

Long-Term and Related Care

BACKGROUND

Long-term care (LTC) covers a range of medical and/or social services for people who have disabilities or chronic care needs. It may refer to nursing-home care or to other types of care listed in the glossary, and its importance is growing because

GLOSSARY

Adult day care

Mainly nonmedical, daytime supervision and arranged social interaction for seniors; typically 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 state licensure is not required.

Adult foster care

Care provided in 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. State licensure is required.

Assisted/independent living

A residential arrangement for seniors who can live independently; may be government subsidized 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 the LTC context, shifting payment for care from the public to the private sector.

- Americans are living longer;
- people aged 85 and over comprise the fastest-growing segment of the population; and
- the oldest of the “babyboomers” are aged 55 and will begin to use LTC services in this decade.

In 2000 there were more than one million Michiganders aged 65 and older, and more than 90 percent of those who require LTC in a given year are in this group. The U.S. Bureau of the Census projects that by 2020 this group will number nearly 1.7 million, and half will spend time in a nursing home. The financial implications of the future demand for LTC are staggering.

- In 2001 the average annual cost per resident for nursing home care in Michigan was \$54,000; assuming 3.3 percent annual inflation, the cost in 2020 will be \$97,000.
- Home-health care is considerably less expensive than nursing home care but still averages \$12,500 annually; annual inflation of 3.3 percent brings the cost in 2020 to \$22,500.
- Michigan Medicaid spending for LTC in 2001 totaled about \$1 billion; 3.3 percent annual inflation brings the bill in 2020 to \$1.9 billion (this projection does not take into account the burgeoning growth of the LTC age group).
- Nationwide, in 2000, LTC nursing home spending from all sources (state, federal, public, private) was \$92 billion; the Congressional Budget Office estimates that LTC will grow nationally by 2.6 percent annually and in 2020 the figure will reach \$207 billion (again, the growth in the LTC age group is not calculated into the projection).

From 1995 to 2000, nationwide Medicaid LTC spending for the 65-and-older age group increased an average of 4 percent annually, more than the general rate of inflation. Although the growth rate 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 3.3 percent annual inflation rate, a nursing home that costs \$150/day now will cost \$268/day in 20 years.

Today Medicaid and out-of-pocket spending are the primary financing sources for LTC for the elderly in the United States (see the exhibit). Although Medicare picks up almost 10 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 \$101.50 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

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Home health care

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

Homes for the aged

Facilities that provide custodial/personal care for individuals aged 60 and older and not capable of living independently; for residents, it is similar to living in their own home except that they reside in a group setting. Supplemental Security Income often offsets/covers the cost of such care. State licensure is not required.

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 (1) coordinates patient care so as to ensure the appropriate use of services and (2) routinely monitors and measures health providers' performance so as to control cost and maintain or improve the quality of care. Under capitated managed care, a fixed amount per beneficiary is paid to the health insurance carrier.

Medicaid

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

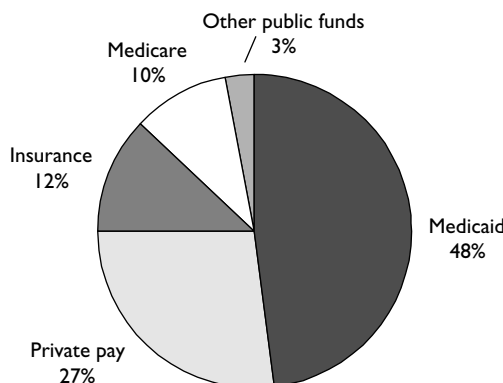
Medicare

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

MIChoice

The state program (with some federal funding) that provides participants with resources (e.g., homemaker services, home-delivered meals, transportation) that make it possible for them to stay in their own residence.

Payment Sources for Long-Term Care, 2001



SOURCE: Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration), 2001.

covered by Medicaid—if the patient's income is sufficiently low—which picks up 48 percent of the nation's LTC costs. Patients and their families pay for 27 percent, usually from savings, pensions, and annuities; private health insurance pays for 12 percent; and other public funds cover the remainder.

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 improving the quality of care provided.

DISCUSSION

Long-term care costs are increasing principally because

- 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; and
- 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 may 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

- encouraging people to carry private long-term care insurance;

Nursing home (basic)

A facility providing 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)

A facility providing 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 caregiver of responsibility for periods ranging from a few hours to a few weeks. Services may range from simply being present to providing the complex care needed by someone on life-support equipment.

Skilled care

Care that 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. Facility must be licensed by the state.

Supplemental Security Income (SSI)

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

- more strictly enforcing the asset-related provisions of the laws governing Medicaid; and
- reducing Medicaid eligibility, reimbursement, and services.

Long-Term Care Insurance

Currently, only 6–7 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. Pending federal legislation would allow LTC-insurance purchasers to deduct from their income tax the total cost of the premiums. Analysts say, however, that this is unlikely to provide enough tax relief to encourage people to buy the insurance.

