Long-Term and Related Care

BACKGROUND

Long-term care (LTC) is assistance for people unable to care for themselves because they have a prolonged illness or disability. It typically refers to care provided in a nursing home, but it also may include the other kinds of care listed in the glossary. Michigan has about 460 nursing homes (basic and skilled) that serve more than 52,000 residents.

Advances in health care, nutrition, medication, and fitness means that Americans are living longer than ever before. With an aging population (people aged over 85 comprise the fastest-growing segment of the population, and the baby boomers will begin to retire in the next decade), long-term care's importance to society is growing considerably.

- Ninety percent of those who require LTC in a given year are aged over 65.
- In 1990 there were more than one million Michigan citizens aged 65 and over; by 2020 the U.S. Bureau of the Census projects that this age group will number nearly 1.7 million—about 17 percent of the state population.
- Also by 2020 it is estimated that about half of this age group—approximately 850,000 people—will spend time in a nursing home.

The financial implications of this future demand for LTC are staggering.

- In Michigan the average annual cost of nursing home care per individual currently is $36,000; assuming an annual inflation rate of 3 percent, the cost in 2020 will be $75,000.
- Home-health care is less expensive than nursing home care but averages $12,000 annually; annual inflation of 3 percent brings the cost in 2020 to $25,000.
- Michigan Medicaid spending for LTC in 1995 totaled almost $7 billion; annual inflation of 3 percent brings the bill in 2020 to $2 billion.
- Nationwide 1995 LTC spending from all sources (state, federal, public, private) was $107 billion; annual inflation of 3 percent brings the cost in 2020 to $224 billion.

But inflation is not the only factor that will influence the future cost of LTC—as mentioned, the 65-and-older age group is expanding rapidly, and the cost of providing LTC is rising at a alarming rate. From 1990 to 1995 nationwide Medicaid LTC spending for the elderly increased an average of 10.7 percent annually (compared to 2–3 percent for general inflation). Although the rate of growth

GLOSSARY

Adult day care
Mainly nonmedical daytime supervision and arranged social interaction for seniors; typically is paid for with personal funds. May enable some seniors to reside at home by allowing the caregiver—e.g., spouse or child—to work while the senior is in a supervised environment. Facilities must be approved by the state, but licensure is not required.

Adult foster care
State-licensed facilities that offer transitional or long-term living for people aged 18 and older who need supervision, personal, and other basic care. Residents may be aged, mentally ill, developmentally disabled, and/or physically challenged, but they do not require continuous nursing care. Supplemental Security Income often offsets/covers residents' costs.

Assisted/independent living
Residential living for seniors who can live independently; may be subsidized (i.e., financial assistance is provided by the government) or unsubsidized; out-of-pocket rent is based on the person's income. Housekeeping and limited medical services are available. State licensure is not required.

Basic care
Supervision and assistance with the needs of daily living that can be provided by nonlicensed personnel.

Cost shifting
In this instance, shifting payment for long-term care from the public to the private sector.

has slowed recently, it still presents a major problem for policymakers and consumers who must find a way to continue paying for LTC. Assuming a 3 percent inflation rate a year, a nursing home that costs $98/day now will cost $177/day in 20 years.

Today Medicaid and out-of-pocket spending are the primary sources for financing long-term care for the elderly in the United States. Although Medicare picks up almost 12 percent of total LTC costs, its coverage is limited: Medicare pays for care provided by skilled medical personnel for certain medical conditions (referred to as *skilled* care) but only for 100 days (the full amount for the first 20 days and all but $95 for days 21–100); it does not cover helping a person to perform activities of daily living (*custodial* care). After Medicare coverage is exhausted, nursing-facility care may be paid by Medicaid—if the patient's income is sufficiently low—which picks up 67 percent of the nation's LTC costs. Patients and their families pay for the remaining 20 percent of the expense, usually from savings, pensions, annuities, or a long-term care insurance policy; private LTC health insurance pays for less than one percent.

If LTC costs continue to climb at the current rate, it is unlikely that Medicaid and Medicare will be able to pick up the portion of costs that they traditionally have. Policymakers at the state and federal levels are exploring strategies to reduce LTC expenditures for the elderly while maintaining the quality of care provided.

Homes for the aged
Custodial/personal care, provided at state-licensed facilities for individuals who are aged 60 and older and not capable of living independently; the situation is similar to living in one's own home except that residents reside in a group setting. Supplemental Security Income often offsets/covers the cost of such care.

Home health care
Medical and personal care, homemaker and chore services (heavy cleaning and yard work), meals and transportation provided to the homebound by nurses, other health professionals, and home-health aides; may be covered in part or in total by Medicaid, Medicare, or private insurance.

