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Managed Care and Long-Term Care: The Integration of Financing and Services

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People with disabilities currently receive care in a splintered and uncoordinated financing and delivery system (Evashwick, 1987; National Chronic Care Consortium, 1991). Financing for acute care is largely the province of Medicare and the federal government, while long-term care is dominated by Medicaid and state governments. Because of the bifurcation of financial responsibilities, there is a strong incentive for the federal government to shift costs to the states and vice versa. At the very least, there is indifference in each quarter about initiatives that would save money for the other level of government.

In terms of service delivery, fragmentation exists both within and between the acute care and long-term-care systems. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system (Finch et al., 1992). For example, some elderly patients may remain unnecessarily in acute care hospitals because appropriate nursing home or homecare services are not immediately available,

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appropriate follow-up physician care cannot be arranged, or financing is not available.

Because of the growing awareness of the inadequacies of the current system, there is increasing policy interest in finding ways to bring the acute care and long-term-care sectors together into a single integrated system. Almost all of these initiatives depend on managed care. Under these models, capitated organizations (those that receive a per capita payment or fee)

have financial incentives to avoid both the functional decline that can result from unmet needs and the unnecessary costs associated with providing services in needlessly expensive settings. At least in theory, this coordinated approach would produce savings in acute care because lower-cost outpatient and home-based services could be substituted for more costly inpatient services when appropriate (Rivlin and Wiener, with Hanley and Spence, 1988; National Chronic Care Consortium, 1991; Leutz, Greenlick, and Capitman, 1994). These acute care savings, in turn, could be used to fund more comprehensive long-term-care benefits or could be captured by third parties as savings.

DEMONSTRATIONS AND OTHER INITIATIVES

A substantial number of demonstration projects are under way to test various approaches to integrating acute care and long-term-care services. The best known of these demonstrations are the social health maintenance organizations (social HMOs), On Lok and its Program of

All-inclusive Care for the Elderly (PACE) replications, and the Arizona Long-Term Care System (ALTCs) program. Several other initiatives also under way either seek to enroll people with disabilities who are eligible for Medicaid in health maintenance organizations for their acute care services or for both their acute care and long-term-care services (Wiener and Skaggs, 1995). Although not directly involved in long-term care, conventional HMOs participating in the Medicare program are required to provide the full range of benefits, including home health and skilled nursing facility services.

Medicare health maintenance organizations. Under rules established by the Tax Equity and Fiscal Responsibility Act of 1982, Medicare beneficiaries may enroll in health maintenance organizations (McMillan, 1993). Congress is currently debating various changes to these rules. Medicare beneficiaries who enroll in HMOs give up their free choice of providers and agree to use the providers approved by the HMO. However, unlike most younger people in HMOs who are "locked in" for a year, Medicare beneficiaries may disenroll at any time with one month's notice. These organizations provide or arrange for Medicare-covered services in exchange for a capitated payment, which is based on 95 percent of the estimated costs of serving an enrollee in the fee-for-service system.

Social health maintenance organizations. Social HMOs extend the traditional HMO concept by adding a modest amount of long-term care to the benefits provided (Leutz, Greenlick, and Capitman, 1994; Harrington and Newcomer, 1991; Greenberg et al., 1988; Rivlin and Wiener, 1988; Leutz, Greenberg, and Abrahams, 1985). A coordinated case management system authorizes long-term-care benefits for those who meet the established eligibility criteria. Social HMOs are intended to serve a cross section of the elderly population, including both functionally impaired and unimpaired people. In fact, the overwhelm-

ing majority of enrollees are not disabled. While all enrollees are eligible for Medicare, relatively few Medicaid beneficiaries are enrolled. Enrollees pay premiums to cover the extra benefits. From the original four-site initiative, Congress has authorized a "second generation" of demonstrations.

On Lok/Program of All-inclusive Care for the Elderly. In 1983, On Lok Senior Health Services in San Francisco obtained federal waivers allowing it to receive monthly capitation payments from Medicare, Medicaid, and (in a few cases) individuals to provide a comprehensive range of acute care and long-term-care services (Ansak, 1990; Zawadski and Eng, 1988). The Program of All-inclusive Care for the Elderly (PACE) is an effort to replicate the On Lok model in ten sites throughout the country (Kane, Illston, and Miller, 1992; Irvin et al., 1993). Enrollment is limited to people who are so disabled that they meet nursing home admission criteria. Because expenditures per person are so high, very few people can afford to pay an actuarially fair insurance premium. As a result, almost all enrollees are Medicaid-eligible. PACE sites operate as geriatrics-oriented, staff-model HMOs, with primary care physicians as employees of the organization. Finally, the approach makes heavy use of adult day healthcare, which is integrated with primary care.

Arizona Long-Term Care System. The Arizona Health Care Cost Containment System (AHCCCS) is a statewide demonstration project that finances medical services for the Medicaid-eligible population through prepaid contracts with providers. Beginning in 1989, the Arizona Long-Term Care System (ALTCs) program incorporated Medicaid long-term-care services into the AHCCCS program (Northrup, 1994; McCall, Korb, and Bauer, 1994; McCall et al., 1993; Irvin et al., 1993). Participation in the program is limited to individuals who are certified to be at risk of institutionalization. ALTCs covers acute care services, as well as care in nursing facilities, intermediate care facilities for the

mentally retarded, and home- and community-based services. Under the ALTCs model, the state contracts with one entity in each county to assume responsibility for covered services to eligible elderly and physically disabled people. In the overwhelming majority of cases, the contractor for elderly people and people with physical disabilities is the county government.

WHAT HAVE WE LEARNED?

Research on Medicare HMOs, social HMOs, On Lok/PACE, and ALTCs provides evidence regarding enrollment, satisfaction, quality of care, and utilization and costs. With the exception of the ALTCs program, these demonstration projects generally depend on voluntary enrollment, which provides both a market test of different plans and a check on quality of care. In most areas of the country, these capitated approaches, which require enrollees to give up freedom of choice of providers, have had a difficult time enrolling the elderly and disabled populations (McMillan, 1993; Harrington and Newcomer, 1991; Finch et al., 1992; Leutz et al., 1993; Kane, Illston, and Miller, 1992; Branch, Coulam, and Zimmerman, 1995). As more older people become familiar with managed care, this resistance appears to be diminishing, at least for the Medicare HMO program.

Evidence from conventional HMOs and the social HMOs suggests that Medicare enrollees tend to be healthier and less disabled than people remaining in the fee-for-service system (Brown et al., 1993; Riley, Rabey, and Kasper, 1989; Newcomer et al., 1995; Manton et al., 1994). Some researchers and administrators associated with the social HMOs strongly challenge these findings as methodologically flawed (Leutz, Greenlick, and Capitman, 1994). Although the On Lok/PACE enrollees are clearly very disabled, they appear to be less disabled in the activities of daily living than nursing home patients and may have other characteristics that distinguish them from people who are institutionalized (On Lok, 1993). Medicare

HMOs and social HMOs tend to have fairly high disenrollment, but Medicare makes it extremely easy to disenroll (Brown et al., 1993; Harrington, Newcomer, and Preston, 1993).

An argument in favor of integrated systems is that quality of care and consumer satisfaction will be improved because artificial barriers between care providers will be eliminated. Overall, evidence concerning Medicare and social HMOs suggests generally high levels of consumer satisfaction among enrollees (U.S. Department of Health and Human Services, Office of the Inspector General, 1995; Brown et al., 1993; Newcomer, Weinstock, and Harrington, 1989). Enrollees were most satisfied with covered benefits and the out-of-pocket costs. However, compared to people receiving fee-for-service care, HMO enrollees were generally less happy with the care provided. A notable exception to this generalization is the "impaired" group within the social HMO, who were more satisfied than the comparison group on almost all dimensions of care.

Formal studies of quality of care have shown mixed results. Although evaluations of Medicare HMOs generally show that they produce outcomes roughly comparable to those of the fee-for-service sector, HMO enrollees receive less care (Brown et al., 1993; Greenwald and Henke, 1992; Carlisle et al., 1992; Yelin, Shearn, and Epstein, 1986). Of concern is the finding of some studies that outcomes for people with disabilities and people with chronic illness are worse in HMOs than in the fee-for-service sector (Shaughnessy, 1994). Within the social HMOs, at least some disabled groups had higher mortality rates than people receiving fee-for-service care (Manton et al., 1993), although, again, these results have been challenged by the social HMOs on methodological grounds (Leutz, Greenlick, and Capitman, 1994). In an evaluation of nursing home care, quality of care was lower in Arizona, under the ALTCs program, than in New Mexico which has a conventional Medicaid program, but it is

difficult to know the cause of the differences (Balaban, McCall, and Paringer, 1994).

To policy makers, one of the major attractions of the integration of acute care and long-term-care services is the potential for cost savings in acute care that could be used to finance long-

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term care or to reduce overall expenditures. In evaluating this issue, it is difficult to separate the effects of capitation from the effects of integrating acute care and long-term-care services. Evidence concerning Medicare HMOs, social HMOs, and On Lok/PACE shows that acute care utilization can be reduced in capitated care settings, but it is less clear that integrating acute care and long-term-care services generates additional savings (Brown et al., 1993; Finch et al., 1992; Harrington and Newcomer, 1991; On Lok, Inc., 1995; On Lok, Inc., 1993). Social HMOs did not appear to do substantially better than conventional HMOs in reducing acute care expenditures. The early evidence from On Lok/PACE is more encouraging, but the data are very preliminary, do not adjust for case mix, and involve a relatively small sample. Complicating the evaluation of cost savings are the inadequacies of the Medicare and Medicaid payment methodologies, which do not adjust adequately for risk (National Chronic Care Consortium, 1993; Kane, Illston, and Miller, 1992; Leutz et al., 1993; Brown et al., 1993).

As a result, for conventional HMOs the evidence suggests that Medicare is overpaying the plans, and thus losing money (Brown et al., 1993).

The ALTCs program appears to save money, largely because of how it provides services to the population with mental retardation and developmental disabilities (McCall et al., 1993). For older people and people with physical disabilities, savings are smaller and derived largely from providing services to fewer people than would have received them in a traditional Medicaid program. It is unclear whether the savings come from acute care or long-term-care services. In an early assessment of the home- and community-based services provided under ALTCs, the program appeared to successfully target people at high risk of institutionalization and was cost-effective in its provision of non-institutional long-term-care services (Weissert, 1994).

POLICY CONSIDERATIONS

As states and the federal government explore ways to reform the system of financing and paying for acute care and long-term-care services for people with disabilities, at least seven issues should figure in the calculus:

Do managed care organizations understand low-income elderly and long-term care? To date, managed care organizations have mostly focused on providing acute care to the nonelderly population. Nationally, only about 10 percent of the elderly Medicare beneficiaries are enrolled in HMOs (Health Care Financing Administration, 1995). In addition, the vast majority of states have focused their Medicaid managed care programs on children and nondisabled adults; few states have actively attempted to enroll the elderly or people with disabilities in managed care programs (Rowland et al., 1995). Only a scattered number of health maintenance organizations provide long-term-care services. As a result, few managed care organizations have any experience with low-income elderly, and virtually none has any experience with long-term care.

Thus, it may take time before a substantial number of providers become knowledgeable about caring for this population.

Will the managed care be good for long-term care? A persistent concern of long-term-care advocates is that the integration of acute care and long-term-care services will have negative consequences for the provision of long-term-care services (Wiener and Illston, 1994; Schlesinger and Mechanic, 1993; Batavia, 1993). One concern is that fiscal pressures within integrated systems will end up shortchanging long-term care. Within the social HMOs, there is some evidence that chronic care benefits were reduced because of rising acute care costs and market resistance to higher premiums (Harrington and Newcomer, 1991). Another concern is that long-term care will become "over-medicalized" in integrated settings and that services will become less consumer-directed. After all, many would argue that the essence of managed care is that the balance of power shifts from the individual client and the client's chosen provider to HMOs, insurance companies, or other administrative entities. On this issue, there are virtually no data in the published literature, although managed care supporters deny that this has been a problem in the demonstrations (Leutz, Greenlick, and Capitan, 1994).

What model of integration should be promoted? Proposals to "integrate" acute care and long-term-care services are receiving increasing attention as a way to save money and provide better care. Conceptually, financial integration is relatively straightforward, referring to the pooling of funds from Medicare, Medicaid, insurance, and consumers.

On the other hand, there is little consensus about what constitutes "integration" in the delivery system. One view conceives of integration as improving the transitions and referrals back and forth between the acute care and long-term-care services (Leutz et al., 1995). The alternate view conceives of integration as dramatically

changing how acute care and long-term-care services are provided and puts multidisciplinary teams trained in geriatrics at the center of the care process (Harrington, Lynch, and Newcomer, 1993). The shape of the delivery system will depend on which model, if any, is promoted.

How will quality of care and access to services be assured? A major issue with all managed care initiatives is how to make sure that the drive to reduce utilization does not result in underservice to beneficiaries. This possibility is a particular concern when managed care organizations enroll disabled individuals who are likely to have high needs for both acute care and long-term-care services. Unfortunately, at this time, the states and the federal government lack the technology, personnel, and data systems to monitor the quality of care in managed care organizations. As limited as their general capability to monitor quality of acute care is, there is no experience in assessing quality of long-term care in managed care settings.

How should managed care organizations be paid? With the exception of the ALTCs, almost all managed care providers of integrated acute and long-term care are paid a rate based on a percentage (usually 90 to 100 percent) of estimated enrollee costs had the enrollee remained in the fee-for-service system. The model for this reimbursement methodology—Medicare's adjusted average per capita cost (AAPCC)—does a poor job predicting an individual's use of services (U.S. General Accounting Office, 1994; National Chronic Care Consortium, 1993; Kane, Illston, and Miller, 1992; Leutz et al., 1993; Brown et al., 1993). The payment rate varies with the individual's geographic location, age, gender, reason for entitlement (age or disability), institutional status (residing in a nursing home or not), and according to whether the person is Medicaid-eligible. In spite of these adjustments, Medicare spends approximately 5.7 percent more for people who enroll in HMOs than it would have spent per person

on fee-for-service care (Brown et al., 1993). Thus, Medicare is currently losing money on its HMO program. The increase in costs to the Health Care Financing Administration is due primarily to the fact that Medicare beneficiaries who choose HMOs are healthier on average and would have spent less than the HMOs receive in payment had they stayed in the fee-for-service system. Because of lack of confidence in the reimbursement methodology, HMO providers fear that they will not be adequately reimbursed, while policy makers worry that the government is spending more than is necessary.

In addition, capitated Medicaid rates, which generally follow the Medicare model of a percentage of the costs that would have been incurred in the fee-for-service system, are difficult to calculate because they must be relative to some comparison group. States are uncertain whether the appropriate comparison group for rate calculation is nursing home residents, nursing home-eligible or certifiable clients, community care clients, or some blend of these. The fact that some beneficiaries become Medicaid-eligible only after they have been admitted to a nursing home and impoverished themselves further complicates the computation of Medicaid payment rates for integrated systems.

Who gets the savings? In general, integrating acute care and long-term-care services has a goal of reducing hospital and physician utilization by increasing the use of home- and community-based services and sometimes nursing home care. Thus, cost savings usually accrue to the acute, rather than long-term-care, side of service delivery. As a result, Medicare rather than Medicaid may claim the savings. In addition, if the proposals to control Medicare expenditures are enacted, then Congress will extract the savings that managed care organizations may be able to obtain. In addition, as noted above, limited research raises questions as to whether the addition of long-term-care services produces additional acute care savings.

How much freedom of action will states have? Under current law, most projects that integrate acute care and long-term-care financing require waivers of Medicare and Medicaid regulations. For example, to operate a social HMO, administrators must obtain waivers of regulations regarding open enrollment, covered services, payment methodologies and levels, and the limitation on the percentage of HMO enrollment that can be Medicare or Medicaid beneficiaries. But these waivers are only available for research purposes, and the process for receiving waivers is cumbersome and time-consuming, and approval is not guaranteed. Moreover, because these waivers are for research demonstration purposes, the waivers are time-limited and tied to specific populations.

Under changes being considered by Congress, states will have much greater freedom of action to fashion their Medicaid managed care programs, but they will not have any control over the Medicare program. Since Medicare reimburses most of the acute care expenditures of elderly Medicaid beneficiaries, Medicaid agencies will either have to obtain Medicare waivers or work around the Medicare program. Because Medicaid pays only the deductibles, coinsurance, and uncovered services (mostly prescription drugs), the state may not have a great deal of leverage over the HMO's provision of acute care services. In addition, given the relatively small role of Medicaid in acute care for the elderly, it may be difficult to mandate that the elderly enroll in HMOs.

CONCLUSIONS

One of the great successes of the twentieth century has been the prevention and treatment of acute illnesses (such as pneumonia). As a result, the leading causes of morbidity and mortality are now almost all related to chronic illnesses (Pawlsion, 1994). The population with chronic illnesses and disabilities requires a broad array of acute care and long-term-care services. While it is commonly recognized that the disabled

population needs nursing home, home care, and other long-term-care services, it is less widely appreciated that disabled people are also heavy users of physician and hospital care. Currently, people with disabilities receive care in a splintered and uncoordinated delivery system that may result in higher costs than would occur in a more integrated system.

For reasons of both quality of care and cost, there is increasing interest in approaches that integrate acute care and long-term-care services. Almost all of these initiatives depend on extending managed care beyond traditional acute care services to include long-term care. These approaches face numerous technical, political, and attitudinal barriers. To a large extent, policy makers and providers are just beginning to learn how to create a seamless financing and delivery system for people with disabilities. Data from evaluations of demonstrations suggest both problems and opportunities. How to meet the needs of the "whole" person is something we do not understand very well, but with the rising number of people with disabilities, society will have to learn. ☺

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REFERENCES

- Ansak, M. 1990. "The On Lok Model: Consolidating Care and Financing." *Generations* 14(2): 73-4.
- Applebaum, R., and Austin, C. 1990. *Long-Term Care Case Management: Design and Evaluation*. New York: Springer.
- Balaban, D., McCall, N., and Paringer, L. 1994. *Quality of Care in the Arizona Long-Term Care System (ALTCs): A Study of Quality Indicators Among Nursing Home Residents*. San Francisco: Laguna Research Associates.
- Batavia, A. 1993. "Health Care Reform and People with Disabilities." *Health Affairs* 12(1): 40-57.
- Branch, L., Coulam, R., and Zimmerman, Y. 1995. "The PACE Evaluation: Initial Findings." *Gerontologist* 35(3): 349-59.
- Brown, R., et al. 1993. "The Medicare Risk Program for HMOs—Final Summary Report on Findings from the Evaluation." Princeton, N.J.: Mathematica Policy Research, Inc.
- Carlisle, D., et al. 1992. "HMO vs. Fee-for-Service Care of Older Persons with Acute Myocardial Infarction." *American Journal of Public Health* 82(12): 1,626-30.
- Evashwick, C. 1987. "Definition of the Continuum of Care." In C. Evashwick and L. Weiss, eds., *Managing the Continuum of Care*. Gaithersburg, Md.: Aspen.
- Finch, M., et al. 1992. "Design of the 2nd Generation S/HMO Demonstration: An Analysis of Multiple Incentives." Minneapolis, Minn.: Institute for Health Services Research.
- Greenberg, J., et al. 1988. "The Social HMO Demonstration: Early Experience." *Health Affairs* 7(2): 66-79.
- Greenwald, H., and Henke, C. 1992. "HMO Membership, Treatment, and Mortality Risk Among Prostatic Cancer Patients." *American Journal of Public Health* 82(8): 1,099-104.
- Gruenberg, L., Rumshiskaya, A., and Kaganova, J. 1993. "An Analysis of Expected Medicare Costs for Participants in the PACE Demonstration." *PACE: Progress Report on the Replication of the On Lok Model*. San Francisco: On Lok, Inc.
- Harrington, C., Lynch, M., and Newcomer, R. 1993. "Medical Services in Social Health Maintenance Organizations." *Gerontologist* 33(6): 790-800.
- Harrington, C., and Newcomer, R. 1991. "Social Health Maintenance Organizations' Service Use and Costs 1985-89." *Health Care Financing Review* 12(3): 37-52.
- Harrington, C., Newcomer, R., and Preston, S. 1993. "A Comparison of S/HMO Disenrollees and Continuing Members." *Inquiry* 30(4): 429-40.
- Health Care Financing Administration. 1995. Unpublished data. Baltimore, Md.
- Irvin, K., et al. 1993. *Managed Care for the Elderly: Profile of Current Initiatives*. Portland, Me: National Academy for State Health Policy.
- Kane, R., Illston, L., and Miller, N. 1992. "Qualitative Analysis of the Program of All-inclusive Care for the Elderly (PACE)." *Gerontologist* 32(6): 771-80.
- Leutz, W., et al. 1993. "Design of Second Generation Social Health Maintenance Organization Sites." Waltham, Mass.: Institute for Health Policy, Brandeis University.