Many people do not purchase LTC insurance because of the cost: \$400 to \$5,000 a year, depending on the insured's age, health, and the policy's benefits. Studies find that only 10–20 percent of the elderly can afford it. Moreover, even with LTC coverage, individuals may have out-of-pocket costs not covered by their insurance; for example, a policy may cover \$120/day in a nursing home, but if the cost is \$160, the resident is liable for the remaining \$40. Michigan P.A. 4 of 2001 requires LTC insurance carriers to define and provide policyholders with a detailed coverage explanation.

Asset Enforcement

A second way to increase nongovernment payment for LTC is to enforce 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—so-called Medicaid estate planning—is to appear poor on paper while preserving private wealth for one's heirs. Although Congress repeatedly has legislated against such practices, many point out that the prohibitions are easy to circumvent and the practice of Medicaid estate planning has surged in recent years.

Another asset-related concern for government-funded LTC is estate recovery. According to the U.S. Department of Health and Human Services, only about one-half of one percent of Medicaid nursing home expenditures are recovered each year, despite a federal law requiring states to recover them from the estate of deceased program beneficiaries. Michigan has not yet instituted such a program. The Michigan Department of Community Health contends that it cannot implement a recovery program without legislation, and the legislature has not acted for a number of reasons. First, it has not been determined how much such a program will cost or recover, although an earlier (FY 1994–95) recovery estimate was about \$4 million. Second, the success of recovery attempts elsewhere has been limited. For example, Colorado's program has yet, after four years, even to recover the cost of running the program. To date, the federal government has not imposed penalties for noncompliance.

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 options (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 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

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- limiting the extent to which long-term care 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 but to reduce them without sacrificing quality.

System Reform

The second general strategy for controlling LTC costs is to reorganize the delivery system to 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/or
- offering more home- and community-based services.

Managed Care

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

Policymakers increasingly are looking at *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 an enrollee's care. For such a system to incorporate LTC and function smoothly, many policymakers argue that monies from Medicaid (the principal payer for LTC) and Medicare (the principal payer for most other health costs for seniors) must be combined.

Various states have applied for a federal waiver to create a capitated managed-care system that incorporates LTC and combines Medicaid and Medicare funds to pay for it; Minnesota and Wisconsin have received approval. Michigan has not applied for a waiver, instead choosing to focus on integrating health-care financing and delivery only for Medicaid services.

Home- and Community-Based Services

Managed LTC is evolving slowly, but there are alternatives that may result in LTC savings. One is to expand home- and community-based services for older adults, and Michigan has received federal approval to do so.

In 1992 the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) approved Michigan's Home and Community Based Services for the Elderly and Disabled, and in 1998 it became available statewide. The program gives 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 daycare, training, durable medical equipment, medical supplies, and private-duty nursing. The expansion is part of Michigan's MIChoice initiative, which is meant to provide participants with resources (e.g., homemaker services, home-delivered meals, transportation) that make it possible for them to stay in their own residence.

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

Quality Control

Although expense is the major issue surrounding LTC, policymakers and industry officials also struggle with improving LTC quality. According to a 2000 survey conducted by the Health Care Association of Michigan (HCAM, an association of for-profit nursing homes), 89 percent of respondents reported being satisfied with the services they or their loved ones receive in a Michigan nursing home. The association reports that nationally, on average, there were 8.3 citations per facility in 2000 for violations of the quality regulations that were implemented in 1995. Michigan averaged 2.4 citations per facility, well below the national average.

In 2001 Michigan officials investigated 1,704 complaints and reports of poor care. Many LTC providers argue that many deficiencies found in Michigan facilities may not necessarily be due to inadequate staff and administrative practices but rather to the regulation system, which they say 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 opinion and is vulnerable to surveyor bias.

Critics of the LTC system argue that enforcement is not strict enough, and they say that serious violators go undetected and unpunished. They contend that the few facilities that do provide poor care (most of the violations involve only 45–50 of the state's 437 nursing homes) do not receive nearly enough regulatory attention.

In recent years two programs to improve LTC care in Michigan have been implemented.

- *Resident Protection Initiative* This program identifies homes that need accelerated review and, in some cases, such intervention as directed in-services or a clinical or administrative advisor to assist in complying with regulations. The Michigan Department of Consumer and Industry Services (MDCIS) has received national attention for this effort.
- *Governor's Quality Care Awards* This program recognizes outstanding Michigan care providers who go the extra mile in creating a safe, healthy, and nurturing environment for the elderly.

The MDCIS also provides facility licensure status and inspection reports on its Web site, and this helps consumers and their families to choose an LTC option that will give good care—in terms of cost *and* quality—to the patient. In addition, measures are pending to (1) require administrators to give residents a monthly itemized bill for services rendered (SB 574), (2) create a consumer rating index for nursing homes and require that residents be surveyed annually as to their satisfaction with the facility (SB 572), and (3) allow electronic monitoring of nursing home residents (SB 1120 and HB 5603).

Conclusion

Given the growing need for and expense of LTC services both in Michigan and nationwide, LTC reform is inevitable. Policymakers are exploring numerous options to make LTC affordable both for individuals and government. Most believe that success best can be achieved through both cost shifting and system reform. The challenge 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 Aging; Consumer Protection; Domestic Violence; Health Care Costs and Managed Care.

FOR ADDITIONAL INFORMATION

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