Hospice
Offers palliative care—including pain management—to terminally ill patients. Some hospice care is covered by Medicare and Medicaid. Hospice providers are state licensed.

Managed care
A broad term for any comprehensive approach to health care delivery that (a) coordinates patient care so as to ensure the appropriate utilization of services, and (b) routinely monitors and measures health providers' performance so as to control cost and maintain or improve the quality of care; capitated managed care *entails a fixed amount per beneficiary being paid to the health insurance carrier.*

Medicaid
Federal/state program that pays for many health care services for low-income people who qualify, including children, pregnant women, and the elderly.

Medicare
Federal program that pays for many health care services for people who are (1) blind and/or have a long-term disability or (2) are aged 65 and older.

MIChoice
A state program providing participants with resources (e.g., homemaker services, home-delivered meals, transportation) that make it possible for them to stay in their homes rather than having to enter a nursing home.

DISCUSSION

LTC costs are increasing principally for three reasons.

- The nation's elderly population is burgeoning.
- Far more women—traditionally, the elderly's primary caretakers—are employed now than in the past and therefore are unavailable to provide informal long-term care for their loved ones; as a result, the demand—and, thus, the expense—for LTC options continues to grow.
- Neither public policy nor LTC industry practices have been able to keep pace with changing demand.

There are no practical ways to affect the consequences of the first two causes, so debate on reducing the system's expense focuses mainly on public policy changes and industry reform. There are two generally accepted strategies that policymakers can use to control spending: (1) shifting the cost, i.e., offsetting government expenditures by increasing private contributions and (2) reforming the delivery system so as to provide care less expensively.

Cost Shifting

The debate about generating additional private resources to offset LTC costs traditionally absorbed by Medicaid and Medicare—and thus by state and federal government—revolves primarily around the following three issues:

- Encouraging people to carry private long-term care insurance
- More carefully enforcing asset-related provisions of the laws governing Medicaid
- Reducing Medicaid eligibility, reimbursement, and services

Nursing home (basic)
Regular medical, nursing, social, and rehabilitation services, in addition to room and board for people who cannot live independently; provides basic medical services short of 24-hour skilled nursing care and must meet state licensure requirements. Most residents qualify for Medicaid.

Nursing home (skilled)
Provides intensive, around-the-clock nursing care and supervision; registered nurses, licensed practical nurses, and nurse aides provide services under the guidance of the patient's physician. Medical nursing care is provided as well as restorative, physical, occupational, and other therapy. About one-third of patients pay from private funds; the remainder receive Medicaid and/or Medicare benefits. Facilities must be licensed by the state.

Respite care
In-home service, provided through a community-based program, that gives intermittent care to people in their residence; its purpose is to relieve the primary care giver of responsibility for periods ranging from a few hours to a few weeks. Services may range from simply being present to the complex care of persons on life-support equipment.

Skilled care
Requires licensed nursing personnel.

Subacute care
Features services more intensive than those provided in skilled nursing facilities but less intensive than acute care (hospitalization); provides treatment for specific, complex medical conditions immediately after or instead of hospitalization. Care is provided to Medicare and Medicaid eligibles and private payers. Facility must be licensed by the state.

Supplemental Security Income (SSI)
Federal assistance program for people who are aged 65 or older and meet certain asset and income requirements; SSI also assists the blind or extremely visually impaired and those who suffer from a physical or mental disability.

Long-Term Care Insurance

Currently, only 5 percent of the elderly have private LTC insurance. States are trying to encourage people to purchase such policies so as to enable them to pay for their own LTC rather than relying on government programs. Michigan and some other states have legislation pending that allows LTC-insurance purchasers to deduct from their taxes the total cost of any LTC-insurance premiums they pay.

Despite states' efforts to encourage people to purchase LTC insurance, many do not because of the expense. Most studies find that only 10–20 percent of the elderly can afford LTC insurance, which can cost from $400 to $4,000 a year, depending on the insured's age and health and the policy's benefits. If one buys coverage for a sizable portion of the daily nursing home cost or a policy that has inflation protection, the policy will come in at the high end of the premium range. Also, even though LTC insurance may cover a large portion of an individual's nursing home stay, s/he still may end up having out-of-pocket expenses; for example, a policy may cover $120/day in a nursing home, but if the cost is $160, the nursing home resident is liable for the remaining $40.