Leutz, W., Greenberg, J., and Abrahams, R. 1985. *Changing Health Care for an Aging Society: Planning for the Social Health Maintenance Organization*. Lexington, Mass.: Lexington/Heath.

Leutz, W., Greenlick, M., and Capitan, J. 1994. "Integrating Acute and Long-Term Care." *Health Affairs* 13(4): 59-74.

Leutz, W., et al. 1995. "Letter to the Editor: Medical Services in Social HMOs: A Reply to Harrington et al." *Gerontologist* 35(1): 6-8.

Manton, K., et al. 1993. "Social/Health Maintenance Organizations and Fee-for-Service Health Outcomes Over Time." *Health Care Financing Review* 15(2): 173-202.

Manton, K., et al. 1994. "A Method for Adjusting Payments to Managed Care Plans Using Multivariate Patterns of Health and Functioning: The Experience of Social/Health Maintenance Organizations." *Medical Care* 32(3): 277-97.

McCall, N., and Korb, J. 1994. "Combining Acute and Long-Term Care in a Capitated Medicaid Program: The Arizona Long-Term Care System." San Francisco: Laguna Research Associates.

McCall, N., et al. 1993. "Evaluation of Arizona's Health Care Cost Containment System Demonstration—Second Outcome Report." San Francisco: Laguna Research Associates.

McCall, N., Korb, J., and Bauer, E. 1994. "Evaluation of Arizona's Health Care Cost Containment System Demonstration—Third Outcome Report." San Francisco: Laguna Research Associates.

McMillan, A. 1993. "Trends in Medicare Health Maintenance Organization Enrollment: 1986-93." *Health Care Financing Review* 15(1): 135-46.

National Chronic Care Consortium. 1991. "Fact Sheet." Bloomington, Minn.: National Chronic Care Consortium.

National Chronic Care Consortium. 1993. "Health Care Reform: Barriers to Integration." Working Paper. Bloomington, Minn.: National Chronic Care Consortium.

Newcomer, R., et al. 1995. "A Response to Representatives from the Social HMOs Regarding Program Evaluation." *Gerontologist* 35(3): 292-94.

Newcomer, R., Weinstock, P., and Harrington, C. 1989. "Comparison of the Consumer Satisfaction of Medicare Beneficiaries in Social HMOs and Fee for Service." Minneapolis, Minn.: Annual Scientific Meeting of the Gerontological Society of America.

Northrup, F. 1994. "Arizona's Integrated Acute and LTC Program." *LTC News & Comment* 4(11): 5.

On Lok, Inc. 1993. "PACE: Who is Served and What Services Are Used?" *PACE*:

Progress Report on the Replication of the On Lok Model. San Francisco: On Lok, Inc.

On Lok, Inc. 1995. "PACE Fact Book: Information about the Program of All-inclusive Care for the Elderly." San Francisco: On Lok, Inc.

Riley, G., Rabey, E., and Kasper, J. 1989. "Biased Selection and Regression Toward the Mean in Three Medicare HMO Demonstrations: A Survival Analysis of Enrollees and Disenrollees." *Medical Care* 27(4): 337-51.

Rivlin, A., and Wiener, J., with Hanley, R., and Spence, D. 1988. *Caring for the Disabled Elderly: Who Will Pay?* Washington, D.C.: Brookings Institution.

Rowland, D., et al. 1995. *Medicaid and Managed Care: Lessons from the Literature*. Washington, D.C.: Kaiser Commission on the Future of Medicaid.

Schlesinger, M., and Mechanic, M. 1993. "Challenges for Managed Competition from Chronic Illness." *Health Affairs Supplement*: 123-37.

Shaughnessy, P. 1994. "Home Health Care Outcomes Under Capitated and Fee-for-Service Payment." *Health Care Financing Review* 16(1): 187-222.

U.S. Department of Health and Human Services, Office of the Inspector General. 1995. *Beneficiary Perspectives of Medicare Risk HMOs* (OEI-06-91-00739). Washington, D.C.

U.S. General Accounting Office. 1994. *Medicare: Changes to HMO Rate Setting Method are Needed to Reduce Program Costs*. Prepared by the Health, Education, and Human Resources Division, General Accounting Office. Washington, D.C.

Weissert, W. 1994. "Effectiveness of the Preadmission Screening Instrument and Level of Care Determination." In N. McCall et al., eds., *Evaluation of the Arizona Health Care Cost Containment System Demonstration: Second Implementation and Operation Report*. San Francisco: Laguna Research Associates.

Wiener, J., and Illston, L. 1994. "Health Care Reform in the 1990s: Where Does Long-Term Care Fit In?" *Gerontologist* 34(3): 402-8.

Wiener, J., and Skaggs, J. 1995. "Current Approaches to Integrating Acute and Long-Term Care Financing and Services." Public Policy Institute No. 9516. Washington, D.C.: American Association of Retired Persons.

Yelin, E., Shearn, M., and Epstein, W. 1986. "Health Outcomes for a Chronic Disease in Prepaid Group Practice and Fee for Service Settings: The Case of Rheumatoid Arthritis." *Medical Care* 24(3): 236-47.

Zawadski, R., and Eng, C. 1988. "Case Management in Capitated Long-Term Care." *Health Care Financing Review Annual Supplement*: 75-81.

Coming Up
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GENERATIONS



LEGACY AND AGING



Rosalie Kane
Guest Editor

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During 1995 and 1996 Congress debated numerous proposals that would dramatically reduce the rate of growth in Medicaid spending, initiatives that inevitably would affect long-term care for the elderly. There are three broad strategies that states might use to control long-term care spending — bring more private resources into the long-term care system to offset Medicaid's expenditures, reform the delivery system so that care can be provided more cheaply, and reduce Medicaid eligibility, reimbursement, and service coverage. Based on the available research evidence, there is little evidence to suggest that large savings are possible without adversely affecting beneficiaries' eligibility, access to services, and quality of care received.

Key Words: Medicaid, Long-term care, Budget

Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced?¹

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In 1995 Congress passed legislation (vetoed by President Clinton) that would convert Medicaid from an open-ended entitlement program with a number of federal requirements to a block grant (MediGrant) with few national standards. Moreover, federal expenditures for Medicaid would be capped and indexed at far below the expected rate of growth under current law. Federal Medicaid expenditures would be cut by \$167 billion during the years 1996 to 2002; in that year, federal Medicaid expenditures would be 28% below what would be expected under current law (Holahan & Liska, 1995a). In 18 states, federal expenditures would be more than 30% below estimates under current law.

For his part, President Clinton has proposed establishing per-beneficiary limits on the growth of federal expenditures, while giving states greater flexibility in contracting with managed care organizations, setting reimbursement rates, and organizing long-term care services. President Clinton's proposal would cut federal Medicaid expenditures by \$54 billion by the year 2002, substantially less than the Congressional Medi-Grant plan.

More recently, the National Governors' Association has developed a proposal that attempts to marry the block grant approach of the MediGrant with the per beneficiary limits on the growth of expenditures proposed by the Clinton Administration. Although a

dollar savings level was not proposed by the governors, most analysts assume that it would be between President Clinton's and Congressional Republicans' last budget offers — \$59 and \$85 billion, respectively.

A key issue in evaluating these proposals is how states will live within the budget levels envisioned by these proposals. Unlike proposed welfare and Medicare reforms, advocates of greater state flexibility and substantially reduced federal Medicaid spending have not put forth a detailed blueprint of how states could stay within their budgets. The policy debate begins and ends with the notion that if states are given enough flexibility, they will figure out how to reduce the rate of growth in expenditures without hurting beneficiaries. Indeed, many governors explicitly reject the argument that reduced federal funding and requirements will adversely affect the poor (Edgar, 1995; Engler, 1995).

If states are to control Medicaid expenditures, they will have to confront the issue of services for the elderly and persons with disabilities. The following statistics bring this issue into focus:

- Although about three quarters of Medicaid beneficiaries are children and nonelderly, nondisabled adults, they account for only about a third of expenditures (Liska, Obermaier, Lyons, & Long, 1995).
- Older people and persons with disabilities account for the other two thirds of Medicaid expenditures.
- In 1995, 33% of Medicaid expenditures were for long-term care services — nursing facilities, personal care, home health, intermediate care facilities for the mentally retarded, and home- and community-based services (Burwell, 1996).
- In 12 states, long-term care accounts for 45% or more of Medicaid program expenditures (Holahan & Liska, 1995b).

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- Approximately three fifths of Medicaid long-term care expenditures are for the elderly (Kaiser Commission on the Future of Medicaid, 1995).
- Medicaid is the dominant source of public funding for long-term care for the elderly, accounting for 62% of government spending for nursing home and home care in 1993 (Wiener, Illston, & Hanley, 1994b).
- Most Medicaid long-term care spending for the elderly goes for care in a nursing home, where the costs for 69% of residents in 1994 were at least partly financed by the program (American Health Care Association, 1995).

This article focuses on whether or not large savings might be achieved through more widespread implementation of initiatives to control the rate of increase in long-term care expenditures for the elderly. Overall, there are three broad strategies that states might use to control spending — bring more private resources into the long-term care system to offset Medicaid's expenditures, reform the delivery system so that care can be provided more cheaply, and reduce Medicaid eligibility, reimbursement, and service coverage. In brief, based on the available research, there is little evidence to suggest that large savings are possible without adversely affecting beneficiaries' eligibility, access to services, and the quality of care received. As a result, claims that large Medicaid long-term care savings can be obtained easily should be viewed with caution by policymakers.

Strategies to Control Spending: Increase Private Resources

The first general strategy to control spending is to bring additional private resources into the long-term care system. This could be done in three ways — by encouraging private long-term care insurance, by more strictly enforcing prohibitions against transfer of assets prior to receiving long-term care, and by more aggressively recovering money from the estates of deceased Medicaid nursing home residents. This strategy builds on the observation that a substantial proportion of Medicaid nursing home residents were not poor before they entered the nursing home. Rather, they were impoverished by the \$40,000 per year average cost of nursing home care (author's estimate based on unpublished data from the Office of National Cost Estimates, 1995). About a quarter of discharged Medicaid residents were admitted as private pay residents, exhausted their savings, and then qualified for Medicaid during their course of stay (Wiener, Sullivan, & Skaggs, 1996). Thus, those nursing home residents may have private resources that can be more effectively drawn upon to offset their Medicaid expenditures.

Encourage Purchase of Private Long-Term Care Insurance. — One way to reduce Medicaid long-term expenditures might be to encourage the purchase of private long-term care insurance. For the initially nonpoor Medicaid nursing home population, private long-term care insurance could possibly prevent

both their impoverishment and subsequent Medicaid expenditures. Currently, only about 4 to 5% of the elderly have any type of long-term care insurance, much of which is deficient in terms of coverage (author's calculation based on data from Coronel & Fulton, 1995).

There are several reasons why so few people have private long-term care insurance. First and most importantly, such insurance is unaffordable for most of the elderly. The average annual premium for high-quality insurance policies sold by the leading sellers in 1993 was \$2,137 if bought at age 65 and \$6,811 if bought at age 79 (Coronel & Fulton, 1995). Most studies have found that only 10 to 20% of the elderly can afford private long-term care insurance (Crown, Capitman, & Leutz, 1992; Friedland, 1990; Rivlin & Wiener, with Hanley & Spence, 1988; Wiener et al., 1994b; Zedlewski & McBride, 1992).

Second, many older persons incorrectly believe that Medicare covers long-term care services (Employee Benefit Research Institute, 1993). Obviously, people will not be motivated to buy private long-term care insurance if they think they already have coverage.

Third, although people seem to accept the possibility that they will someday need hospital and physician care, few are willing to admit that they face a significant lifetime risk of becoming disabled and will need extensive nursing home or home care. Yet, research suggests that over two fifths of people who live to age 65 will spend some time in a nursing home and about a quarter of all elderly will stay more than a year (Kemper & Murtaugh, 1991).

To estimate the potential impact of various private long-term care insurance options, Wiener, Illston, and Hanley simulated several different private long-term care insurance options using the Brookings-ICF Long-Term Care Financing Model (Wiener et al., 1994b). Figure 1 describes the assumptions, which represent an optimistic upper-bound estimate of potential market penetration and impact for some of the options. Under these assumptions, affordability is the only barrier to the purchase of policies. The simulations suggest that, even by the year 2018, private long-term care insurance is unlikely to substantially affect Medicaid nursing home expenditures or the number of Medicaid nursing home beneficiaries (Table 1). Because nursing home residents must deplete virtually all of their income and assets in order to qualify for Medicaid, the number of Medicaid nursing home beneficiaries is a rough estimate for the number of persons who incur catastrophic out-of-pocket nursing home expenses. Assuming people purchase insurance when they are elderly, Medicaid nursing home expenditures might be 1 to 4% less than what they would be without private long-term care insurance in 2018. Similarly, for these same options, the number of Medicaid nursing home beneficiaries might fall from 0 to 2% compared with what they would be without private insurance. Thus, private long-term care insurance has little impact because it is too expensive for the elderly who currently depend on Medicaid to pay for their nursing home care.

All persons purchase insurance policies that cover two or four years of nursing home and home care and pay an initial indemnity value of \$60 per day for nursing home care and \$30 per visit for home care in 1986. Indemnity values increase by 5.5% per year on a compound basis. Premiums for nonelderly persons increase by 5.5% per year until age 65 and are then level. All nondisabled persons who meet affordability criteria buy as much insurance as they can afford.

- **5% Income:** All elderly purchase policies if they can afford them for 5% of their income or less and if they have \$10,000 or more in nonhousing assets.
- **Medicaid Insurance:** Elderly who purchase private long-term care insurance may receive Medicaid nursing home benefits while retaining liquid assets beyond what is normally allowed. The additional assets that they keep equal the amount that the private insurance policy pays out in benefits. All elderly persons purchase policies when they can afford them for 7% of their income or less and if they have \$10,000 or more in nonhousing assets.
- **Tax-Favored Insurance:** Provides an income-related tax credit of up to 20% of the premium cost for elderly purchasing insurance. All elderly purchase policies when they can afford them for 5% of their income or less and if they have \$10,000 or more in nonhousing assets.
- **Accelerated Death Benefits:** Persons with cash value life insurance use it to finance their nursing home stay. The amount they use is 2.5% a month of the life insurance face amount, following a six-month deductible.
- **Employer-Sponsored Insurance:** Persons as young as age 40 purchase group or individual long-term care insurance policies. Nonelderly purchase policies if premiums are between 2% and 4% of income (depending on age). Elderly persons purchase policies if they can afford them for 5% or less of income and if they have \$10,000 or more in nonhousing assets.

Source: Wiener et al., 1994b.

Figure 1. Private long-term care insurance options: simulation assumptions.

Table 1. How Much Can Private Insurance Do?
Simulation Results of Five Major Options, Year 2018

Option	Reductions in Medicaid Nursing Home Spending (%) ^a	Reductions in Number of Medicaid Nursing Home Patients (%) ^a
Five percent income	-2%	-2%
Medicaid insurance	-4	-2
Tax-favored insurance	-3	-2
Accelerated death benefits	-1	0
Employer-sponsored insurance	-31	-17

Source: Wiener et al., 1994b.

^aCompared to what they would be without private long-term care insurance.

Only the option where large numbers of younger persons purchase private long-term care insurance through their employers provides the potential for significant reductions in Medicaid nursing home expenditures and the number of Medicaid nursing home beneficiaries. If employers sponsor but do not help pay for private long-term care insurance, Medicaid expenditures could decline as much as 31% and the number of Medicaid nursing home residents could fall by as much as 17% by the year 2018. How-

ever, this option would require a dramatic increase in the employer-sponsored market, since less than .1% of the nonelderly population currently has private long-term care insurance (author's estimate based on data from Coronel & Fulton, 1995). Moreover, most middle-aged workers are not interested in buying private long-term care insurance, because they have more pressing immediate expenses, such as child care, mortgage payments, and college education for their children. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Prevent Transfer of Assets. — Over the last few years, policymakers and the media have focused attention on middle- and upper-class elderly persons who transfer, shelter, and under-report assets in order to artificially appear poor so that they can qualify for Medicaid-financed nursing home care (Bates, 1992; Burwell & Crown, 1995; Gray, 1992; Kosterlitz, 1991). Often referred to as "Medicaid estate-planning," Congress legislated against these activities in the Tax Equity and Fiscal Responsibility Act of 1982, the Medicare Catastrophic Coverage Act of 1988, and the Omnibus Budget Reconciliation Act of 1993. However, some observers argue that the legislative prohibitions are easy to circumvent and that the prevalence of Medicaid estate-planning has increased dramatically in recent years (Moses, 1994, 1995a, 1995b, 1995c; Serafini, 1995). Speaker Newt Gingrich alleged that transfer of assets by "millionaires" to gain Medicaid eligibility is a "very common problem" (Schmidt & Rich, 1995). Moreover, according to some estimates, as much as \$5 billion a year — roughly 20% of Medicaid nursing home expenditures — could be saved by reducing the incidence of Medicaid estate-planning (Cantwell, 1995).

Perhaps no other policy issue in long-term care has generated as much passion as this one. Opponents of asset transfers contend that Medicaid is meant only for those who really need it and that manipulating loopholes to gain eligibility is a perversion of the program's intent (Moses, 1990). Moreover, they argue that money going to artificially eligible nursing home residents is money that cannot be spent on Medicaid services for low-income children and non-elderly adults.

Defenders of the practice insist that transferring or sheltering assets to qualify for Medicaid is morally indistinguishable from using the tax code to avoid paying estate taxes. Moreover, the disabled elderly who do not want their life savings totally destroyed by the costs of long-term care and who want to leave some inheritance to their spouse and children have few alternatives.

While it seems likely that an increasing number of persons are transferring their assets, the very limited available evidence suggests that the current numbers are much smaller than commonly thought. The only direct evidence is from a 1993 U.S. General Accounting Office study of applicants for Medicaid nursing home care in Massachusetts, a state chosen in part because asset transfer was believed to be common

there (U.S. General Accounting Office, 1993). Of the 403 Massachusetts Medicaid applicants reviewed, 49 had transferred assets, three quarters of whom had shifted less than \$50,000 in resources. Furthermore, 26 of the 49 applicants were either denied eligibility or withdrew their application. Six of the seven applicants who transferred more than \$100,000 were denied eligibility. Thus, although some clients did transfer assets, existing rules kept most off the Medicaid rolls.

Beyond this direct evidence, there is more indirect data to suggest that asset transfer is not as common as is often assumed. First, logically, older persons cannot transfer large amounts of assets they do not have. Existing data suggests that very elderly, disabled widows, who account for the vast bulk of nursing home patients, have quite low incomes and assets (Wiener, Hanley, & Harris, 1994a). As shown on Table 2, about two thirds of the disabled elderly who were admitted to nursing homes from 1982 to 1984 had incomes below 150% of the federal poverty line in 1982; about a third had incomes below the poverty level. Furthermore, using a synthetic estimate based on data on the noninstitutionalized elderly population from the Survey of Income and Program Participation, Wiener, Hanley, and Harris calculated that about three quarters of nursing home patients had less than \$50,000 in nonhousing assets (in 1989 dollars) at the time of their admission to the nursing home; almost half had less than \$10,000 in nonhousing assets (Table 3) (Wiener et al., 1994a). In contrast, only about 11% had the level of assets (\$100,000 or more) considered typical of estate planners' clients. Of this more wealthy population, about

half had enough annual income to pay for nursing home care without recourse to any assets. Thus, this group has little incentive to engage in Medicaid estate-planning.

Second, if a large and rapidly increasing number of the elderly are transferring their assets, then the number of Medicaid nursing home beneficiaries should be rising rapidly. In fact, as shown on Table 4, the number of Medicaid nursing home beneficiaries is increasing slowly and only slightly faster than the number of nursing home beds. Between 1990 and 1993, the average annual compound rate of increase in Medicaid nursing home beneficiaries was 3.3% a year, while the increase in the number of nursing home beds was 1.5% a year. All of the excess increase in Medicaid beneficiaries is due to a relatively large increase in Medicaid nursing home residents in one year — 1992.

Expanding Estate-Recovery. — In general, the home is an excluded asset in determining financial eligibility for Medicaid. However, for a long time states have had the option of recovering Medicaid expenditures for nursing home care from the estates of deceased Medicaid beneficiaries, principally from the sale of their houses. As of 1993, 24 states operated estate-recovery programs (Office of the Inspector General, 1994). The Omnibus Budget Reconciliation Act of 1993 mandated that all states operate such programs, but some states have refused to do so because these initiatives are politically unpopular.

