is currently limited to providers of publicly funded services. This includes Medicare/Medicaid certification of home health agencies and minimal training requirements under Title XX. This, however, excludes a number of agencies and providers from any regulation.

Regulation can be used to accomplish a number of goals: the control of new agencies entering the market, quality assurance, and the expansion of additional agencies into the Medicare and Medicaid programs. Depending upon the intended goal, different types regulation can be used.

Certificate-of-need is one type of regulation for home health agencies. It serves to limit the number of agencies in an area by requiring new agencies to prove an unmet need for their services. This is particularly useful if there is an adequate supply of services in an area and a need to prevent over-expansion or duplication. Certificate-of-need does not control quality nor does it insure an adequate distribution of services across the state. Minnesota does not currently include home health agencies under Certificate-of-need.

Certification is the procedure which non-profit home health agencies must go through in order to receive reimbursement under Title XVIII (Medicare) and Title XIX (Medicaid).

Federal regulations stipulate that proprietary agencies cannot be certified unless licensed by the state. Certification serves to maintain minimum levels of quality and training for services paid for with Medicare and Medicaid funds.

Licensure is a possible state regulation of home care agencies. It can be as lenient or as stringent as the state desires. Typically it is used to guarantee certain levels of quality by enforcing training requirements and minimum levels of supervision, in combination with inspections of the agencies' premises. If a state has a licensure law, no agency can operate without meeting the standards. However, no matter how strigent the licensure requirements, licensure does not supplant certification requirements. Licensure allows proprietary agencies the option of becoming certified for Medicaid or Medicare reimbursement but does not automatically make them eligible for reimbursement. Minnesota does not currently have a licensure law.

All of these types of regulation have different goals and outcomes. However, the home care industry may be in need of some type of regulation, particularly if new money is appropriated to further expand services. The Departments of Health and Public Welfare should be directed to examine the various types of home care regulation and make recommendations to the 1980 Minnesota legislature regarding action that should be taken.