Asset Enforcement

A second way to increase nongovernment payment for LTC is to enforce more carefully Medicaid-related asset transfer/recovery provisions. There is evidence that many people, to become eligible for Medicaid benefits, purposefully divest their assets. The purpose of such transfers—known as "Medicaid estate planning"—is to appear poor on paper while preserving private wealth. Although Congress repeatedly has legislated against such practices, many argue that the prohibitions are easy to circumvent and the prevalence of Medicaid estate planning has surged in recent years.

Another asset-related concern for government-funded LTC is estate recovery. The federal Omnibus Budget Reconciliation Act of 1993 requires states to recover Medicaid LTC expenditures from the estates of program beneficiaries who have died. The success of such recovery attempts has been limited, however; according to the U.S. Department of Health and Human Services, in 1995 total estate recovery nationwide was $124.8 million—less than half of one percent of Medicaid nursing home expenditures for the elderly.

Reducing Program Scope

If government does not succeed in substantially increasing private LTC contributions by encouraging the purchase of private insurance and/or discouraging private asset transfer, it will have to consider more traditional cost-shifting op-

tions (which also will result in individuals having to pay more out of pocket). These include

- cutting the rates at which LTC facilities are reimbursed for their services (since the Boren Amendment was repealed in the federal Balanced Budget Act of 1997, states have almost complete freedom in setting nursing-home payment rates);
- raising eligibility standards for government-funded LTC services (e.g., setting more stringent income standards for people who wish to have Medicaid pay for nursing home care); and
- limiting the extent to which LTC services are covered.

Effect of Cost Shifting

Although many applaud personal accountability and responsibility when it comes to long-term care, others argue that cost shifting harms those who most need the government's support—the frail elderly and their families. This view is leading policymakers at all government levels to find ways not just to shift LTC costs to private individuals, but to legitimately reduce them.

System Reform

The second general strategy for controlling LTC costs is to reorganize the delivery system in ways that will make it more efficient. Many states, including Michigan, are seeking to accomplish such reform by

- integrating acute (hospital) and long-term care systems under the managed-care umbrella;
- creating a managed-care system that encompasses LTC only; and
- offering more home- and community-based services.

Managed Care

People who need LTC services often encounter a fragmented financing and delivery system: private insurance, Medicare, and the federal government mainly finance acute care, and Medicaid and state government mainly finance LTC. This separation of financial responsibility creates a strong incentive for the federal and state governments to shift costs to one another. It also results in a breakdown of coordination in service delivery.

To patch the fragmented long-term and acute care delivery systems, policymakers increasingly are looking to capitated managed care—an arrangement whereby a single, state-administered payment is made, on a per-patient basis, to a managed-care organization (e.g., health maintenance organization) to pay for the enrollee's care. To keep costs down, capitated managed-care programs require every enrolled patient to have a primary care provider, who serves as a *gatekeeper*, i.e., s/he directs the patient to appropriate specialist care, if required, and the proper care setting, be it an acute-care hospital or a nursing home. For such a system to incorporate LTC and function smoothly, many policymakers argue that Medicaid and Medicare monies must be combined.

Various states (e.g., Colorado, Maine, Massachusetts, Minnesota, Texas, Wisconsin) have applied for waivers to the federal Health Care Financing Administration (HCFA) in hope of creating a capitated managed-care system that incorporates LTC, but the HCFA to date has permitted only Minnesota to combine Medicaid and Medicare funds. The administration has objected to the initiatives of several other states because they have not allowed those who are eligible for Medicare or for both Medicare and Medicaid to *choose* whether they will participate in a managed-care system.

Despite being unable to obtain approval for managed-LTC plans that combine both Medicaid and Medicare funds, some states successfully have obtained approval for demonstration projects that involve only Medicaid funds. For example, for 12 years Arizona's Long-Term Care System (ALTCS) has made capitated payments to contractors (typically county governments) that provide Medicaid LTC services to elderly (and other) people at risk of institutionalization.

In 1996 Michigan policymakers launched their own managed-LTC initiative by issuing a call for ideas from managed-care organizations as to the best way to develop a Medicaid managed-care system that "integrate[s] and deliver[s] primary, acute, and [LTC] services to [the elderly]." The state intends to select by competitive bid the organizations best qualified to provide such services. The plan's details are not yet available, but officials expect to implement it in 1999.

Supporters claim that coordinating acute and LTC services under the managed-care umbrella will save money and improve service quality. Nevertheless, many oppose such integration, contending that

- most managed-care providers have little experience with the elderly and disabled and none with long-term care and, thus, may not be adept in serving this population;
- fiscal pressures within an integrated system could shortchange LTC by shifting funds from long-term to acute care if providers do not view LTC as a priority or if acute care overruns its budget;
- consumers will be required to select as their "gatekeeper" physician one who agrees to participate in the plan; this can necessitate a person's having to change physicians and may be particularly troubling to the elderly; and
- because capitation limits the amount carriers are paid to cover LTC services, some managed-care organizations, in order to save money, may deny needed medical services or limit access.