It is likely that a significant proportion of elderly persons discharged from nursing homes own their homes. In an analysis of the 1982–84 National Long-Term Care Survey, Wiener, Hanley, and Harris found that 55% of disabled elderly persons entering nursing homes owned a home, a percentage that is well below the 75% of all elderly who are homeowners, but is still substantial (Wiener et al., 1994a). However, the proportion of deceased Medicaid nursing home residents who own houses is probably much smaller, in part because an unknown proportion sell their homes in order to help pay for their nursing home care. Sheiner and Weil (1992) found that only 42% of all elderly households will leave behind a house when the last member dies. In an analysis in eight states in 1985, the U.S. General Accounting Office found that only 14% of Medicaid nursing home residents owned a home, with an average

Table 2. Distribution of Income of Disabled Elderly Admitted to a Nursing Home from 1982 to 1984

Income in 1982 as Percent of Federal Poverty Level	Percent Distribution
Less than 100%	35.3%
100–149	31.4
150–199	15.0
200–299	11.0
300 +	6.7
Total	99.4

Source: Wiener et al., 1994a.

Note: Percent distribution does not total to 100% due to rounding.

Table 3. Estimated Income and Financial Assets of Nursing Home Population, 1989

Income	Personal Net Worth, Percent of Patients (Non-Housing Assets)				
	Total	0–\$9,999	\$10,000–\$49,999	\$50,000–\$99,999	\$100,000 +
\$7,499 or less	44	34	8	2	0
7,500–14,999	36	12	14	8	2
15,000–29,999	15	2	4	4	6
30,000 +	5	0	1	0	3
Total	100	48	27	14	11

Source: Wiener et al., 1994a.

Table 4. Number of Medicaid Nursing Home Beneficiaries and Nursing Home Beds, 1990–1993 (In Thousands)

Year	Medicaid Beneficiaries	Beds
1990	1,461	1,660
1991	1,490	1,685
1992	1,573	1,734
1993	1,610	1,768
Annual compound rate of growth	3.3%	1.5%

Source: Statistical Supplement, 1995, "Health Care Financing Review; and Charlene Harrington, University of California at San Francisco, personal communication, October 11, 1995.

value of about \$31,000, at the time of application for Medicaid (U.S. General Accounting Office, 1989).

Experience with currently operating estate-recovery programs suggests that they are likely to recoup only a small proportion of nursing home expenditures. As shown on Table 5, the amount recovered from the estates of deceased Medicaid beneficiaries averaged 1.03% of Medicaid nursing home expenditures in 1993 for the top 10 states, falling rapidly from a high of 2.51% in Oregon to .53% in Wisconsin. Because of the already significant effort underway in many states, additional savings are likely to be limited mostly to those not currently operating estate-recovery programs.

Strategies to Control Spending: System Reform

Another general strategy for saving money is to reorganize the delivery system in ways that make care more efficient and effective. This can be done by adding long-term care to the set of services provided by managed care organizations or by expanding home care and nonmedicalized, residential long-term care services.

Integrating Acute and Long-Term Care Services Through Managed Care. — Persons with disabilities currently receive care in a fragmented and uncoordinated financing and delivery system (Evashwick, 1987; National Chronic Care Consortium, 1991). Financing for acute care is largely the province of Medicare and the Federal Government, whereas long-term care is dominated by Medicaid and state governments. Because of the bifurcation of financial responsibilities, there is a strong incentive for the Federal Government to shift costs to the states and vice versa. At the very least, there is indifference about initiatives that would save money for the other level of government.

In terms of delivery of care, fragmentation exists both within and between the acute and long-term care systems. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system (Finch et al., 1992). For example, some elderly patients may remain unnecessarily in expensive acute care hospitals because appropriate nursing home or home care services are

Table 5. Top Ten Medicaid Estate-Recovery Programs, 1993

State	Recovery \$ as Percent of Nursing Home Expenditures
Oregon	2.51%
New Hampshire	1.36
California	1.16
Massachusetts	1.00
Minnesota	0.91
North Dakota	0.87
Idaho	0.85
Illinois	0.57
Utah	0.57
Wisconsin	0.53

Source: U.S. Department of Health and Human Services, Office of the Inspector General, 1994.

not immediately obtainable, appropriate follow-up physician care cannot be arranged, or financing for long-term care is not available.

Because of the growing awareness of the inadequacies of the current system, there is increasing interest among policymakers in finding ways to integrate the acute and long-term care sectors. Almost all integration initiatives depend on expanding the role of managed care to include long-term care services. Under these models, managed care organizations receive a fixed payment per enrollee to provide a range of acute and long-term care services, creating financial incentives to avoid both the functional decline that can result from unmet health care needs and the unnecessary costs associated with providing services in needlessly expensive settings. In theory, this coordinated approach would produce acute care savings because lower-cost outpatient and home-based services could be substituted for more costly inpatient services when appropriate (Leutz, Greenlick, & Capitman, 1994; National Chronic Care Consortium, 1991; Rivlin et al., 1988). These acute care savings, in turn, could be used to fund more comprehensive long-term care benefits or could be captured by third parties as savings.

Although the integration of acute and long-term care services offers the opportunity for improved quality of care, long-term care advocates are concerned with this model for a variety of reasons. One apprehension is that health maintenance organizations and other managed care providers have little experience with the elderly and none with the disabled elderly and their long-term care. Another concern is that fiscal pressures within integrated systems will end up shortchanging long-term care (Harrington & Newcomer, 1991). Finally, there is a fear that long-term care will become overmedicalized and that services will become less consumer-directed because the balance of power shifts from the individual client and his or her chosen provider to HMOs, insurance companies, or other administrative entities.

Demonstration Projects and Other Initiatives. — A substantial number of demonstration projects and

other initiatives are underway to test various approaches to integrating acute and long-term care services. The best known of these demonstrations are the Social Health Maintenance Organizations (Social HMOs), On Lok and its Program of All-Inclusive Care for the Elderly (PACE) replications, and the Arizona Long-Term Care System (ALTCS). Several other initiatives either seek to enroll Medicaid eligibles with disabilities in HMOs for their acute care services or for both their acute and long-term care services (Wiener & Skaggs, 1995). Although not directly involved in long-term care, conventional HMOs participating in the Medicare program are required to provide the full range of benefits, including home health and skilled nursing facility services.

Social HMOs extend the traditional HMO concept by adding a modest amount of long-term care benefits (Leutz, Greenberg, & Abrahams, 1985; Leutz, Greenlick, & Capitman, 1994; Rivlin et al., 1988). A coordinated case management system authorizes long-term care benefits for those who meet the established eligibility criteria. Social HMOs are intended to serve a cross-section of the elderly population, including both functionally impaired and unimpaired persons. In fact, the overwhelming majority of enrollees are not disabled. While all enrollees are Medicare-eligible, relatively few Medicaid beneficiaries are members. Enrollees pay premiums to cover the extra benefits. Originally a four-site initiative, Congress has authorized a "second generation" of demonstrations.

In 1983, On Lok Senior Health Services obtained federal waivers allowing it to receive monthly capitation payments from Medicare, Medicaid, and (in a few cases) privately paying individuals to provide a comprehensive range of acute and long-term care services (Ansak, 1990; Zawadski & Eng, 1988). As an offshoot, PACE is replicating the On Lok model in 10 sites throughout the country (Irvin, Riley, Booth, & Fuller, 1993; Kane, Illston, & Miller, 1992). Enrollment is limited to persons who are so disabled that they meet nursing home admission criteria. Because expenditures per person are so high, very few persons can afford to pay an actuarially fair insurance premium out-of-pocket. As a result, almost all enrollees are Medicaid-eligible. PACE sites operate as geriatrics-oriented, staff model HMOs, i.e., their primary care physicians are employees of the organization. Finally, the approach makes heavy use of adult day health care, which is integrated with primary care.

The Arizona Health Care Cost Containment system (AHCCCS) is a statewide demonstration project that finances medical services for the Medicaid-eligible population through prepaid, capitated contracts with providers. Beginning in 1989, the ALTCS program incorporated Medicaid long-term care services into the AHCCCS demonstration (Irvin et al., 1993; McCall, Korb, & Bauer, 1994; McCall et al., 1993; Northrup, 1995). Participation in the program is limited to individuals who are certified to be at high risk of institutionalization. ALTCS covers acute care services, as well as care in nursing facilities, intermedi-

ate care facilities for the mentally retarded, and home- and community-based services. Under the ALTCS model, the state contracts with one entity in each county to assume responsibility for covered services to elderly and physically disabled eligibles. In the overwhelming majority of cases, the contractor for elderly people and persons with physical disabilities is the county government.

Potential for Cost Savings. — As with more traditional acute care services, it appears that capitation can reduce expenditures. Evidence concerning Social HMOs and On Lok/PACE show that acute care utilization can be lowered in capitated care settings, but it is less clear that integrating acute and long-term care services generates additional savings (Leutz et al., 1994; National Chronic Care Consortium, 1991; On Lok, Inc., 1993; Rivlin et al., 1988). Social HMOs did not appear to do substantially better than conventional HMOs in reducing acute care expenditures. The early evidence from On Lok/PACE is more encouraging, but the data are very preliminary, do not adjust for case mix, and involve a relatively small sample. PACE sites tend to be very small, enrolling on average about 200 persons per site. Complicating the evaluation of cost savings are the inadequacies of the current Medicare and Medicaid payment methodologies, which do not adjust sufficiently for risk (Brown, Bergeron, Clement, Hill, & Retchin, 1993; Kane et al., 1992; National Health Care Consortium, 1993). As a result, estimating costs under a traditional, unintegrated fee-for-service system is difficult, and, hence, comparisons are hard to make.

In an evaluation of the ALTCS, Laguna Research Associates compared the total costs of ALTCS with an estimate of what a traditional Medicaid program in Arizona would cost (McCall et al., 1993). Evaluating the cost effectiveness of the Arizona program was extremely difficult because the state has never had a conventional Medicaid program. As a result, evaluators were forced to develop a synthetic estimate of what the costs of a traditional Medicaid program in Arizona would have been had it had one. Unfortunately, the choice of states used to develop the synthetic estimate was largely determined by data availability rather than whether states were "comparable" to Arizona in terms of ethnicity, style of care, and other factors.

The ALTCS program appears to save money, largely because of how it provides services to the population with mental retardation and developmental disabilities (McCall et al., 1993). For fiscal year 1993, Laguna Research Associates estimated that service costs for the elderly population were 18% less for ALTCS than they would be under a conventional Medicaid program (see Table 6). ALTCS' higher administrative costs offset a significant portion of these savings. Savings derive almost entirely from providing services to 16% fewer people than would be served in a traditional Medicaid program. Indeed, unlike many other Medicaid programs, the program appears to successfully limit services to persons at

high risk of institutionalization (Weissert, 1992). However, per-member per-month costs, which are an indicator of the ability to provide services more efficiently, were only about 2% lower.

Expand Home- and Community-Based Services. — The most persistent dream in long-term care is that the expansion of home care and other nonmedicalized residential long-term care services could reduce overall long-term care expenditures. The fundamental hope has been that lower-cost home care could replace more expensive nursing home care. However, there is substantial, rigorous research to suggest that expanding home care is more likely to increase rather than decrease total long-term care costs (Kane & Kane, 1987; Kemper, Applebaum, & Harrigan, 1987; Weissert, Cready, & Pawelak, 1988; Wiener & Hanley, 1992).

Older people's aversion to nursing homes explains this increase. Given a choice between nursing home care and no formal services, many elderly people will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset relatively small reductions in nursing home use.

To some extent, ending the entitlement to home care and nursing home care as envisioned under the MediGrant plan could solve this cost problem by allowing states to predetermine how much money they will spend for institutional and for noninstitutional services. In this way, a substitution of home care for nursing home care could be forced, which is a strategy being used by some European countries (Wiener, 1996). Within the United States, some states such as Wisconsin and Washington have a conscious policy of limiting growth in nursing home supply while increasing home care services (Fralich et al., 1995; U.S. General Accounting Office, 1994).

A problem with this strategy is that noninstitutional services may not be cost effective for this population. Home care for nursing home-level persons without extensive family supports is expensive. In an analysis of Connecticut's Medicaid home- and community-based waiver program, Liu et al. found that a substantial number of persons who met the eligibility criteria of being at high risk of institutionalization were prevented from receiving home services because their care plan was too expensive (Liu, Han-

son, & Coughlin, 1995). These persons tended to be substantially more disabled and to have far fewer informal supports — strong indicators of being at high risk of institutionalization — than persons who were allowed to participate in the program.

Recognizing that there are certain economies of scale in residential settings that are lacking in traditional home care where services must be provided to one person at a time, Oregon has developed nonmedicalized residential alternatives to nursing homes (Kane, Kane, Illston, Nyman, & Finch, 1991). By aggressively expanding assisted living and adult foster care, the state hopes to promote residential settings that are more homelike, provide greater personal autonomy, and cost less. In particular, the state has concentrated on older persons with Alzheimer's disease, who need a lot of supervision but not a great deal of medical care.

Although highly innovative, this approach has been very controversial. For example, the nursing home industry has charged that these alternative residential settings are just substandard nursing homes, and there have been some recent reports of quality of care problems (author's personal communication with Steven Lutzky, December 28, 1995). Moreover, for a portion of the population, Stark et al. found that going to an adult foster home in Oregon was associated with less improvement and more decline in physical functioning than going to a nursing home (Stark, Kane, Kane, & Finch, 1995). Furthermore, there has been no rigorous evaluation of whether money has been saved with this strategy, or how much.

As a first approximation of the potential of expanding home- and community-based services to control expenditures, Table 7 presents the percent increase in Medicaid long-term care expenditures for the elderly from 1988 to 1993 for the United States as a whole and for Oregon, Washington, and Wisconsin — states that have been active in reorganizing the long-term care delivery system. Over that time period, both Oregon and Washington had rates of increase in Medicaid long-term care expenditures that were substantially greater than for the United States as a whole (U.S. General Accounting Office, 1994). Wisconsin had a much lower rate of increase,

Table 6. Comparison of Arizona Long-Term Care System (ALTCS) and "Traditional" Medicaid Program Service Costs, FY 1993

	Traditional	ALTCS	Percent Difference
User Ratio	100.0%	84%	-16.0
Number of Months	124,667	104,460	-16.0
Per Member Per Month			
Cost	\$2,059	\$2,015	-2.0
Total Cost	\$256.7 million	\$210.5 million	-18.0

Source: Laguna Research Associates, Inc., personal communication, November 15, 1995.

Table 7. Percent Increase in Medicaid Long-Term Care Expenditures, 1988 to 1993

Location	Total Percent Increase from 1988 to 1993
United States	87%
Oregon	164
Washington	128
Wisconsin	54

Source: Urban Institute analysis of HCFA 2082 and HCFA 64 data.

Note: Long-term care expenditures include spending for skilled nursing facilities, intermediate care facilities, other nursing facilities, home health, personal care, and home- and community-based waivers. It does not include spending for mental hospitals and intermediate care facilities for the mentally retarded.

but much of its home- and community-based services are financed outside of the Medicaid program.

Strategies to Control Spending: Traditional Cuts in Eligibility, Reimbursement, Services, and Quality

If states do not succeed in substantially reducing the rate of increase in long-term care expenditures through increasing private resources or through delivery system reform, there are still a large number of more conventional mechanisms that can be used. These include cuts in eligibility, reimbursement, covered services, and quality standards. States already have considerable flexibility in these areas, and all of the major Medicaid reform proposals increase their freedom of action further. Because of the vast range of options that states have, this paper can touch on only a few of the possible initiatives.

Tighten Financial Eligibility Standards by Requiring Family Contributions. — Current financial eligibility standards for Medicaid are quite strict, especially for institutional long-term care. In particular, single individuals, who make up the vast majority of nursing home residents, may retain only \$2,000 in nonhousing assets and must contribute all of their income toward the cost of care except for a very small personal needs allowance (generally \$1.00 a day).

One possible mechanism to reduce expenditures would be to allow states to require adult children or other relatives to contribute to the cost of Medicaid nursing home care for their parents. Commonly referred to as "family responsibility" requirements, this practice has been explicitly prohibited in the Medicaid program since 1965 (Section 1902(a)(17)(D) of the Social Security Act). The MediGrant proposal passed by Congress would allow states to impose these requirements on adult children who have more than the state's median income.

Advocates of family responsibility programs see them as a way to promote equity, reduce costs, and encourage family care (Burwell, 1986). Some policymakers argue that it is inequitable to tax lower- or moderate-income people to pay for care of the parent of an affluent adult child, as sometimes happens in the current system. A family responsibility program could also encourage informal caregiving by delaying the point at which families seek institutional placement for their elderly kin. Advocates also contend that family members who know that they would be held financially responsible for part of the cost of institutional care of their parents might be more inclined to seek noninstitutional alternatives or to purchase private long-term care insurance for them. Also, elderly nursing home candidates themselves might be more resistant to placement that could lead to a financial burden for their children.

Opponents of family responsibility initiatives take issue with the implicit assumption that family members of many disabled elderly do not do enough to help these relatives. Much research suggests that relatives make enormous commitments to provide informal home care to disabled elderly relatives (Liu &

Manton, 1986). Fully 84% of disabled elderly people who were admitted to nursing homes between 1982 and 1984 received assistance from relatives and friends (Hanley, Alexih, Wiener, & Kennell, 1990). Other studies suggest that caring for disabled elderly relatives imposes large emotional and physical strains on families (Knight, Lutzky, & Macofsky-Urban, 1993; Mui, 1992; Pearlin, Mullan, Semple, & Skaff, 1990; Semple, 1992; Skaff & Pearlin, 1992). As a result, opponents of family responsibility argue that adult children should not be "punished" because they have a parent who needs expensive nursing home care, and they question the wisdom of discouraging people who need institutional care from seeking it because they do not want to burden their kin.

Because family financial responsibility is prohibited by current law, there is little direct evidence on this issue. However, the available research suggests that this approach would generate little savings, and could have adverse effects on the disabled elderly. In 1983, the Health Care Financing Administration (HCFA) estimated net savings of only \$25 million per year for a national family responsibility initiative, (U.S. Select Committee on Aging, 1983) noting that 75% of the reductions in Medicaid expenditures would be offset by increased administrative costs (Knight et al., 1993; Mui, 1992; Pearlin et al., 1990; Semple, 1992; Skaff & Pearlin, 1992). These costs entail identification of responsible relatives, evaluation of their incomes, distribution of assessments to relatives, and enforcement of collections. Furthermore, compliance with a state's assessment cannot be assumed, especially if the relative lives in another state. Conceivably, states could lower their administrative costs by shifting the burden of collecting the funds to the nursing homes. However, if facilities were unsuccessful in obtaining the funds, then the Medicaid reimbursement level might be inadequate to provide reasonable quality care.

In the early 1980s, Idaho took advantage of a Reagan Administration reinterpretation of the law that allowed family responsibility requirements when contributions are enforced under a general law not imposed solely on Medicaid beneficiaries. The Idaho family responsibility initiative had a goal of \$1.5 million in annual collections, but succeeded in collecting less than \$32,000 in its six months of operation (Burwell, 1986).

Beyond direct expenditure reductions by increased contributions toward the cost of care, savings could also be achieved from the deterrent effect that these family contributions would likely have on persons seeking nursing home admission. However, the size of the deterrent effect is unclear. During the 1960s, family responsibility requirements under the Old Age Assistance program (the forerunner of the Supplemental Security Income program) resulted in many elderly parents choosing not to apply for assistance rather than force their children to contribute (Schorr, 1980). Some who did seek public assistance chose to survive on less income rather than sue their own children for failure to contribute to their support.

Repeal of family responsibility requirements in the

Old Age Assistance program in Washington and Texas was followed by large increases in the case-loads (Schorr, 1980). Likewise, Idaho's short-lived family responsibility program reported that applications for Medicaid nursing home care dropped 8% after enactment of the law and rose 8% after program termination (Burwell, 1916). On the other hand, few studies have found financial cost to be an important determinant of nursing home placement (Arling & McAuley, 1983; Smallegan, 1985).

Cut Reimbursement Rates. — Under current law, states may set Medicaid payment rates at whatever level they choose for home- and community-based services, but they must meet a minimum standard for nursing home and hospital reimbursement. This standard is prescribed by the "Boren Amendment," which requires that providers be reimbursed under rates that the state "finds and makes assurances satisfactory to the Secretary are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards" (Section 1902(a)(13) of the Social Security Act). Although this law was designed to relax previous standards, many states have had difficulty meeting the new standard; as of 1993, at least 43 nursing home reimbursement lawsuits were filed for violation of the Boren Amendment's substantive or procedural standards (Harrington, Weinberg, Stawder, & DuNah, 1993). Repeal of the Boren Amendment has long been sought by state governors, who contend that it unnecessarily limits their flexibility in setting reimbursement rates. The MediGrant legislation and President Clinton's and the National Governors' Association proposals would all give states complete flexibility in setting payment rates.

Even with the Boren Amendment, some states currently pay in excess of the required level and could cut payment levels further. Without the constraint of the Boren Amendment, however, states would have much greater freedom to reduce their payment rates to fit the level of funds available.

The problem with this strategy is that reimbursement rates are already fairly low, especially in comparison with Medicare and private pay rates. In 1993, average Medicaid nursing home payment rates were \$82 per day, while average Medicare payment rates were \$170 per day (American Health Care Association, 1995). These figures should be viewed with some caution since not all Medicaid providers participate in Medicare and vice versa. Thus, these two figures are not the average of exactly the same families. Moreover, there are case-mix differences between Medicare and Medicaid nursing home residents that account for some of the rate disparity (Dor, 1989).

Although there is great variation across facilities and states, private pay charges generally tend to be substantially higher than Medicaid rates. Not surprisingly, then, nursing homes prefer private pay to

Medicaid patients (Harrington & Swan, 1987; Nyman, 1988a, 1988b; Nyman, Levey, & Rohrer, 1987; Scanlon, 1980). As a result, Medicaid beneficiaries often have difficulty gaining access to nursing homes. To the extent that states cut reimbursement rates and the payment differential between private pay and Medicaid patients widens, access problems may worsen.

In addition, while there is little evidence of a simple relationship between cost and quality, there is probably some threshold level of reimbursement below which it is impossible to provide adequate level quality of care. Repeal of the Boren Amendment would eliminate the safeguard that Medicaid payment levels do not go below that threshold. Thus, if nursing home reimbursement rates are cut substantially, then quality of care in nursing homes might decline because of inadequate financial resources.

Reduce Nursing Home Quality Standards and Enforcement. — Largely in response to concerns about inadequate care in nursing homes, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) dramatically revised and strengthened the Medicaid and Medicare quality standards and the survey and certification process. Facilities that do not meet the standards are not eligible for Medicaid and Medicare reimbursement.

Many states chafe under these quite specific requirements and would like to see them changed. The House of Representatives-passed version of the MediGrant program would have eliminated most of these standards. While the final MediGrant legislation retains the current OBRA 1987 standards, it also gives states much more flexibility in the implementation of the survey and certification process, with federal enforcement of the standards being almost entirely eliminated. In contrast, the Clinton proposal would make only small changes in the survey and certification process; the National Governors' Association proposal is silent on this issue.

Advocates for greater state flexibility in quality enforcement argue that the existing system is unduly bureaucratic and inflexible. Moreover, they contend that state government is, if anything, more concerned about assuring adequate quality of care in nursing homes than the Federal Government because it is their citizens who are in the nursing homes. From a financial perspective, different quality standards might make reimbursement cuts more feasible.

Consumer advocates strongly oppose the proposed changes in the MediGrant proposal. They note that prior to OBRA 1987, quality standards and their enforcement were weak in many states (Institute of Medicine, 1986; Wiener, 1981). Moreover, they argue that it is the threat of the loss of federal funds that motivates states to make the quality improvements. In addition, if accompanied by repeal of the Boren Amendment, they worry that state reimbursement rates will be inadequate to provide quality care. Thus, there will be a strong incentive for

state survivors to "look the other way" because they know that it is unfair to require facilities to meet certain staffing and other standards if the state will not pay enough to satisfy those standards.

While not perfect, there is substantial evidence that the quality standards imposed by OBRA 1987 actually improved quality of care and may have saved money. An evaluation led by Research Triangle Institute, Inc., found that the OBRA 1987 standards reduced the use of physical and chemical restraints, lowered hospitalizations, reduced use of indwelling catheters, and decreased the number of dehydrated patients (Hawes, 1995). The standards also increased the percentage of residents who participated in activities and the proportion of residents who used hearing aids if they needed them.

Stop Construction of New Nursing Home Beds. — Another strategy for controlling Medicaid costs would be to prohibit construction of new nursing home beds on the assumption that they would likely be filled largely with Medicaid-eligible residents. Thus, by controlling the supply of institutional services, expenditure growth would be curbed. As of 1994, 15 states had a moratorium on new construction of nursing homes (Bedney et al., 1995).

There are at least three problems with this strategy. First, the care needs of the disabled elderly do not disappear just because there are no nursing home beds available. Alternative home- and community-based services may not serve the people who need nursing home care, and any additional expenditures for these services would reduce the savings from freezing the bed supply. Moreover, home- and community-based services may be at risk if overall Medicaid expenditures are highly constrained.

Second, although the situation varies across states, the number of nursing home beds per 1,000 elderly aged 85 and over fell by 18% between 1978 and 1994 (Bedney et al., 1995). In addition, while hospital occupancy rates have dropped over the last 15 years, nursing home occupancy rates have remained extremely high, averaging 90% in 1994 (Bedney et al., 1995). Thus, relative to need, the bed supply already has substantially tightened in recent years. It is uncertain how much further it can decline without causing substantial backlogs of nursing home-ready patients in hospitals or increasing unmet needs in the community.

Third, the strategy of freezing the bed supply does not address the underlying demographic reality that the United States is an aging society. Because of demographic changes, projections using the Brookings-ICF Long-Term Care Financing Model suggest that demand for nursing home care will grow by about 1.9% per year from 1993 to 2008 (Wiener et al., 1994b).

Reduce Coverage for Home- and Community-Based Services. — Over the last 15 years, states have moved to create a more balanced long-term care delivery system by expanding home- and community-based care. In 1993, approximately 15% of Med-

icaid long-term care expenditures for the elderly were for home- and community-based care (Wiener et al., 1994b). However, most of these expenditures were for the optional personal care and home- and community-based waiver services, rather than for mandatory home health care.

If faced with strict budget constraints, states may choose to reduce coverage for home- and community-based services, especially if they are not cost-effective substitutes for nursing home care. In the political process, home care agencies tend to be politically weak at the state level compared to other provider groups, such as hospitals, nursing homes, and physicians (Vladeck, 1980; Wiener, 1981). Thus, in a free-for-all battle for resources at the state level, home- and community-based care may not do particularly well. Moreover, given limited funds, states may decide to allocate resources first to persons with the most severe disabilities without family supports. If they make that allocation decision, then funds will be primarily spent on nursing home care and only secondarily on home care, because the average nursing home resident is far more disabled and has fewer informal supports than the average home care user. In 1994, the average nursing facility resident had 3.95 dependencies in the activities of daily living (American Health Care Association, 1995). In 1989, the average home care user had 2.11 dependencies in the activities of daily living (Liu & Manton, 1994).

Obviously, if states choose to cut back on home care, then the long-term care delivery system will be even more oriented toward institutional care than it is now.

Conclusions

Given the substantial flexibility that states already have in terms of coverage, reimbursement, and eligibility, there is little doubt that they could substantially lower long-term care spending if they were determined to do so, even under current law. However, this study questions whether the rate of increase in Medicaid long-term care spending for the elderly can be substantially reduced without adversely affecting beneficiaries. Furthermore, while there are promising developments in the integration of acute and long-term care services and in creative home- and community-based programs, this review of the literature raises serious questions as to whether obtaining additional private resources or delivery system reform could substantially reduce the rate of increase in long-term care spending, at least over the period from 1996 to 2002. Unfortunately, the research literature does not offer any "silver bullets" that will allow states to easily and painlessly obtain large savings. Whereas it is conceivable that major changes in the Medicaid program could dramatically alter the dynamics under which providers operate so as to generate significant savings, the burden of proof rests on the shoulders of advocates of greater state flexibility and reduced funding to demonstrate that the current research findings are not applicable.

To reduce the rate of growth in expenditures sharply, states will likely turn to more traditional methods of cost control — reducing eligibility, cutting reimbursement, and limiting covered services. These cuts may negatively affect beneficiaries and providers, both in terms of access to services and quality of care. These overall conclusions are consistent with the Urban Institute evaluation of the potential impact of proposals to cap the rate of growth in Medicaid expenditures at far below historical experience (Holahan et al., 1995).

The hard reality is that the current method of Medicaid long-term care financing is actually a pretty economical system. Payment rates are much lower than Medicare and the private sector. Individuals receive government help only after depleting almost all of their assets, and they must contribute virtually all of their income toward the cost of care. Medicaid pays only the costs that the elderly themselves cannot. Finally, the institutional bias of the delivery system limits services largely to persons with the most severe disabilities who do not have family supports. Within this system, it is difficult to obtain large additional savings.

References

- American Health Care Association. (1995). *Facts and trends: The nursing facility sourcebook, 1995*. Washington, DC: author.
- Ansak, M.-L. (1990). The On-Lok model: Consolidating care and financing. *Generations*, 14(2), 73-74.
- Arling, G., & McAuley, W. J. (1983). The feasibility of public payments for family caregivers. *The Gerontologist*, 23, 300-305.
- Bates, A. (1992, February 3). Golden girls. *New Republic*, 206, 17-18.
- Bednev, B., Carrillo, H., de Wit, S. K., Curtis, M., Swan, J., & Harrington, C. (1995). *State data book on long-term care program and market characteristics*. San Francisco, CA: University of California, San Francisco, Department of Social and Behavioral Sciences.
- Brown, R., Bergeron, J., Clement, D., Hill, J., & Retchin, K. S. (1993). *The Medicare Risk Program for HMOs — Final Summary Report on Findings from the Evaluation*. Princeton, NJ: Mathematica Policy Research.
- Burwell, B. (1986). *Shared obligations: Public policy influences on family care for the elderly* (Medicaid Program Evaluation Working Paper 2.1). Baltimore, MD: Health Care Financing Administration, Office of Research and Demonstrations.
- Burwell, B. (1996). *Medicaid long-term care expenditures in Fiscal Year 1995*. Cambridge, MA: The MEDSTAT Group.
- Burwell, B., & Crown, W. H. (1995). Medicaid estate planning: Case studies of four states. In J. M. Wiener, S. B. Clauser, & D. L. Kennell (Eds.), *Persons with disabilities: Issues in health care financing and service delivery* (pp. 61-94). Washington, DC: The Brookings Institution.
- Cantwell, J. R. (1995). *Solutions to the Medicaid funding problem*. Dallas, TX: National Center for Policy Analysis.
- Coronel, S., & Fulton, D. (1995). *Long-term care insurance in 1993*. Washington, DC: Health Insurance Association of America.
- Crown, W. H., Capitan, J., & Leutz, W. N. (1992). Economic rationality, the affordability of private long-term care insurance, and the role for public policy. *The Gerontologist*, 32, 478-485.
- Dor, A. (1989). The costs of Medicare patients in nursing homes in the United States. *Journal of Health Economics*, 8, 253-270.
- Edgar, J. (1995, June 8). *Testimony. Statement before the Health and Environment Subcommittee of the Commerce Committee*. Washington, DC: U.S. House of Representatives.
- Employee Benefit Research Institute. (1993). *Public attitudes on long-term care, 1993: Summary report*. Washington, DC: author.
- Engler, I. (1995, June 8). *Testimony. Statement before the Health and Environment Subcommittee of the Commerce Committee*. Washington, DC: U.S. House of Representatives.
- Evashwick, C. (1987). Definitions of the continuum of care. In C. Evashwick and L. Weiss (Eds.), *Managing the Continuum of Care*. Gaithersburg, MD: Aspen Publishers.
- Finch, M., Kane, R. A., Kane, R. L., Christianson, J., Dowd, B., Harrington, C., & Newcomer, R. (1992). *Design of the second generation S-HMO demonstration*. Minneapolis, MN: Institute for Health Services Research.
- Fralich, J., Riley, T., Mollica, R., Snow, K. I., Carr, D. J., and McDonough, S. (1995). *Reducing the cost of institutional care: Downsizing, diversion, closing and conversion of nursing homes*. Minneapolis, MN: The University of Minnesota Long-Term Care Resource Center and the National Academy of State Health Policy.
- Friedland, R. B. (1990). *Facing the costs of long-term care*. Washington, DC: Employee Benefit Research Institute.
- Gray, J. (1992, August 4). Governors seek to shed burdens of Medicaid. *The New York Times*, p. A8.
- Hanley, R. J., Alech, L. M. B., Wiener, J. M., & Kennell, D. L. (1990). Predicting elderly nursing home admissions: results from the 1982-1984 National Long-Term Care Survey. *Research on Aging*, 12, 199-228.
- Harrington, C., & Newcomer, R. (1991). Social health maintenance organizations' service use and costs, 1985-1989. *Health Care Financing Review*, 12, 37-52.
- Harrington, C., & Swan, J. H. (1987). The impact of state Medicaid nursing home policies on utilization and expenditures. *Inquiry*, 24, 157-171.
- Harrington, C., Weinberg, J., Stawder, K., & DuNah, Jr., R. (1993). *Nursing home litigation under the Boren amendment: Case studies*. San Francisco, CA: University of California, San Francisco, Institute for Health and Aging.
- Hawes, C. (1995, October). *Statement. Presented at a U.S. Senate Forum, The Impact of Proposals to Alter Medicaid on Long-Term Care*. Washington, DC: U.S. Senate.
- Holahan, J., Coughlin, T., Liu, K., Ku, L., Kuntz, C., Wade, M., & Wall, S. (1995). *Cutting Medicaid spending in response to budget caps*. Washington, DC: Kaiser Commission on the Future of Medicaid.
- Holahan, J., & Liska, D. (1995a). *The impact of the "MediGrant" plan on federal payments to states*. Washington, DC: Kaiser Commission on the Future of Medicaid.
- Holahan, J., & Liska, D. (1995b). *The impact of the House and Senate Budget Committees' proposals on Medicaid expenditures*. Washington, DC: Kaiser Commission on the Future of Medicaid.
- Institute of Medicine. (1986). *Improving the Quality of Care in Nursing Homes*. Washington, DC: National Academy of Sciences Press.
- Irvin, K., Riley, T., Booth, M., & Fuller, E. (1993). *Managed care for the elderly. Profile of current initiatives*. Portland, ME: National Academy for State Health Policy.
- Kaiser Commission on the Future of Medicaid. (1995). *Medicaid and the elderly*. Washington, DC: author.
- Kane, R. L., Illston, L. H., & Miller, N. (1992). Qualitative Analysis of the Program of All-Inclusive Care for the Elderly (PACE). *The Gerontologist*, 32, 771-780.
- Kane, R. A., & Kane, R. L. (1987). *Long-Term Care: Principles, Program, and Policies*. New York: Springer.
- Kane, R. A., Kane, R. L., Illston, L. H., Nyman, J. A., & Finch, M. D. (1991). Adult foster care for the elderly in Oregon: A mainstream alternative to nursing homes? *American Journal of Public Health*, 81, 1113-1120.
- Kemper, P., Applebaum, R., & Harrigan, M. (1987). Community care demonstrations: What have we learned? *Health Care Financing Review*, 8(4), 87-100.
- Knight, B. G., Lutzky, S. M., & Macofsky-Urban, F. (1993). A meta-analytic review of interventions for caregiver distress: Recommendations for further research. *The Gerontologist*, 33, 240-248.
- Kosterlitz, J. (1991). Middle class Medicaid. *National Journal*, 23, 2728-2732.
- Leutz, W., Greenberg, J., & Abrahams, R. (1985). *Changing Health Care for an Aging Society: Planning for the Social Health Maintenance Organizations*. Lexington, MA: Lexington/Health.
- Leutz, W., Greenlick, M., & Capitan, J. (1994). Integrating acute and long-term care. *Health Affairs*, 13(4), 59-74.
- Liska, D., Obermaier, K., Lyons, B., & Long, P. (1995). *Medicaid expenditures and beneficiaries: national and state profiles and trends, 1984-1993*. Washington, DC: Kaiser Commission on the Future of Medicaid.
- Liu, K., Hanson, J., & Coughlin, T. (1995). Characteristics and outcomes of persons screened into Connecticut's 2176 program. In J. M. Wiener, S. B. Clauser, & D. L. Kennell (Eds.), *Persons with Disabilities: Issues in Health Care Financing and Delivery* (pp. 215-244). Washington, DC: The Brookings Institution.
- Liu, K., & Manton, K. G. (1986, June). *Disability and long-term care*. Paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Workshop, sponsored by the National Institute on Aging, The American Council of Life Insurance, and the Health Insurance Association of America, Bethesda, MD.
- Liu, K., & Manton, K. G. (1994). *Changes in home care use by disabled elderly persons: 1982-1989*. Washington, DC: Congressional Research Service.
- McCall, N., Korb, J., & Bauer, E. (1994). *Evaluation of Arizona's health care cost containment system demonstration — Third outcome report*. San Francisco, CA: Laguna Research Associates.
- McCall, N., Korb, J., Babalan, D., Wrightson, C., Wilkin, J., Wade, A., & Watkins, M. (1993). *Evaluation of Arizona's health care cost containment system demonstration — Second outcome report*. San Francisco, CA: Laguna Research Associates.
- Moses, S. A. (1990). The fallacy of impoverishment. *The Gerontologist*, 30, 21-25.
- Moses, S. A. (1994). *The Florida fulcrum: A cost savings strategy to pay for long-term care*. Seattle, WA: LTC.
- Moses, S. A. (1995a). *The long-term care financing crisis: Danger or opportunity: a case study of Maryland*. Seattle, WA: LTC.

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National Conference of State Legislatures

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The Task Force Report: Long-Term Care Reform in the States

Solutions

July 1997

referred

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Solutions

Analysis of Recommendations

Between 1994 and mid-1997, 13 of the 19 task forces identified--California Colorado, Florida, Idaho, Maryland, Minnesota, Nebraska, New Mexico, New York, North Carolina, North Dakota, South Dakota and Texas--published their recommendations and distributed them to state legislatures, governors' offices and health departments or commissions. Most recommendations incorporated comprehensive LTC reforms. Twelve of the 13 (the exception being South Dakota) made more than one recommendation because they felt that multiple, cohesive strategies were needed to improve the current LTC systems. At the same time, they recognized that the systems can not be reformed with a quick fix.

For the most part, the task forces began their work with concrete goals or principles. From there, they developed specific recommendations to achieve these principles. In most cases, the task forces discussed the ideal LTC system and the recommendations they could offer to achieve a more rational continuum of care. This chapter describes their principles and recommendations.

Principle I: Reducing Fragmentation

The LTC system should be seamless, with coordinated funding streams and administrative structure.

Recommendation 1: Consolidate multiple state agencies that administer LTC services. (California, Idaho, New Mexico and Texas)

In the vast majority of states, a variety of state agencies coordinate LTC services, resulting in duplicative services and confusion. Thus, four of the task forces recommended consolidating the organizational structures that administer LTC services in their respective states.

California and Texas called for creation of a single agency to administer LTC to all populations to

centralize state policy, reduce duplication among several agencies and streamline administration.

- New Mexico wanted to consolidate a number of HCBS programs into a Division of Home and Community Services within the Department of Health.

- Idaho took a less direct approach, recommending that the state simply look into "the feasibility of consolidating elderly services now being provided by the Department of Health and Welfare, the Commission on Aging and other private or public sources."

Recommendation 2: Provide a "one-stop shopping" model, through which clients could more easily obtain information, rather than having to maneuver through a maze of state offices. (California, Nebraska, New Mexico and Texas)

Task forces in California, Nebraska, New Mexico and Texas agreed that the key goal of their proposed systems would be to coordinate services to facilitate easy access from one service to another. Under the "one-stop shopping" model, clients would be able to obtain services and learn about various options through one agency within the region. As stated by the LTC Services Coordination Work Group in Nebraska, internal procedures at all levels should encourage a "no wrong door" model in which people who come to the wrong place for information or assistance are directed to the right place.

To implement the "no wrong door" approach, there must be at least one accessible site in each locality where consumers can gain access to the entire range of LTC services, according to the Texas Health and Human Services Commission. In addition, more communities should control needs assessments, priority setting, service planning, budgeting, contracting and monitoring.

Recommendation 3: Base eligibility on clients' needs rather than on their diagnoses. (Florida, Minnesota, New Mexico and Texas)

Task forces in four states agreed that service coordination must be based on clients' needs, not on their diagnoses. Currently, people with similar LTC service needs often are eligible for different levels of care because of differing ages, disabilities, geographic locations and financial resources. Conversely, two clients with the same diagnosis could very well need different services, particularly if one has strong caregiver support and the other does not. Thus, the task forces recommended developing a uniform system for basing eligibility on functional rather than on categorical program standards.