Home- and Community-Based Services

Despite slow progress in resolving the many issues facing managed LTC, most policymakers are optimistic that there are other alternatives that may result in LTC savings. In particular, many are advocating for expanding home- and community-based services for older adults (typically, such services have focused largely on younger populations with disabilities). Michigan is among the states that have received federal approval to expand noninstitutional long-term care programs through home- and community-based services.

In 1992 the HCFA approved Michigan's Home and Community Based Services for the Elderly and Disabled (HCBS/ED); in 1995 approval was extended for another five years. Currently, people in 19 Michigan counties benefit from the program, which provides them with home-based rather than nursing-home care; in 1997 over 3,000 people were enrolled in HCBS/ED at a cost, on average, of one-third of nursing-facility care. The state plans to expand the program to the rest of the state by late 1998 and give recipients access to personal care, homemaker services, home-delivered meals, transportation, help with chores, respite care, counseling, personal emergency response, home modifications, equipment aids, adult day care, training, durable medical equipment, medical supplies, and private-duty nursing. The expansion is part of Michigan's MIChoice initiative, which is meant to enable LTC recipients to choose from a variety of settings and providers.

Despite Michigan's success story, many policy experts believe that home health care actually will *increase* LTC expenses over time. The reason is the so-called woodwork effect: Many people will forgo LTC if the only choice is a nursing home, but many will use LTC if home-care services are an option. Thus, providing broad-based home care actually could increase demand for LTC services, resulting in expenses that exceed any cost savings stemming from reducing the demand for nursing home services.

Quality Control

Although expense is the major issue surrounding LTC, policymakers and industry officials also are struggling with controlling the quality of care provided. According to a 1996 survey conducted by the Health Care Association of Michigan (HCAM), an association of for-profit nursing homes, 84 percent of respondents reported being satisfied with the services they or their loved ones received in a Michigan nursing home (38 percent were extremely satisfied; 46 percent moderately so). Despite this, the HCAM reports that Michigan "leads the nation in number of citations [for violations of] and rate of noncompliance [with]" national quality regulations implemented in 1995.

Many LTC providers argue that Michigan's poor performance may not necessarily be due to inadequate nursing home staff and administrative practices. Rather, they argue, the new regulation system is extreme: It encompasses a zero-tolerance policy toward mistakes or errors—even those that have little to do with patient care. LTC providers also complain that the system is based on subjective surveyor opinion and is vulnerable to surveyor bias.

Critics of the LTC system argue that enforcement efforts are not strict enough and that serious violators go undetected and unpunished. They contend that the few facilities that do provide poor care do not receive nearly enough regulatory attention. In 1996, 89 Michigan officials investigated 2,615 complaints and reports of poor care; most concerned only 45–50 of the state's 458 nursing homes.

In response to the continued high number of citations and complaints for nursing homes in the state, in 1997 Michigan officials unveiled the latest effort—the Resident Protection Initiative—to improve the quality of care provided. Its purpose is to (1) tighten enforcement of state and federal regulations and (2) create a private-public partnership among the state, Michigan Peer Review Organization (MPRO), and Michigan Public Health Institute (MPHI) that will help nursing homes to improve their track record. Part of the initiative is a computerized system meant to help the state track inspections and alert officials to the worst offenders. Also the result of the joint effort, MPRO and MPHI staff will participate in inspections, thus bolstering the state inspection teams.

In the legislature, the Nursing Home Consumers Right-to-Know Act is pending. The bill would require nursing home facilities annually to submit to the state information on various matters, including licensure status, average employee hours worked per patient day, nursing staff turnover, profits, and other data. Supporters of the legislation hope that such information will help consumers and their families to choose an LTC option that will result in the best care—in terms of cost *and* quality—for the patient.

Conclusion

Given the growing need for and expense of LTC services both in Michigan and nationwide, reform of the LTC system is inevitable. Clearly, policymakers are exploring numerous options to make LTC affordable both for individuals and government. Most believe that success can be achieved if both cost shifting and system reform take place. The challenge, however, is to determine the optimal degree to which both should be pursued. Debate on this matter is heated, but regardless of any disagreement among policymakers, most agree that the goal is to develop a system that ensures the availability of affordable, high-quality long-term care.

See also Consumer Protection; Health Care Access; Health Care Costs and Managed Care; Medicare and Medicaid.

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