Recommendation 4: Integrate acute and LTC delivery systems. (Florida, Minnesota and North Carolina)

Although most of the task forces argued that the LTC delivery systems in their respective states are in need of reorganization, the Florida, Minnesota and North Carolina panels also said that the fundamental problem is the disparity between funding sources. As a result, they issued recommendations aimed at integrating acute and LTC systems.

Although the elderly and disabled are high users of both acute and LTC, the two systems are separate: one is a medical model, the other a social model. As explained by the Acute/Long-Term Care Integration Liaison Work Group in Minnesota, the two types of care have distinct caregivers, sites, styles of care and financing arrangements--factors that often lead to fragmentation of care.

Older and disabled people typically receive acute care from physicians in either hospitals and clinics and pay for it with Medicare. In contrast, they generally receive LTC services from nurses in nursing homes or families in home-like settings and pay for it either with their own money or Medicaid.

Table 9			
Differences between Acute and Long-Term Care for the Aged and Disabled			
Type of Care	Primary Caregivers	Care Settings	Primary Payers
Acute	Physicians	Hospitals and Clinics	Medicare
Long-Term Care	Nursing Staff and Families	Nursing Homes and HCBS Settings	Medicaid and Out-of-Pocket

Attempts to integrate the two systems of care have mainly involved demonstration projects that experiment with capitation. Under the demonstration projects, acute and LTC services are purchased as a package for individuals who are "dually eligible" for Medicare and Medicaid. Although managed care is the primary strategy, the integration of acute and LTC is a broader concept that can include other approaches such as uniform assessments and benefit packages, as well as promotion of personal responsibility through the purchase of LTC insurance (discussed later in this paper).

Recommendation 5: Create demonstration projects to experiment with managed LTC. (Colorado, Florida, Maryland, Minnesota, New Mexico, New York, North Carolina, North Dakota and Texas)

During the 1990s, states have moved rapidly to enroll Medicaid beneficiaries who are relatively young and healthy--mainly mothers and young children on welfare--into managed care organizations (MCOs). As a result of the mandates, they have realized large savings. Despite the success of managed care, however, state legislatures in general are questioning whether older people and those with disabilities should also receive their care in MCOs. For the most part, task forces took a "go slow" approach toward moving older and disabled people into managed care.

To remove the complex and emotionally charged debate from the political arena, most of the task forces were asked to examine different LTC alternatives, including managed care. The majority of them (10 of 13) thus studied the possibility of moving more older and disabled Medicaid beneficiaries into managed LTC. However, most chose to proceed cautiously because of states' lack of experience and plans to meet the needs of special populations and because of concerns that quality care could suffer and cost savings might never materialize.

Lack of state experience. Most states lack experience in providing care to older people and those with disabilities in MCOs. According to the Alliance for Health Reform, only seven states--Arizona California, Florida, Massachusetts, Minnesota, Ohio and Wisconsin--have some form of managed care demonstration project for one or both populations. Of those, Arizona's is the only program that has operated statewide and has been in existence for many years.

Quality and cost concerns. Recent research has raised concerns about the cost-effectiveness and health outcomes of older and disabled populations in managed care. An article in the October 2, 1996, *Journal of the American Medical Association* reported that older and poor chronically ill patients "were more than twice as likely to decline in health in an HMO than in a [fee-for-service] plan." The findings "sound a cautionary note to policy makers who expect overall experience to date with HMOs to generalize to specific subgroups, such as Medicare beneficiaries or the poor."

In addition, research from the Urban Institute has questioned whether managed care systems really are capable of saving money. The institute studied some of the best known demonstration projects--the Social

Health Maintenance Organizations (Social HMOs), the On Lok/Program of All-Inclusive Care of the Elderly (PACE) and the Arizona LTC System ALTCS)--and concluded that "it is not clear that integrating acute and LTC services generates additional savings." It does note, however, that the ALTCS program saves money, but primarily because it serves significantly fewer people than conventional Medicaid programs.

Compounding the uncertainty about the value of managed care have been politically active senior citizen and disability groups, as well as nursing home providers, who have been vocal in expressing their concerns to state legislatures about the effect of managed care on LTC populations. Advocacy groups and nursing home providers are concerned about the changes being debated in many states, reflecting clients' concerns that a capitated system will result in rationed health care.

Most task forces left the details to health departments, recognizing their integral role in designing and developing managed LTC. Maryland's advisory committee, for example, was created specifically to advise the secretary of the Department of Health and Mental Hygiene on the development of a managed care proposal for the Medicaid LTC population. Others also specified the populations and services that health departments should explore for incorporation into a managed care system.

Populations. Once a state has decided to proceed with managed care, two major questions to be answered are who should be covered, and whether participation in the demonstration project should be mandatory. Florida's commission, for instance, recommended that pilot projects should be disability-specific with mandatory participation. Maryland's advisory committee, on the other hand, proposed separate demonstration projects, one that incorporates non-institutionalized, dual eligibles; another that tests the effectiveness of Integrated Care Systems by providing care to Medicaid-only and dual eligibles; and a third for the developmentally disabled. Minnesota's work group mentioned disabled children and also recommended expanding the state's voluntary dual eligible waiver program to other populations.

Several task forces recommended slowly making managed LTC options available for low-income older and disabled people who receive Medicaid and Medicare benefits. Of the 6 million people across the United States who are "dual eligible," only 3 percent are enrolled in a Medicare MCO. It appears that task forces concentrated primarily on that group because of the complexity of risk-contracting with both Medicare and Medicaid and because of the large amount of resources used by dual eligibles. According to the Alliance for Health Reform, more than 10 percent of the nation's health spending goes toward their care, even though they make up just over 2 percent of the population.

Services and level of capitation. The next questions to be answered are which services to cover under capitation, and whether institutional, mental health, a full array of HCBS or some combination thereof should be capitated. While most task forces did not address these issues, a few did to some extent. Maryland's advisory committee, for example, recommended providing mental health services through MCOs to dual eligibles, with the exception of certain specified populations. Minnesota's work group encouraged the health department to explore variations on the capitated, risk-based system such as setting partial capitation and an expansion of payment methodologies based on disability, not on care setting.

Although most task forces did not provide detailed plans, eight of the 10 task forces took a "go slow" approach. Florida and Nebraska were the only exceptions. Florida's commission wanted to create a managed LTC system over a five-year phase-in period. However, a Medicaid official from Florida acknowledged that the commission's timeline was "much too aggressive," given the lack of managed care models for older people and those with disabilities. Taking the opposite approach, Nebraska's work group was the only one to warn against the use of managed care. Instead, it recommended a fee-for-client option (discussed in the next recommendation).

The "go slow" approach, however, does not mean task forces were not excited about the prospects of

managed LTC. Many were enthusiastic about the potential of managed LTC to improve the access to and quality of care.

Recommendation 6: Monitor other states' demonstration projects.

Several task forces stressed that policy makers should monitor LTC demonstration projects in other states. In fact, many panels themselves studied the LTC systems in other states even before making their recommendations.

Cash and Counseling

As an example, the Nebraska Medicaid LTC System Development Work Team proposed creating a demonstration project modeled after the Cash and Counseling program instead of providing managed LTC for older and disabled populations. (However, our contact with the Nebraska HHS system acknowledged that further research will be required before a final decision to pursue can be made.)

Cash and Counseling--a four-year demonstration project cosponsored by The Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation--aims to give elderly and disabled Medicaid recipients a choice between being given money, along with counseling services upon request, to purchase their own personal assistance services or receiving services through traditional channels. The program will likely be operational in Arkansas, Florida, New Jersey and New York sometime during 1998.

By giving the funds--along with information and referral services--directly to the Medicaid recipients, the program hopes to keep older and disabled participants independent, cut down on administrative paperwork, provide appropriate services based on need rather than on program eligibility and reduce administrative costs associated with implementing services through the established system.

An evaluation of the project is to be completed by summer 2001, three years and three months from the time the first client enrolls. Among other things, the evaluation will measure the differences between this project and the traditional system in terms of costs, quality of care, consumer satisfaction, distribution of money, and the level of burnout in family and friend caregivers.

Principle II: Creating a Consumer-Centered System

The LTC system should encourage consumer information, choice, quality of care and safety.

Recommendation 1: Arrange for case management to provide consumer information, assessment and referral. (Florida, Minnesota, Nebraska, New Mexico, North Dakota and Texas)

Case managers are the crucial link to a coordinated LTC delivery system. Six task forces proposed enhanced case management. The task forces recognized that "one-stop shopping" cannot occur unless personnel have the skills and training to guide clients through the maze of options. Case managers also can be used as gatekeepers to manage services for clients to ensure that they receive quality care in the most cost-effective manner.

In North Dakota, an Ad Hoc Committee on Case Management specifically addressed this issue because, as in other states, case management is provided to only a limited number of clients through private and public agencies. Likewise, many of the people who could benefit from such services often are unaware of the

existing resources. As a result, the Legislative Assembly approved two pilot projects to test an expanded case management system, making case managers available to everyone in need of LTC services, regardless of funding source, age or service needs. Statewide implementation of the expanded case management system will be based on the findings of the pilot projects.

Recommendation 2: Use one assessment tool to measure medical and functional needs. (Florida, Idaho, Maryland, Nebraska, New Mexico, North Dakota and Texas)

Seven task forces proposed using a single uniform assessment tool to measure both medical and functional needs to ensure that people are screened for appropriate LTC services regardless of age, disability, geographic region or services needed.

The proposals often went hand-in-hand with the concept of providing better organized care through case managers and managed care. The panels envisioned a system in which case managers would assess people in need of LTC services with a uniform assessment tool to provide ongoing coordination of care. Likewise, several panels that advocated a managed LTC system saw uniform assessment as a necessary tool for reducing inappropriate, costly institutionalization.

Status of Uniform Assessment Tool. There is currently no objective, federal uniform assessment tool with which to measure a person's medical and functional needs to ensure appropriate LTC placement and services. Nursing homes now can prescreen applicants with the resident assessment instrument as part of the Minimum Data Set requirements, but use of this instrument is mandatory only for nursing homes. The Health Care Financing Administration (HCFA) currently is designing the Uniform Needs Assessment tool to measure functional capacity, nursing and other care requirements, as well as family and community resources. The instrument is being designed for use along a continuum of care and for use by discharge planners, HCBS providers and nursing home administrators. The instrument currently is being tested for reliability and validity. HCFA officials expect the testing to be complete in 18 months to two years.

- *Florida.* In the absence of such an instrument, the panel recommended that eligibility under a proposed new managed LTC program be "based upon the application of a newly designed screening tool" that weighs financial need; disability status and severity of functional impairment, regardless of cause; and availability of family, social and community supports.

- *Idaho.* The task force made a similar recommendation related only to the screening of Medicaid clients.

- *Maryland.* The committee proposed expanding preadmission screening to anyone at risk of requiring nursing facility or assisted levels of care.

- *Nebraska.* The LTC Assessment Work Team actually set out some parameters for information to be included in a common assessment tool. It proposed that the tool should address four service levels.

1. *High need level:* Includes the full array of available services such as nursing home care, HCBS waiver services and, at the client's option, any services in the lesser levels.

2. *Moderate need level:* Includes services provided in a group or assisted living arrangement and, at the client's option, any services in the lesser levels.

3. *Low need level:* Includes basic HCBS needed to allow the person to remain in an independent living situation, as well as referral services.

4. *No need*: Includes information and referral only because the applicant does not have an identified need for services through the LTC system but may qualify for other programs.

The team recommended that "no level have priority over another." In addition, it outlined the elements that should be considered in determining the four levels of care: activities of daily living (ADLs), instrumental activities of daily living (IADLs), as well as behavior, cognition, medical and health concerns, and safety or risk. ADLs refer to functions performed routinely each day (e.g., eating, bathing, dressing, continence, transferring to a bed or chair and walking). IADLs include going outside the home, keeping track of finances, cooking, doing light housework, using the phone and taking medicine.

The work group also created a scheme for "numerical scoring to weigh one category against another," but warned that "extensive testing and evaluation would be needed to validate the criteria before using any score to determine funding levels." It also advocated combining into the common assessment tool the preadmission screening process used to determine appropriate nursing home placement for those with mental illness or mental retardation.

Recommendation 3: Collect outcomes and patient satisfaction data to ensure that the needs of consumers are met. (California, Florida, Minnesota, Nebraska, New Mexico and Texas)

Task forces in six states specifically recommended that quality of care be measured to ensure that consumer-driven LTC delivery systems are working. The panels addressed quality assessment, but their proposals were made within the context of their newly proposed LTC systems. Minnesota and Nebraska serve as good examples.

- *Minnesota*. Within the context of integrating acute and LTC, the work group stressed the importance of collecting and analyzing data to determine the effects of an integrated system. It recommended that the state conduct empirical analysis on the effects of various financing strategies to analyze, for example, the interaction between private insurance and Medicaid and the tax treatment of LTC premiums and services. It also recommended making regulations more supportive of integrated care by developing projects that demonstrate quality assurance strategies that are more market-based and less prescriptive.

- *Nebraska*. Within the context of HCBS, the work team recommended screening in-home providers, inspecting adult family homes and monitoring quality assessment. To assess quality, it recommended that "three full-time equivalent staff be employed to develop and monitor quality activities in Medicaid LTC settings." However, the group noted that quality assessment tools should not be too long or used too frequently in a way that might burden the providers and clients.

Recommendation 4: Develop and disseminate user-friendly materials to inform consumers about their choices. (Maryland, Minnesota, Nebraska, New York, North Dakota and ~~Texas~~)

In general, task forces offered recommendations with the goal of giving older people and those with disabilities more choices about the types of care they receive. Stressing the importance of helping consumers make informed decisions within the new continuum of care, they recommended conducting public education campaigns to inform consumers about the financial risks of LTC as well as about available services and options. (This strategy will be discussed later in more detail.)

Another recommended strategy was to develop and disseminate user-friendly materials to inform consumers about their choices. Minnesota's work group, for instance, suggested that an integrated, consumer centered system in part is created by developing materials that are easy for consumers to read and use. Consumers should be able to compare services through marketing information, report cards and consumer guides. In addition, the work group recommended creating incentives for systems of integrated care to involve

consumers in planning for their care.

Recommendation 5: Ensure the safety of older and disabled populations. (California, Nebraska, New Mexico, North Dakota and Texas)

Because older and disabled populations can be vulnerable to abuse and mistreatment and often are incapable of caring for and defending themselves, regulation is imperative for nursing homes and other LTC providers that care for them. The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) set a precedent for improving the safety of nursing home residents by requiring prescreening of residents using the resident assessment profile, a written plan of care with as much consumer involvement as possible, a ban on chemical and physical restraints without informed consent, a patient's right to privacy, a licensed nurse on staff around the clock and 75 hours of training for nursing home aides.

Although OBRA '87 has led to improvements within the nursing home industry, problems persist. Certified nursing assistants (CNAs), who often spend the most time with people receiving LTC services, are grossly underpaid and have insufficient career opportunities, leading to high turnover rates and a lack of quality care. Both licensed and unlicensed personnel in the LTC system often have received no formal training--in geriatrics, for example--to provide adequate care to the vulnerable populations they serve. Finally, state offices, many of which run on shoestring budgets, have been accused of being unresponsive to consumer complaints. In light of those problems, five task forces made the following recommendations.

Education and training. New Mexico's committee said that health professionals and other service providers should receive training "to address special considerations of the diverse and multi-faceted LTC population." The Little Hoover Commission in California proposed "adding more gerontology and human relations issues to CNA training." To lower turnover rates, the commission also recommended creating "a career ladder for CNAs" by allowing education and work experience to lead to licensed nursing status. Based on its task force's recommendations, the 1997 North Dakota Legislature passed a study resolution directing the Legislative Council to study options for training additional service providers. The Texas task force recommended that licensed health professionals also undergo training to care for specific target groups such as the mentally ill and physically disabled.

Adequate staffing. The Texas task force recommended developing and maintaining "a registry for appropriately trained and/or qualified attendants." The Little Hoover Commission suggested that the state move to a nursing home system with adequate staffing levels, instead of requiring a specific number of hours from licensed nurses.

Responsive complaint system. By recognizing that inspections and quality assessment activities will not capture all the problems, the Nebraska work group suggested maintaining an 800 telephone line to serve as a complaint or response system in addition to regular contact with service coordinators, the regulation and licensure agency or the LTC ombudsman (a nursing home advocate program located in each state). The Little Hoover Commission recommended increasing funding and expanding "the state role in standardizing adult protective services throughout the state."

Principle III: Expanding Home and Community-Based Services

(California, Colorado, Florida, Idaho, Maryland, Nebraska, New Mexico, New York, North Carolina, North Dakota and Texas)

The LTC system should accommodate the preferences of consumers, most of whom prefer to remain independent and in their own homes and the community for as long as possible.

In general, task forces recommended an expansion of HCBS to allow people to remain at home and in the community when appropriate, instead of placing them in nursing homes. Also motivating the recommendation is the fact that HCBS tend to be less expensive than institutional care. Home and community-based services are defined to include homemaker services, home health, respite care, personal care, skilled nursing care, transportation, chore services, home modification, assistive devices, counseling, private duty nursing, adult day care, assisted living and adult foster care.

Some policy makers have been leery about expanding funding for HCBS for fear of the "woodwork effect," a theory that many more older and disabled people will come forward to claim these attractive HCBS benefits. Over the years, some experts have also questioned whether states can actually save money by expanding Medicaid funding for HCBS. Recent studies--including a 1994 General Accounting Office report and a November 1996 Lewin Group study commissioned by the American Association of Retired Persons--attempt to put that debate to rest, concluding that HCBS can be more cost-effective than nursing homes and that states with expanded HCBS have saved money.

Thus, to give more people who have LTC needs more choice--and to save money--task forces in 11 states made some of the following proposals to expand HCBS.

Recommendation 1: Expand Medicaid coverage of HCBS.

To provide a variety of support services to older, disabled and developmentally disabled Medicaid recipients, states must apply for 1915(c) waivers from HCFA. The waiver allows states to provide optional HCBS to those in the target group who would otherwise require institutional care. Every state has 1915(c) waivers for those populations except Arizona, which has a Section 1115 waiver, and the District of Columbia, which has a 1915(c) waiver for the developmentally disabled but not for the aged or physically disabled. Task forces proposed using the Medicaid waiver process as one method to expand HCBS.

Expanding current Medicaid waiver programs. Colorado, Idaho and Maryland specified expansion of current waiver programs. Idaho's advisory council, for example, recommended that the state request a federal waiver amendment to add an adult day care option to the HCBS waiver for those with developmental disabilities.

Creating new Medicaid waiver programs. The Idaho council also wanted the state to explore an independent living pilot program for attendant care.

Directing more Medicaid money toward HCBS. The Texas task force proposed making more funds available for community-based services. Its premise is that money should follow recipients, allowing them to choose from a variety of LTC services. If the state Legislature does not provide the additional money, the task force said that "some funding should be redirected from institutional services to community-based options as necessary to ensure consumer choice and maximize resources."

Changing Medicaid eligibility standards. Most people must pay for assisted living and personal care services themselves. To ease that burden, Maryland's advisory committee recommended establishing "eligibility standards, as allowable, for Medicaid coverage of LTC that will assist individuals to remain in the community."

Removing Medicaid waiver caps on HCBS. Idaho has a cap on the number of participants in its HCBS waiver program for the developmentally disabled. To expand services and to prevent further institutionalization of the population, the advisory council recommended seeking legislative approval for a waiver amendment to remove the cap on participants.

Expanding spousal impoverishment rules. A spousal impoverishment provision allows only spouses in need of nursing home care to receive Medicaid benefits, without leaving the healthier spouse destitute. Task forces in New York and North Dakota recommended that their legislatures consider expanding the spousal impoverishment provision to those who receive HCBS. However, the North Dakota task force warned in its report to the legislature that "additional funds would be needed to pay for the increase in the number of recipients who could become eligible for Medicaid," and the New York task force made its spousal impoverishment proposal part of a larger, omnibus package of reforms.

Recommendation 2: Encourage informal networks of caregivers by expanding respite care, adult day care and personal care services to help family and friends care for loved ones.

Family and friends play a large role in providing care to loved ones with LTC needs. According to the American Association of Retired Persons, as many as 80 percent of older people who need LTC live in their own homes or in community settings. To provide more support to these caregivers, task forces in California, Florida, New Mexico and Texas recommended expanding HCBS to provide support for and encouragement of informal support networks.

Recommendation 3: Ensure that consumers know about HCBS options before entering institutions.

New Mexico's interagency committee went beyond making recommendations encompassing only Medicaid recipients. It proposed mandatory counseling on HCBS options for all people--both Medicaid and private pay--before they enter nursing homes. Minnesota and Oregon currently are informing consumers of their HCBS options to prevent their institutionalization.

Recommendation 4: Encourage LTC insurance companies to include a HCBS option.

LTC policy coverage can vary greatly. Some policies cover only nursing home care, home care or care in community facilities, while other comprehensive policies cover all types of care. The types of home care that are covered also vary by policy. To move toward HCBS, task forces in Florida, New Mexico and North Dakota said that states should encourage private LTC insurers to include HCBS options in their policies.

Principle IV: Promoting Personal Responsibility

The LTC system should ensure greater reliance on private funding rather than on Medicaid.

Recommendation 1: Encourage people to purchase private LTC insurance. (California, Florida, Idaho, Maryland, Minnesota, Nebraska, New York, North Carolina, North Dakota and Texas)

LTC insurance is one way for people to avoid spending their entire life savings on services and becoming reliant on Medicaid. To increase the number of LTC insurance policies purchased, 10 task forces proposed a number of different strategies, the most popular of which was tax credits.

Tax credits. Task forces in California, Idaho, Maryland, Nebraska, New York, North Carolina and North Dakota recommended that the state provide tax incentives for the purchase of LTC insurance. North Dakota and Maryland proposed not only tax incentives for individuals to buy such insurance but also suggested that the state consider providing a tax incentive to employers who offer LTC insurance as part of their benefits.

Although tax deductions for LTC insurance is a popular concept, few state legislatures have acted on the

recommendation. Only six states--Alabama Illinois, Maine, Montana, New York and North Dakota--allow state tax deductions for the purchase of LTC policies.

Last year, however, Congress enacted a law that could give the idea more credibility. Under the Health Insurance Portability and Accountability Act of 1996 (better known as the Kassebaum-Kennedy Act), the tax deduction now allowed for standard health insurance plans and expenses extends to federally qualified LTC plans. Critics contend, however, that tax credits will not generate much new business because LTC insurance is so expensive and the definition of who qualifies for the deduction under Kassebaum-Kennedy is so narrowly drawn.

LTC insurance for state employees and health insurance pools. Task forces in Minnesota, Nebraska and North Carolina said that states should set the example for individuals and employers by offering LTC insurance to their employees. In addition, the Minnesota work group suggested "developing LTC insurance group purchasing pools or creating incentives for adding LTC to the offerings of existing acute care purchasing pools." At least Alaska and Utah currently offer LTC insurance to state employees as part of an optional benefit package.

Studies. Task forces in Florida, Minnesota and Nebraska asked that studies be conducted on creative LTC insurance options. For example, the Florida panel wanted the Legislature to form a work group to study how to encourage the purchase of LTC insurance. Minnesota's task force suggested a study to examine "the interaction between life, health and disability insurance and LTC insurance." And the Nebraska LTC Insurance Work Team proposed that the insurance industry continue to examine benefit structures and seek innovations that make the products more acceptable to the marketplace by, for example, allocating a percent of total life insurance payments normally made at death to fund premiums for LTC, and blending long-term disability and LTC insurance to reduce the overall cost of the policies.

Managed LTC insurance. New York's recommendations centered on private LTC insurance incentives. In addition to supporting tax deductions, the task force supported encouraging "insurance companies marketing LTC insurance products to consider including managed LTC as a cost-effective benefit."

Recommendation 2: Prevent estate planning by tightening laws and Medicaid regulations. (Maryland, Minnesota, Nebraska, New York and North Dakota)

It is a common perception that wealthy older people divest their estates and shelter their assets in their children's names to become eligible for Medicaid nursing home benefits and avoid spending down their savings--a practice often referred to as Medicaid estate planning.

Five state task forces recommended tightening laws to prevent such activity. Maryland and Minnesota, for example, made broad recommendations that called for examining the relationship between asset transfers and LTC financing and continuing to tighten state laws and regulations to inhibit Medicaid estate planning. The Nebraska, New York and North Dakota panels made more specific recommendations.

Specific Transfer of Asset Recommendations.

- *Nebraska.* Endorsed 1) establishing procedures for Medicaid estate recovery to "ease up" on eligibility workers; 2) developing state regulations that require life expectancy tables for nursing home residents, rather than the general population, be used to evaluate whether land contracts, life estates and annuities have been disposed of to qualify for assistance; 3) changing the look-back period to 60 months (currently 36 months) for all transfers; and 4) requiring at least 75 percent of the spousal impoverishment nursing home spouse's excess resources be spent for medical services when an assessment of resources has been completed.
- *New York.* Proposed tightening Medicaid eligibility rules for LTC, including applying the asset transfer penalty to home care.

- *North Dakota.* Recommended educating consumers to discourage the transfer of assets and applying the Uniform Transfer on Fraud of Creditors Act to asset transfers.

Generally speaking, the goal of the recommendations was to prevent "greedy geezers," as critics disparagingly call wealthy older people, from defrauding the Medicaid system. Despite the attention focused on estate planning, however, specifics have been difficult to pinpoint. While some seniors transfer assets to apply for Medicaid nursing home coverage, for instance, little is known about the extent to which the practice occurs.

The issue is currently in the spotlight because of the recent enactment of Kassebaum-Kennedy. Before the law was enacted, senior citizens who sheltered assets could face civil penalties. Now, the transfer of assets can result in criminal penalties. Advocates for seniors are outraged by the provision, saying it could scare older people who may legitimately qualify for Medicaid into not applying. It appears that the provision will never be enforced, and Congress is talking about repealing it.

Recommendation 3: Launch public education campaigns. (Maryland, Minnesota, Nebraska, New Mexico, New York, North Dakota and Texas)

Many task forces argued that people do not plan to finance their own LTC needs because they are not aware of the potential need for such services or of their cost. As a result, task forces in seven states recommended launching public education campaigns for various reasons:

- To prevent transfer of assets (Maryland and North Dakota);
- To encourage the purchase of private LTC insurance policies (Nebraska and New York);
- To discuss the financial risks associated with LTC and the limitations with current financing systems (Maryland and Minnesota); or
- To inform the public about LTC services and options (New Mexico and Texas).

Recommendation 4: Allow families of Medicaid recipients and middle income people to contribute to LTC services. (Florida, Nebraska, New Mexico and Texas)

Task forces in four states offered other strategies to improve access to care for Medicaid recipients and the middle class, while promoting privately paid policies for wealthier residents. These recommendations primarily encompass sliding fee scales and a buy-in into Medicaid programs.

- *Florida.* Recommended 1) that "people eligible for the proposed managed care program and their caregivers be given the opportunity to purchase enhanced services for a premium," and 2) that families of adults eligible for Medicaid be allowed to contribute to that care, without considering the contributions as income or assets of the Medicaid-eligible adult.
- *Nebraska.* Proposed that a study be conducted on allowing families to provide supplemental funds for family members who are receiving Medicaid to stay in a private room. Current state regulation prohibits a Medicaid resident's family from supplementing the Medicaid payment, even though most facilities would welcome the additional revenue.
- *New Mexico.* Called for fostering "the development of community-based options that attract private pay

involvement and avoid a two-tiered LTC service delivery system." The report cited Oregon, where assisted living facilities in the state serve high- and low-income residents.

- *Texas*. Promoted access, regardless of income, with sliding scales.

Recommendation 5: Develop demonstration projects that permit the low-income senior citizens and people with chronic illnesses to be eligible for extended Medicaid coverage. (New York)

The LTC system often has been criticized for being out of reach for the lion's share of Americans--the middle class. Medicaid finances LTC for the poor and the wealthy can purchase their own services, but those in the middle class, for the most part, must spend their life's savings until they become eligible for Medicaid.

To prevent that scenario, the New York task force made many recommendations to encourage the public to save for and pay for LTC expenses. It realized, however, that these long-term solutions would take years to accomplish. In the interim, it recommended that the state establish a transitional program, called a "Defined Private Contribution" option, for today's older and disabled populations.

Under the demonstration project, older people born before a certain date, low-income chronically ill residents and some hardship cases would be eligible for extended Medicaid coverage, but they would be allowed to protect a portion of their assets. In exchange, program participants would sign a contract with the state committing themselves to a defined private contribution toward their own LTC expense.

"At the time of assessment for chronic impairment, a consumer would disclose assets and income and sign a contract with the state that identifies the consumer's commitment necessary to obtain extended Medicaid coverage, which would mean waiving the asset test and estate recovery on the balance of the estate. --New York Task Force on Long-Term Care Financing

Principle V: Limiting Long-Term Care Expenditures

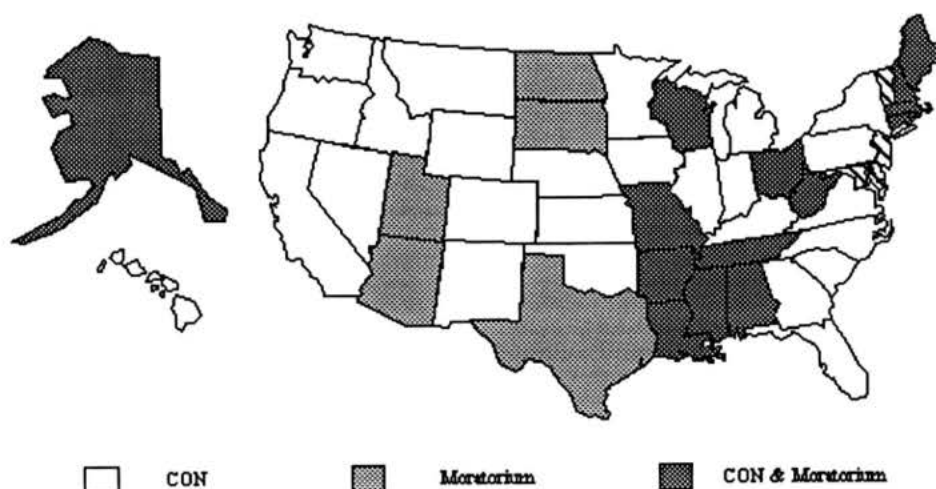
The LTC system should offer a balanced array of services that are cost-effective and meet consumers' needs.

Recommendation 1: Place CON and moratoriums on the expansion of nursing home beds. (Colorado, Florida, North Dakota and South Dakota)

Most states have certificate of need (CON) requirements or moratoriums to regulate the supply of nursing home beds. According to figures from the Missouri CON program, 20 states have a moratorium on nursing home beds, which means they either have stopped construction of new nursing home facilities and/or capped the number of beds in existing facilities. In addition, 36 states and the District of Columbia require that nursing homes receive a CON from the state before they can build new facilities or add new beds. Some states with CON for nursing homes also apply the requirements to other LTC facilities such as intermediate care facilities for the mentally retarded ICF-MR

A handful of states control nursing home growth without using CONs. Texas, for example, limits the number of Medicaid nursing home contracts it issues. This means a new nursing home can be built, but it would not be able to obtain a Medicaid contract. Since more than 70 percent of nursing home residents in the state are on Medicaid, this limit has curtailed construction of new nursing homes.

Figure 7
States with CON and/or Moratoriums on Nursing Homes



Since the repeal of the National Health Planning and Resources Development Act in the mid-1980s states have not received federal funds for their CON programs. Even so, CON programs for nursing homes have continued in most cases because state policy makers view them as effective programs for controlling the growth of nursing home beds. The task forces tended to agree. The panels in Colorado, Florida, North Dakota and South Dakota, for instance, offered recommendations to refine or continue state-enforced caps on nursing home beds.

Colorado and Florida proposed more stringent methods to determine nursing home bed need. In Colorado, which does not have a CON law, the task force recommended "refining Medicaid's bed need determination method concerning the nursing home bed supply," while Florida's proposed further limiting the number of nursing home beds by modifying its CON bed need methodology.

The Dakotas chose to extend moratoriums on nursing home beds. South Dakota's task force recommended continuing the moratorium until the year 2000. North Dakota's said that the state should consider making permanent its moratorium on nursing home beds, with the goal of reducing capacity to 60 beds per 1,000 over age 65 by the year 2002. It also asked the legislature to consider establishing a "bed bank," through which nursing home beds that are no longer licensed could be reallocated to other localities where additional beds may be needed.

Recommendation 2: Reduce payments by moving from cost-based reimbursement toward case-mix and prospective payments. (Colorado, Nebraska and North Dakota)

Medicaid reimbursement methodologies and rates vary by state. Some states pay nursing homes for certain services based on their costs; others pay a flat rate for several services that are "bundled" together; and still others reimburse based on a prospective rate. Although reimbursement varies by state, payment systems have been changing from cost-based to prospective rates.

In light of that trend, task forces in Colorado, Nebraska and North Dakota addressed the issue of lowering

nursing home payments. For the most part, the task forces provided few details, instead calling for studies--perhaps because of the complexity of reimbursement systems and the strong nursing home lobby.

- *Colorado*. Suggested that nursing home payment rates could probably drop to an average of 100 percent of costs while HCBS provider rates increase.
- *Nebraska*. Recommended the "establishment of a nursing facility classification that recognizes as an appropriate level of service care for individuals whose professional nursing requirements are not at a 24-hour per day level." It also called for numerous studies.
- *North Dakota*. Proposed two studies to be presented to the 1999 legislature: 1) a review of the number of current and potential nursing home residents who could receive LTC services in alternative settings and an estimate in the cost difference between caring for them in nursing homes versus community settings, and 2) a study on the payment structure of nursing homes and other residential care settings to determine "what financial, regulatory or other impediments exist that would prevent the development of alternative LTC services." Based on that information, the Department of Human Services would be authorized to develop a package of financing incentives to encourage nursing homes to reduce the number of beds and to develop alternative LTC services.

Recommendation 3: Provide incentives for nursing homes to convert to alternative, community settings.
(California, Idaho and North Dakota)

Three task forces made recommendations to provide incentives for nursing homes to convert to less skilled, community-like facilities or offer multiple levels of care.

• *California*. The Little Hoover Commission recommended creating a unified licensing plan for LTC providers to offer different services within a single facility. The commission found that, although facilities would like to offer multiple levels of care, they often are constrained from doing so because of the dual licenses that are required. If the licensure system were unified, large retirement communities could provide more HCBS for those who need assistance but do not need 24-hour skilled nursing care.

• *Idaho*. In addition to converting nursing homes and allowing facilities to provide multiple levels of care, the advisory council went a step further by proposing not to pay for unused nursing home beds.

• *North Dakota*. The task force proposed that several pilot projects be designed to convert existing nursing homes to community-like settings for Alzheimer's and dementia patients to provide effective services priced below nursing home costs.

Recommendation 4: Base regulations on outcomes rather than on burdensome, irrational standards.
(California, Minnesota and Texas)

Because nursing homes are one of the most heavily regulated industries, the three task forces cited above recommended that regulations be based on outcome data rather than on prescriptive processes. As the Little Hoover Commission reported:

"It is counterproductive to have more than one set of regulations governing an industry and to layer complexity with redundancies. Regulations should be focused on outcomes, allow for flexibility of methods, lend themselves to consistency of interpretation and be easily understood by industry, consumers and state

workers."

Thus, to reduce unnecessary regulations, the Texas task force advocated that the state "develop ways to recognize history of compliance and self-monitoring processes and lessen the state regulatory burden in return." It recommended encouraging "regulators to develop means for granting waivers to regulations on individual and common-sense bases." The task force gave as an example allowing a retirement community with a good record to arrange for shared attendant services for a few residents, without requiring it to obtain a personal care license.

Recommendation 5: Increase reliance on qualified allied health care professionals to provide care, when appropriate. (California and Texas)

To further reduce LTC costs, the Washington Legislature in 1995 amended the Nurse Practices Act to allow nurse delegation of tasks in certain residential settings. Despite the anticipated conflicts between different health care professions, task forces in California and Texas also recommended increasing reliance on nonphysician providers. The Little Hoover Commission, for instance, proposed moving to a "more economical, preventive model" that advances the use of allied health professionals when appropriate. The task force in Texas offered a more controversial recommendation: to "encourage service provision by qualified unlicensed people."

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THE WHITE HOUSE

WASHINGTON

August 11, 1998

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research

MEMORANDUM FOR THE PRESIDENT

FROM: GENE SPERLING
BRUCE REED
CHRIS JENNINGS

SUBJECT: LONG-TERM CARE INITIATIVE

cc. THE VICE PRESIDENT, ERSKINE BOWLES, ROBERT RUBIN,
JACK LEW, SYLVIA MATTHEWS, JANET YELLEN, MARIA
ECHAVESTE, JOHN PODESTA, RON KLAIN, LARRY STEIN,
RAHM EMANUEL, PAUL BEGALA, ELENA KAGAN

Per your request, an interagency NEC/DPC process examined long-term care policy options, specifically how long-term care options could be added to our tax cut package. This memo summarizes our recommendations on both the best policy and the advisability of announcing such an initiative in August or September or waiting until the State of the Union.

We developed a long-term care initiative that both assists people who provide or pay for long-term care and encourages workers to purchase high-quality, private long-term care insurance. The centerpiece of the initiative is a broad-based, non-refundable tax credit for people with long-term care needs or for families who house and care for such relatives. The credit could help defray the costs of formal care (e.g., home health care) and informal care (e.g., assisting parents who are bed-ridden). Second, to complement the ongoing work of your Task Force on the Employment of Adults with Disabilities, we could introduce a tax credit of up to \$5,000 for impairment-related work expenses incurred by disabled individuals. Third, we could announce support for offering private long-term care insurance to Federal employees, which would have virtually no costs and bipartisan support. The long-term care tax options cost a total of \$4 billion over 5 years and \$14 billion over 10 years, and would be fully funded by savings from postponing or modifying our budget revenue proposals, plus a few offsets that were in the Senate IRS bill, but that were not included in the final bill, or in your FY 1998 budget.

The timing of an announcement of a long-term care initiative in a modified tax package depends on a number of factors that will be discussed later in the memo.

BACKGROUND

This policy initiative is motivated by an interest to address long-term care and issues facing the chronically ill, particularly the elderly.

Unlike Social Security and Medicare, long-term care has received little attention. Republicans have begun to raise policy options (e.g., MSAs for long-term care in their Patient Protection Act), but not aggressively. Along with the lack of coverage of prescription drugs, the poor coverage of long-term care represents a major concern for the elderly and their families. Medicare pays for only a limited amount of long-term care, and private insurance even less -- only 10 percent of home health care and 5 percent of nursing home care. As a result, long-term care costs account for nearly half of all out-of-pocket health expenditures for Medicare beneficiaries.

Concern about long-term care costs is not limited to the elderly and people with disabilities. Their children, other relatives and friends provide a large amount of formal and informal long-term care. According to an HHS study that has not yet been released, one in three Americans voluntarily provide some unpaid informal care to an ill or disabled family member or friend. Over 90 percent of people with three or more limitations in activities of daily living (ADLs) living in the community receive some kind of informal care, most often from a spouse or relative. This means that middle-class families may find themselves caring both for their parents and their children.

A second motivation for this initiative is to make our targeted tax cut package include a more progressive, senior-focused tax option. Most people with long-term care needs have lower incomes. For example, the poverty rate for the elderly with two or more limitations in ADLs is twice as high as the rate for all elderly.

POLICIES

The proposed long-term care initiative would consist of three policies: two new tax credits plus offering quality private long-term care insurance to federal workers. Savings to pay for this initiative would come from new offsets and savings from postponing or modifying our existing tax cut proposals.

1. Long-term care tax credit

The centerpiece of the long-term care initiative would be a tax credit for people with long-term care needs or the families who house and care for such relatives. A \$500, non-refundable credit would cost \$3.9 billion over 5 years and \$12.4 billion over 10 years (according to preliminary Treasury estimates) and would help a total of 3.4 million chronically ill individuals (described below). People with long-term care needs are defined as having two or more limitations in ADLs (bathing, dressing, eating, toileting, transferring and incontinence management) lasting for longer than six months or severe cognitive impairment, as certified by a doctor. Virtually all people who meet these criteria need some type of long-term care. The credit would be given on

the basis of illness rather than expenses because, otherwise, it would not help people who receive unpaid long-term care. For example, a wife who cares for her husband herself rather than paying someone to do it would not receive a credit if it were based on receipts for long-term care expenses. This approach is also easier to administer than alternatives. About 1.7 million chronically ill individuals would directly get this credit on their own tax returns.

Certain families with “dependents” with long-term care needs could also receive the credit. Under current law, adults can be claimed by tax filers as dependents if they are related, have very low income, and receive at least half of their support from the tax payer (among other criteria). Adult dependents are generally not required to file tax returns themselves. For the purpose of this credit, we would broaden the definition of a “dependent” to include a person who needs long-term care (described above), lives with the family member, and generally does not have any income tax liability. Because by definition they live in the community, dependents are rarely nursing home residents. Simply stated, this allows families (other than spouses) who house and care for relatives needing long-term care to apply for the credit on their behalf. This improves the ability of the credit to help people who do not have enough income to file tax returns, although it does not help the elderly with no tax liability living alone or outside of their relatives’ homes. Another 1.7 million families would get the credit in this way.

Over half of the chronically ill individuals benefiting from this credit are elderly, since the need for long-term care increases with age. Preliminary conversations with aging advocates suggest that this tax credit would be well received. However, private long-term care insurers could oppose the credit for fear that it will decrease interest in insurance since people may think that the credit protects them against long-term care costs.

Key Issues

Should the credit be refundable? A large proportion of people with long-term care needs are low-income and do not have tax liability. Refundability could improve the effectiveness of this policy at reaching its target population.

Pro:

- An additional several hundred thousand people would benefit from the credit if it were refundable, and, for those with a low tax liability, they would get the full amount of the credit.

Cons:

- It adds complexity to the policy because it creates a need to exclude certain groups. A large number of non-filers with long-term care needs are already receiving assistance through SSI and Medicaid if in a nursing home. Because a refundable credit would count against their eligibility for these programs, it makes sense to exclude them from the credit. However, this would be difficult, administratively and politically.
- It could jeopardize the initiative. Although we have been successful in our support for

the refundability of the E.I.T.C. despite the strong Republican opposition, adding another refundable credit could risk the passage of the initiative and potentially undermine support for existing refundable credits as well.

- This proposal, as a refundable credit, may not be administrable at acceptable levels of compliance and intrusiveness.

Should we give a larger credit to few people or a smaller credit to more people? If we make the definition of needing long-term care stricter (i.e., three or more ADL limitations as opposed to two), fewer people would be eligible but we could increase the credit amount within the budget constraints.

Pros:

- Raising the credit amount to \$1,000 would make the amount more meaningful. For example, it is enough to purchase a few hours of respite care per week.
- Eligibility based on two or more limitations in ADLs could be more subject to fraud, since it is a less strict standard.

Con:

- Even with \$500 credit and the broader definition of needing long-term care, the policy helps a subset of the people who need long-term care or their families. According to one estimate, about 50 million Americans provide some type of informal long-term care to family and friends.
- Because most people meeting the stricter definition (three plus limitations in ADLs) are ill enough to require institutionalization, even a \$1,000 may be perceived as being too small relative to the larger costs incurred by these people and their family.

2. Tax credit for impairment-related work expenses for people with disabilities

To complement the work of the Task Force on Employment of Adults with Disabilities, people with disabilities could receive a new tax credit of up to \$5,000 for their impairment-related work expenses. This credit could be used to offset expenses for personal care in the workplace, for example, which is often a pre-condition for leaving home for work. A similar credit was in the Health Security Act and a Republican “return-to-work” proposal this year. It costs about \$500 million over 5 years, \$1.2 billion over 10 years, and helps about 300,000.

Key Issue

Should this credit remain as part of the long-term care initiative or be saved for a separate announcement? Although this credit can be considered a long-term care policy, it also fits in the context of return-to-work policies for people with disabilities and could be announced by itself or in the State of the Union.

Pro:

- Omission of a policy for people with disabilities within a long-term care initiative would be noticed. There is a heightened attention to disability issues both in Congress and the community, and especially close attention is being paid to Administration actions. Even the aging advocates support including people with disabilities to avoid this criticism.

Cons:

- The disability community seems happy with the Administration's work on the Jeffords-Kennedy legislation, so that an additional policy at this point may not be needed.
- Since we do not exclude people under age 65 from the long-term care tax credit, we would be helping people with more severe disabilities even if we dropped this specific credit. The overlap between the two credits, however, may be low.

3. Offering private long-term care insurance to Federal workers

The third piece of the initiative is the small but symbolic non-tax option to offer Federal employees and annuitants a range of high-quality private long-term care insurance policies. There would be no Federal contribution for this coverage, but Office of Personnel Management (OPM) would set standards for the plans and sort them into benefit classes (e.g., "core" policy plus several types of "enhanced" policies) to facilitate informed choice. A seriously flawed bill to allow an open-ended long-term care insurance option was introduced by Representative Mica (R-FL) last week. Democratic members of the Civil Service Subcommittee, plus some Republicans (e.g., Connie Morrell), have expressed interest in a substitute. Proposing an alternative would add to our series of policies for Federal workers that demonstrates our leadership as a responsible employer.

Key Issues. None on policy grounds, although it is not a tax policy like the others. However, your advisors recommend that we act on this as soon as possible to preempt the Republicans from claiming the policy.

4. Offsets

This long-term care initiative would cost about \$4 billion over 5 years and \$14 billion over 10 years. It could be offset by modifying our existing tax package and adding a few new policies. First, we would postpone the effective date of our proposed tax initiatives until January 1, 2000. Given the Year 2000 problem, we would probably have to do so regardless. Second, we would scale back the child and dependent care credit (make it a 40 percent credit as opposed to 50 percent and slow the phase-down). Third, we would add two new policies that were in the Senate IRS package, but weren't included in the final bill and that were in your FY 1998 budget. The first is to modify the Foreign Tax Credit carryover rules; the second is to reform the treatment of Foreign Oil and Gas Income and dual capacity taxpayers.

Key Issues. None on policy grounds, although like any offsets, they are not universally liked.

RECOMMENDATIONS. Your advisors (Chief of Staff, Office of the Vice President, NEC, DPC, CEA, Legislative Affairs, Treasury and OMB) generally agree on all of the components of this long-term care initiative. On the issue of refundability of the long-term care tax credit, we recommend against it. In particular, NEC, DPC Treasury and Legislative Affairs fear that making the credit refundable could spur an overall attack against refundability and jeopardize the gains that we have made on the E.I.T.C. It does, however, leave us somewhat vulnerable to criticisms that it is regressive. We suggest responding to this concern by stating that we are willing to work with Congress to make this credit more progressive. There is also agreement choose a broader definition of eligibility (two plus limitations in ADLs) even though we would have to lower the credit to make it affordable. This could help broaden the base of support for the initiative. Finally, even though the credit for people with disabilities could be part of the long-term care package, we recommend making it a separate announcement. NEC/DPC think that this credit might be best announced in the State of the Union, since it is likely to be recommended by the Task Force's November report and such an announcement would be viewed as acting on that recommendation.

Long-term care tax credit:

- ☐ Include refundable credit
- ☐ Include non-refundable credit (RECOMMENDED)
- ☐ Do not include in the package

Tax credit for impairment-related expenses for people with disabilities:

- ☐ Include tax credit for people with disabilities
- ☐ Do not include in the package (RECOMMENDED)

Offering private long-term care insurance to federal employees:

- ☐ Include in package (RECOMMENDED)
- ☐ Do not include in the package

☐ Discuss some or all options further

ISSUES RELATED TO THE TIMING OF AN ANNOUNCEMENT

Assuming that the long-term care initiative and modified tax cut package are acceptable on policy grounds, the next question is about timing of an announcement. The following outlines the pros and cons of announcing this initiative in August or early September.

Pros:

- **Secures ownership of the long-term care issue.** A strong, affirmative long-term care message would not only be popular amongst the elderly, people with disabilities and most

advocacy groups, but it would probably be well received by validators who think that this is the great, untouched baby-boom issue. This could complement and affirm your leadership on major, societal issues facing the country in the next century.

- **Provides an alternative to private long-term care insurance and MSAs as the only solution to the problem.** In September, the Republicans will probably take up the Mica federal employees' private long-term care insurance proposal and the Senate Patient Bill of Rights legislation that expands MSAs to include long-term care expenses. The mainstream advocates are concerned about the singular focus on private long-term care insurance and MSAs, since they will not come close to covering the costs of long-term care. Even the insurance industry, in its most optimistic projections, does not foresee that private insurance will cover even half of long-term care costs in thirty years. However, in the absence of alternatives, some may feel some pressure to support the Republicans' proposals.
- **Confirms our support for responsible tax cuts.** Presenting a tax cut package with explicit offsets would reaffirm that we support tax cuts, so long as they are paid for. As such, it could complement our Save Social Security First message. These credits also are attractive alternatives to some of the Republican proposals, since they focus on the elderly and people with disabilities who have lower income.

Cons:

- **Could provide impetus for an unacceptable tax cut this year.** The proposal would come at a time when Congressional Democrats, especially in the House, see the Social Security First message as strong and simple. They would probably perceive a new tax package as clouding that message. Also, Gingrich has been musing about settling for a tax cut this year of \$70 billion or even less, so that our announcement of a revised tax package of about \$30 billion could be read as a sign that we are willing to deal with the Republicans on their tax package in September and make our rule of not using the surplus less clear as well. Finally, given that our revenue raising provisions are unpopular on the Hill, an announcement with an attractive set of options could increase the chances of a tax cut that taps the surplus.
- **Democrats may prefer marriage penalty regardless.** The new package could have somewhat limited value for Congressional Democrats because it does not include marriage penalty relief, which is their main concern.
- **May appear political and not receive the attention and validation that it deserves.** Since it is unusual to propose policies with budget implications outside of the State of the Union and Budget process, the timing of the announcement, rather than the substance of it, may be what the press focuses on.

RECOMMENDATIONS. Your advisors generally do not recommend an August or early September announcement. The importance of this initiative to your overall policy agenda would probably be obscured by a media focused on the timing. Moreover, Republicans could seize on the announcement to generate momentum in September for their tax package or one that uses the surplus. It appears, at this point, that Democrats think that inaction on the tax front is a good outcome for them.

However, we think that the question of timing should be revisited in mid-September. At that point, we will have a better sense of the potential ramifications of the announcement for Congress. We can also assess when and how we can make this announcement so it clearly gets the attention it deserves and puts you in a leadership role on this important issue.

- _____ Announce in August or early September
- _____ Revisit timing decision in mid-September (RECOMMENDED)
- _____ Discuss further

Executive Summary

Almost 13 million Americans have chronic health problems that require long-term care -- a constant and costly demand on a health care system that was never designed for prevention and maintenance but instead for identifying illnesses, treating symptoms and sometimes producing cures. The result of this mismatch between need and design is that people often go without help, face conditions that deteriorate prematurely and sometimes are pressed into expensive institutional care before necessary. The magnitude of the problem is large: California spends more than \$5 billion on long-term care services for fewer than half of the 1.5 million people who need assistance.

"Long-term care" focuses on managing on-going conditions over time. Services may include *medical assistance*, such as administering medication or performing rehabilitative therapy. But more typically it involves *personal care*, such as help with bathing and eating, and *supervision*, such as protecting a person from wandering away or inadvertently injuring themselves. The emphasis of long-term care is on enhancing a person's ability to function and enjoy a quality of life rather than on curing a condition. It takes place in a variety of settings -- in homes, in institutions, in community programs -- and is provided by a variety of caregivers -- licensed health care professionals, trained workers, family and friends.

As the Baby Boom generation moves into its declining years and begins to balloon the elderly population, the pressure is building to change the approach to long-term care. In California, the Little Hoover Commission has had a standing commitment to improving the quality of long-term care for the elderly. The Commission has not been a lonely voice in this regard. Dozens of groups and reports at the federal, state and local levels have called for restructuring long-term care services to increase both effectiveness and efficiency.

The same sources who decry today's long-term care services produce similar lists of what a good system would look like: consumer-driven, community-based, social model, choices among least-restrictive options, affordable services, uniform access. And many argue that at least some of these goals can be obtained without massive infusions of new resources, although all maintain a larger slice of the resources pie is easily justified for this growing, vulnerable segment of the population.

Despite the general consensus about what is wrong and what the desirable end result is, little progress has been made toward restructuring long-term care services in California. That the demand for long-term care will increase is a certainty. How the State should respond is the question. The following report is designed to help policy makers shape the answer. Its findings are:

Finding 1: The present state structure for long-term care oversight is not conducive to a coordinated continuum of care and fails to focus state efforts on consumer-centered, least-restrictive, best-value services.

A person in need of long-term care faces a bewildering maze of policies, bureaucracies and programs. Strictly regimented funding streams and fragmented service programs skew decisions toward high-cost, less consumer-desired solutions. Although the State Plan on Aging describes a coordinated continuum of care options that strives to keep consumers in their homes and communities, the State's segmented structure for

overseeing long-term care frustrates the implementation of this federally required plan. The result is consumer confusion, costly choices and premature erosion in the quality of life for many individuals. At a time when the population most likely to need long-term care services is expanding rapidly, the State can ill afford to maintain its present system.

Recommendation 1-A: The Governor and the Legislature should consolidate the multiple departments that provide or oversee long-term care services into a single department.

Interdepartmental cooperation is a hit-and-miss proposition that usually lacks mission unity and aggressive leadership. If the State is serious about creating an effective long-term care system -- and with looming demographics that promise an explosion of those who need such care, the State should be concerned about that goal -- then it must reorganize departments into a single entity to oversee all long-term care. The new department should take advantage of the opportunities presented to create a consumer-centered philosophy that maximizes choice, effectiveness and efficient use of multiple resources.

Recommendation 1-B: The Governor and the Legislature should mandate that the new state department establish an effective one-stop service for consumers to obtain information, preliminary assessment of needs and referral to appropriate options.

What consumers have identified repeatedly as their most pressing need is a reliable source of information so they may understand the choices that are available to them. While the State has the backbone for such a system in place, with the 33 regional Area Agencies on Aging and a special 1-800 number, the resources are not available for personalized, one-stop counseling. In particular, the ability is lacking to access information about programs and individuals by computer so that counseling is person-specific. Over time, as the State makes progress on integrating programs, these referral centers should also serve as program entry points, with unified applications and common eligibility screening.

Recommendation 1-C: The Governor and the Legislature should require departments involved in long-term care to pursue federal waivers and options that will infuse flexibility into programs and funding.

The State has been slow to embrace opportunities to escape federal micromanagement, lagging behind other states in applying for and winning waivers. Although the process for securing waivers is lengthy, it is an investment the State must make if it is to create a long-term care system that focuses on consumer needs rather than one that is driven by artificial -- and often conflicting -- program constraints. Waivers are also a key tool for shifting long-term care services away from high-cost medical models to consumer-preferred, lower-cost community-based social models of care. Specific examples include Wisconsin's cash-and-counseling program, Oregon's targeted removal of people from skilled nursing facilities, and further replication of the On Lok and Social Health Maintenance Organization models.

Recommendation 1-D: The Governor and the Legislature should adopt a multi-pronged strategy for coping with the expected rising demand for and cost of long-term care services.

As the economy expands and state revenues increase, policy makers should give serious consideration to enlarging allocations for long-term care services. But there are other steps that would stretch resources, including further stimulation of the purchase of private long-term care insurance through tax credits; more effective educational outreach about people's financial options for the future; and elimination of program incentives that favor high-cost services.

Recommendation 1-E: The Governor and the Legislature should ensure that the State's policies are consumer-focused by establishing an advisory committee that can have a persuasive voice in policy formation, program implementation and quality assurance.

Consumers who actually use long-term care services can provide valuable input on what components are needed to make an effective system. They also can ensure that the focus of both policy and programs remains on the consumer and not on the convenience of bureaucracy. One option is to convert the existing California Commission on Aging to a body that includes consumers of long-term care services and to provide it with adequate resources to work closely with the restructured, single department in charge of long-term care services.

Recommendation 1-F: The Governor and the Legislature should develop a program for quality assurance and control that is outcome-based and consumer-oriented rather than prescriptive and process-oriented.

Policy makers should take several steps to shift oversight from a prescriptive system to an outcome-based system:

- The regulation-creating process and regulations themselves should be recrafted to emphasize outcome over process. This will lead to less rigid, less prescriptive regulations that may be more difficult for regulators to enforce and industry to understand but that should increase the opportunity for care that is centered on an individual's specific needs.
- More resources should be directed toward increasing training and professionalism of regulators so that less-prescriptive regulations can be enforced with flexibility regarding method but consistency regarding results.
- The check-and-balance structure for enforcement activities should be strengthened by creating a formalized, effective role for public interest and advocacy groups. This will include ensuring open access to information and records, a role for such groups in negotiations and the ability to seek effective legal redress for problems.

In addition, policy makers should focus on improving accountability and credibility for the State's oversight functions. Two possible steps:

- Any structural reform should be accompanied by efforts to minimize conflicting roles. Complaint investigations could be shifted to either the Attorney General's Office or the Department of Consumer Affairs. Similarly, the ombudsman program could be housed in these departments. Such a change, if implemented, should be monitored for several years and then assessed for effectiveness.
- Increasing the resources available to the ombudsman program, which is stretched too thin over many important duties, would allow increased training and more effective outreach to identify a larger pool of volunteers. Added funding could be diverted from fines collected for violations of regulations.

Finding 2: The State's policies and programs do little to encourage the use of community-based services, and too small an effort is made to protect people from premature deterioration that can

result in costly institutional placements.

In many areas of state concern, prevention is an investment that saves long-range costs -- but prevention rarely wins priority over reactive services when resources are limited. In the case of long-term care, the bulk of government dollars is spent on institutionalization, and preventive services that would keep people out of high-cost institutions are stretched thin. Statutes are in place that favor community-based care, and exemptions and waivers for licensing regulations provide limited tools to keep people in home-like environments. But by and large, the state bureaucracy blocks rather than enables community solutions, and policy makers provide little financial support for preventive programs. Programs that have proven their worth but that suffer from financial neglect include:

- Support services for family caregivers.
- Adult day care and adult day health care clinics.
- In-Home Supportive Services.
- Adult Protective Services.

Recommendation 2-A: The Governor and the Legislature should revamp the present highly segmented licensing structure for long-term care service providers to allow a more seamless delivery of service, to allow aging in place whenever possible and to emphasize social models over medical models.

Creating a unified licensing plan that would allow service providers to add-on optional services or provide various types of care in a single setting is a key requirement for moving long-term care toward integrated, consumer-focused service. Those who fear the consolidation of the existing separate licensing systems should have their concerns addressed by requiring any new system to be outcome-based, flexible in implementation, consistent in interpretation and supportive of social models of service delivery. Barriers raised by federal funding and oversight requirements for skilled nursing facilities should be addressed through waivers, demands for federal law reform or, if no other course is feasible, separation from other forms of long-term care licensing.

Recommendation 2-B: The Governor and the Legislature should designate a point person to develop funding streams and provide technical support for adult day care and adult day health care programs.

These programs can play a critical role in providing relief for caregivers and increasing the number of functionally impaired people who can remain at home and out of costly institutions. The State should provide leadership in securing Medicare reimbursement for services by pushing for changes in federal law and waivers. In addition, the State should focus on educating the public about the services available and enhancing the opportunity for development of more programs.

Recommendation 2-C: The Governor and the Legislature should increase funding for family caregiver respite and support services.

For more than a decade, the Caregiver Resource Centers have documented their value in providing services

that allow people with brain impairment to remain home and under the care of family and friends. But funding constraints have kept the waiting lists long, limiting this program's ability to serve as a safety net for the long-term service continuum of care. The California Senior Legislature, which has the responsibility of proposing laws to assist the State's seniors, is backing a statewide respite care program as one of its priorities for 1997. Expanding the existing program would meet their goals.

Recommendation 2-D: The Governor and the Legislature should encourage counties, through funding and other incentives, to form Public Authorities to improve delivery of services under the In-Home Supportive Services program.

The problems with the In-Home Supportive Services program have been well documented and widely acknowledged for years. Improvements have been non-existent, due to lack of funding and governmental abhorrence to becoming involved to a point of being named the employers of caregivers. The Public Authority mechanism, while largely untested, has the ardent support of consumers as a means of improving the quality of care. This mechanism should be given every opportunity to succeed.

Recommendation 2-E: The Governor and the Legislature should require counties to provide multiple modes of services so In-Home Supportive Services recipients who do not want to act as employers have options, including care through agencies, that will meet their needs.

While many IHSS recipients want to retain control over their service provider choices, others neither desire nor can handle the role of employer. Just as recipients who want to be employers should have that choice, recipients who need management assistance for their caregivers should not be left without a program to meet their needs.

Recommendation 2-F: The Governor and the Legislature should increase funding and expand the state role in standardizing adult protective services throughout the state.

Society needs an effective mechanism for protecting people who are functionally impaired and threatened with abuse, neglect or exploitation. The present county-administered programs are not uniform throughout the state and lack the resources to provide effective service. The California Senior Legislature has made increasing the funding and effectiveness of this program, as well as enhancing elder abuse prevention and treatment programs, as two of its top 10 priorities for 1997.

Recommendation 2-G: The Governor and the Legislature should clarify mandated reporting laws to turn them into a more effective tool for protecting vulnerable citizens.

Mandated reporting laws vary with regard to what should be reported, by whom, to whom and what resulting action is required. Providing uniformity to this system would make it more understandable both to those who are required to comply with the provisions and those who are seeking protection from them.

Finding 3: Federal mandates for skilled nursing facilities have brought an improved process to monitoring quality of care -- but many previously identified issues remain unresolved and others are developing as the role of these institutions shifts to a higher level of

care.

Under recently issued federal regulations, skilled nursing facilities (SNFs) are judged by their ability to provide the least restrictive, most socially stimulating environment that a person's condition, desire and needs allow. The State's process of holding SNFs to this standard holds great promise. But many of the problems identified in previous Little Hoover Commission reports continue to exist and have immense negative impact on people's lives. As the role of SNFs shifts more from long-term custodial care for chronically ill people to short-term rehabilitative care for recently acutely ill people, the State has an opportunity to recast the policies and programs that make these institutions the most costly, least consumer-desired long-term care option.

Recommendation 3-A: The Governor and the Legislature should take steps to move medical care in long-term care settings from the costly reactive model to the more economical, preventive model, including encouraging the use of allied health professionals when appropriate.

There is little value in protecting the turf of professionals who do not want to provide service in a long-term care setting but who are loathe to see their competitors gain a foothold. Allied health professionals, such as dental hygienists, nurse practitioners and physician assistants, can play a valuable role in providing preventive health care and alerting the appropriate professionals to the needs of residents in skilled nursing facilities. They should be given the opportunity to do so.

Recommendation 3-B: The Governor and the Legislature should strengthen the opportunities, incentives and requirements for high quality performance by skilled nursing facility staff.

It is difficult to operate effectively in a setting that is understaffed, has incomplete or inadequate training and provides no opportunity for advancement. The following steps would address those concerns:

- Eliminate the doubling of hours for licensed nursing professionals, explore moving to a system that requires adequate staff for proper care rather than a certain number of hours, and/or set higher standards for staffing. The Older Women's League has recommended one caregiver for each eight residents at a minimum.
- Add more gerontology and human relations issues to the certified nurse assistant (CNA) training curriculum and provide more effective oversight to ensure that training is of high quality and actually occurs.
- Create a career ladder for CNAs by establishing progressive educational standards and work experience that would lead to licensed nursing status.

Recommendation 3-C: The Governor and the Legislature should enhance the State's enforcement capability by eliminating counterproductive provisions in the citation and fine system, directing more frequent use of alternative tools and creating a more effective civil liability remedy.

Specific steps that policy makers should take include:

- Eliminating the waiver of fines for B citations and the halving of fines for payment prior to appeal. The Department of Health Services told the Commission it supports both of these reforms.
- Encouraging the Department of Health Services to use more frequently facility decertification, delicensing and frozen admissions, as well as creating a fee system that assesses a facility at a higher rate when frequent violations require more frequent inspections.
- Fines, set in the mid-1980s, should be increased. In addition, consumers should be empowered to sue for civil remedies with the potential for large enough financial damages to act as a deterrent for poor quality care.

These and similar reforms are supported by the California Senior Legislature in its 1997 list of priorities and the California Advocates for Nursing Home Reform.

Recommendation 3-D: The Governor and the Legislature should create a more responsive complaint investigation and resolution process that is separate from the licensing and technical advice function.

The reality is that the Department of Health Services is neither adequately funded nor staffed to be responsive to consumer complaints -- and the perception is that their interest is more aligned with encouraging industry to comply than providing aggressive enforcement. In addition, the current process is heavily weighted toward due process for industry rather than adequate concern for consumers. Restructuring the process and placing it at some distance from the licensing function -- such as at the Attorney General's Office or in the Department of Consumer Affairs -- would address these issues. This reform could be tracked and assessed for effectiveness over time.

Recommendation 3-E: The Governor and the Legislature should eliminate duplicate regulations and streamline the oversight process while ensuring that no deterioration in the quality of care occurs.

It is counterproductive to have more than one set of regulations governing an industry and to layer complexity with redundancies. Regulations should be focused on outcomes, allow for flexibility of methods, lend themselves to consistency of interpretation and be easily understood by industry, consumers and state workers.

Finding 4: Regulatory changes have not kept pace with the changing role of residential care facilities.

Residential Care Facilities for the Elderly (RCFEs) are a consumer-favored option for long-term care because of the home-like setting, lower cost and individual freedom provided. Although conceived as a non-medical approach to long-term care, their function has grown increasingly complex as residents have been given the right to remain in place with greater and greater need for care. While new regulatory categories have been added piecemeal to broaden the role of RCFEs, no comprehensive re-examination of where this service fits in the long-term care continuum has occurred. But as a key service that can keep people from premature institutionalization and foster at least partial independence, RCFEs deserve attention

and reform that will support expanded availability to people with long-term care needs.

Recommendation 4-A: The Governor and the Legislature should restructure state policies regarding RCFE rates.

With market forces driving prices for 70 percent of the residents in RCFEs, state policies to artificially suppress rates for SSI/SSP recipients have had counterproductive affects, including lack of access. In addition, many people who are not poor enough for SSI/SSP benefits but too poor to pay \$1,500 a month are left with no options for out-of-home care other than expensive skilled nursing facilities. Policy makers should take several steps:

- Eliminate the ceiling on the rates RCFEs may charge SSI/SSP recipients.
- Petition the federal government to increase SSI.
- Increase the state-funded SSP portion of the monthly benefit.
- Craft a Medi-Cal benefit using the personal care waiver that will allow RCFEs to collect money for services beyond food and shelter that help keep residents out of skilled nursing facilities where the Medi-Cal bill would be much higher.

Recommendation 4-B: The Governor and the Legislature should revamp the regulatory structure for RCFEs.

An earlier recommendation calls for the complete restructuring of licensing to allow more flexibility and integration of long-term care services. This is particularly true for RCFEs, which would benefit from regulations that are size-specific and that more easily accommodate add-on services to a core package of basic care.

Recommendation 4-C: The Governor and the Legislature should encourage more clarity and consistency in enforcement efforts by dedicating more resources to staff training and enhanced technical support services.

Fairly enforcing regulations that avoid micromanagement and encourage innovative approaches requires state staff who are trained and kept abreast of state-of-the-art developments in long-term care. And the potential for high quality of care is enhanced by sharing with facilities the State's expertise on best methods and practices for complying with regulations.

Recommendation 4-D: The Governor and the Legislature should revise restrictions on RCFE medication practices while at the same time safeguarding consumer protections.

The elderly are a population that is already at risk for over-medication and incorrect usage of medication. But a system that requires event-by-event phone calls to physicians for permission to provide residents with over-the counter cough medicine and aspirin seems to serve no one's best interests.

Recommendation 4-E: The Governor and the Legislature should couple a strengthened process for protecting residents from unwarranted evictions with the creation of a limited probation period when a resident can be asked to move without cause.

While residents should be protected from summarily being forced from a facility, RCFEs also should have tools at their disposal to ensure that residents can live together comfortably.

Recommendation 4-F: The Governor and the Legislature should request that the federal government restructure its health information collection process to include specific data on residential care facility residents.

The federal government should be encouraged to use the Census process to collect data on people who live in different types of out-of-home arrangements. In addition, the federal government's American Housing Survey suffers from the problem of lumping together everyone who lives with more than five unrelated people (including college dorms and half-way houses) rather than examining information by specific categories.

There is little mystery about what an effective, consumer-preferred long-term care system would look like. For years, if not decades, advocates have described a continuum of care that would provide freedom of choice and the least-restrictive type of assistance as a person moves from independence to assisted living to total dependence. Unfortunately, there has been little progress toward such a system.

The Little Hoover Commission believes the timing of this report -- which synthesizes the best-practices trends across the nation -- should enhance the opportunities for reform. The State has already taken good-faith steps toward a home- and community-based ethic of long-term care by creating an integrated services pilot project for five areas of the state and revising the Older Californians Act. The State can continue down this path by providing the oversight structure and leadership to nurture these initial steps.

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APPENDIX A
Witnesses Appearing At
Little Hoover Commission Long-Term Care Public Hearings

February 28, 1996
Sacramento

Richard K. Matros
California Association of Health Facilities

Daniel Polakoff
Gray Panthers

Dr. Dennis Stone
California Association of Medical Directors

Carol Widemon
Department of Social Services

Pat McGinnis
California Advocates for Nursing Home Reform

A. Alan Post
Former Legislative Analyst

Derrell Kelch
California Association of Homes and Services for the Aging

September 25, 1996
Sacramento

Ray Mastalish
California Commission on Aging

Lynn Friss Feinberg
Family Caregiver Alliance

Carol Widemon
Department of Social Services

Benson Nadell
San Francisco Ombudsman Program

Fred Miller
Department of Aging

Sue Hodges
Alameda County Public Authority

Brenda Klutz
Department of Health Services

Hale Zukas
World Institute on Disabilities

Marilyn Ditty
State Long-Term Care Advisory Committee

Mark Beckwith
ADAPT

Toby Kaplowitz
Public Interest Center for Long-Term Care

Lauri Evans
Butte Long-Term Care Network

Judy Boothby
California Dental Hygienists Association

Deborah Doctor
Alameda County Public Authority

APPENDIX B
Little Hoover Commission Long-Term Care Advisory Committee

A. Alan Post
Former Legislative Analyst

John Anderson
California Senior Assemblyman

Dixon Arnett, Director
Department of Aging

Carol Bell
Department of Aging

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California Association for Adult Day Services

Judy Boothby
Dental Hygienists

Teri Boughton
Assemblyman Martin Gallegos

Rocky Burks, Executive Director
Independent Living Services of Northern California

Beth Capell
CNA

Eric Carlson
Bet Tzedek

Michelle Castro
California State Council of Service Employees

Gloria Cavanaugh, Executive Director
American Society on Aging

Mary Charles
Older Women's League

Don Clark
Sacramento County Mental Health Board

Lesley Clement
Attorney at Law

Diane Cooper
The Peg Taylor Center

Sheree Crum

John Kehoe, Executive Director
Commission on Aging

Derrell Kelch
California Association of Homes and Services for
the Aging

Dorothy Kellner

Kathleen Kelly, Executive Director
Family Caregiver Alliance Inc.

Elisabeth Kersten
Senate Office of Research

Ruth Kletzing, President
California Chapter, Older Women's League

Nancy B. Knutsen

Ken Kruser
Addus Health Care

Francis Labaco
ACLU

Martha Lipka

Patricia Longo
Commission on Aging

Martha Lopez, Deputy Director
Community Care Licensing, DSS

Patricia Lorne
Senior Care Network (HMH)

Eldon Luce
San Mateo County In-Home Supportive Services

Gary Marshall
Ray Mastalish, Chairman

California Commission on Aging

John McCune, Vice Chair
California Commission on Aging

Pat McGinnis

California Association of Health Facilities

Rebecca Dowd
Resources for Independent Living

Jennifer Hendrick
California Association of Health Facilities

David Howard
AARP

John Daniel
American Association of Retired Persons/Sacramento

Bonnie Darwin
California Healthcare Association

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No. California Presbyterian Homes, Inc.

Mattie Sawyers Davis, LCSW
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Margaret DeBow, Deputy Director
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Lydia Missaelides
California Association for Adult Day Services

Martha Moehler
National Committee to Preserve Social Services

Irma Weissenberg, Chair
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Katherine Murphy

Benson Nadell, Program Manager
California Long-Term Care Ombudsmen

Ron Nelson, President
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Robert Newcomer
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Daniel Polakoff
Gray Panthers

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California Assisted Living Facilities Association	Sharon Raynor Aaron Read & Associates
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Carol Freels, Chief, Long Term Care & Special Projects Department of Health Services	Carol Risley, Executive Director Organization of Area Boards on Developmental Disabilities
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Calvin Groeneweg, R.N.	Ted Ruhig California Coalition of Seniors
Joe Hafkenschiel California Association of Health Services at Home	Tony Sauer California Federation of Independent Living Centers
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Jim Harrison, Commissioner Adult and Aging Commission	Tanner Silva Community Resources for Independence
Mark Heaney National Homecare Systems	Charles Skoien Jr. Community Residential Care Association of California
Phyllis Heath State Long-Term Care Ombudsman	Perri Sloane, MSG, MPA Jewish Family Service of Los Angeles
Senator Henry Mello Senate Subcommittee on Aging	Betty Soennichsen California Senior Legislature
Carole Herman Foundation Aiding the Elderly	Ila Swan
Elizabeth Hill Legislative Analyst	Assemblyman Tom Bordonaro Assembly Committee on Human Services
Anne Hinton Multipurpose Senior Services Program Site Directors Association	Lisa Trask UC Davis Geriatrics
Jack Horak Triple A Council of California	Burns Vick, Jr.
Sue Hodges Alameda County Public Authority	Lois Wellington, President Congress of California Seniors
Kim Hughes, California Office	Daniel Wessel

National Council on Aging

Michael Humphrey
Community Resource for Independence

Vic Ioppolo
Senior Legislature

Fahari Jeffers
United Domestic Workers of America

Vicky Jones, Director of Social Services
Twin Palms Care Center

Toby Kaplowitz, Deputy Director
Public Interest Center for Long Term Care

Carol Widemon, Deputy Director
Department of Social Services

Mark Wiesel, President
Greater L. A. Chapter, Huntington's Disease Society

Terri Williams, MSG
Watts Health Foundation, Inc.

Veronica Woodards
Lively Pines

Kathleen Zegalia

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UNIVERSITY OF MARYLAND

CENTER ON AGING

Public-Private Partnerships in Long-Term Care

Mark R. Meiners

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Director of The Robert Wood Johnson Foundation Program to
Promote Long-Term Care Insurance for the Elderly.

Edited by: Leslie C. Walker, Elizabeth H. Bradley, and Terrie Wetle,
*Public and Private Responsibilities in Long-Term Care, Finding the
Balance*. The Johns Hopkins University Press, Baltimore, 1998.

Meiners on Partnerships
like NY

CHAPTER 5

Public-Private Partnerships in Long-Term Care

MARK R. MEINERS

This chapter describes an innovative collaboration between public and private sectors to develop an insurance-based approach to financing long-term care. Principles of a Partnership model are outlined, and the utility of this model for a national program is explored.

Recent public policy debates stimulated by the Clinton administration's health care reform proposals sent two critical messages regarding the financing and organization of health care for the elderly and disabled: long-term care is important but expensive, and neither the public nor the private sector alone is capable of providing adequate funding for that component of the health care delivery system (Meiners, 1996). In order to begin to address major gaps in long-term care, the Clinton team recommended the following: incremental policy that encouraged innovation on the part of the states in the area of home and community care; improvements in means-tested public programs; and support for private-sector responsibility (Clinton administration, 1993). Underlying these proposals is the expectation that states will continue to have a major role in administering and reforming the U.S. long-term care system, and that progress will come about on an incremental basis.

Subsequent to the failure of the Clinton health care plan, concern about the financial prospects of Medicare and Medicaid has served to reinforce

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the incremental approach to long-term care system improvements. The recent passage of long-term care insurance tax clarification language in the Kassebaum-Kennedy legislation marked a first step. This legislation is intended to make long-term care insurance more visible and acceptable as a way to prepare for the risk of catastrophic long-term care costs. An early indication of the effect of tax-favored status of long-term care insurance is anticipated within the next few years, as the baby boom generation enters its fifties, the age for pre-retirement planning.

However, it is likely that more than just this incremental step is needed to address long-term care financing needs of the population (Freudenheim, 1996). Significant progress on long-term care will require a public-private financing partnership that includes consideration of Medicaid by careful design, not by default. The private market could be helped by government support of experimentation with new systems of care and financing. Government assistance could occur through innovation in the Medicaid program since it is the principal payer for long-term care. A new means-tested program for long-term care that is designed to complement private-market options is one logical way to proceed.

Means-testing for long-term care is the approach that states are most familiar with, since they have experience with this approach through administration of the Medicaid program. However, means-testing is unacceptable to some policy analysts and interest groups, who maintain that this approach leads to poorly funded, inadequate programs because the political constituency is not broad enough to advocate effectively against these trends. Strategies to minimize this risk must be developed, such as structuring a linkage of the means-tested program with long-term care insurance.

This is the approach being used in the Partnership for Long-Term Care program, a multistate initiative to create a model of long-term care financing that relies on both public and private responsibilities (Meiners & McKay, 1989). Supported by the Robert Wood Johnson Foundation (RWJF), the program focuses on the potential role that private insurance might play in filling the need for long-term care within the nation's health care system (Merrill & Somers, 1989; Somers & Merrill, 1991). This chapter discusses the design features of this program and some of the key learning experiences throughout program development and early implementation. The Partnership program is a real-time case study of one approach to balancing public and private responsibilities for financing long-term care.

Background

The concept of public-private partnerships

A public-private partnership may take many forms, depending on how broadly the issue is defined. For example, most long-term care is either provided by family and friends directly or purchased by them. The inter-relationship between public and private sources of support can be complicated. However, any realistic public intervention must support, not replace, individuals' willingness to accept personal responsibility for long-term care needs.

Private enterprise can be used to forge a strong public-private collaboration. This happens when high-quality, affordable products that meet long-term care needs as perceived by consumers and their families are developed and marketed. Examples that have recently emerged include the growing number of home and community care options, assisted living communities, health systems that are designed to integrate acute and long-term care, and long-term care insurance. Accordingly, one form of partnership is for the government to support the formulation and promulgation of such options, leaving the payment decision and responsibility up to the individual.

A more aggressive strategy is to reform the financing of long-term care. One approach is to segment the risk, covering some of it through public programs and leaving the rest as the responsibility of individuals. For example, the long-term care risk could be partitioned so that nursing home care is paid publicly and home and community care is paid privately. Another approach would require the individual to assume the initial risk, and the government to bear the long-term catastrophic risk. Currently, Medicare provides selected skilled nursing home and home care benefits while Medicaid offers extensive coverage of nursing home care. This configuration bears a striking resemblance to ideas of segmenting risk, although more by default than by design. The Partnership for Long-Term Care attempts to improve the system, within the limitations of current and future public financing.

The Partnership for Long-Term Care program

To stimulate the long-term care insurance market and to help balance competing pressures between product value and price, four states (California, Connecticut, Indiana, and New York) implemented an innovative

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long-term care insurance program. The program involves a public-private partnership that protects consumers from depletion of their assets in the financing of long-term care. Under an asset protection model, individuals who purchase a state-certified Partnership insurance policy are allowed to access Medicaid-covered benefits without becoming impoverished.

The states expect to benefit if the long-term care insurance market can be expanded to include those at risk of spending down their resources to the level of impoverishment where Medicaid must pay. Program incentives encourage the elderly and their children to buy insurance policies that will protect them from ever having to spend all of their life savings on home care or nursing home services. The policies may also serve as an alternative to the growing appeal of Medicaid estate planning (as discussed in Chapter 8).

Partnership long-term care insurance policies work in the following way. By buying a Partnership policy, a person qualifies for Medicaid benefits under special Medicaid rules. Once non-Partnership policy benefits run out, individuals must spend virtually all of their savings before they qualify for Medicaid. In contrast, when a Partnership policy's benefits are exhausted, the policyholder is permitted to retain assets equal to the amount his or her insurance paid out (in New York, policyholders can keep all remaining assets). The person is then eligible for coverage under Medicaid without having to entirely deplete previous savings.

Insurers participating in the Partnerships must meet the program certification standards (McCall, Knickman, & Bauer, 1991), which ensure that approved long-term care policies are of high quality. Among the standards required in each state are inflation protection and minimum benefit amounts. Participating insurers are also required to provide the state with information on purchasers of certified products and the utilization of benefits.

Asset protection models

There are two Partnership asset protection models. The model in California, Connecticut, and Indiana provides a dollar of asset protection for each dollar paid out by a state-certified long-term care insurance policy (Mahoney & Wetle, 1992). The program allows for a variety of product designs with benefits ranging from one year of coverage on up. This flexible approach allows persons of different means the option of choosing the amount of protection most in line with their resources and ability to pay.

The impoverishment protection feature of the Partnership programs being implemented by the participating states is designed to be budget-neutral. Impoverishment protection encourages individuals to plan for their long-term care needs by purchasing long-term care insurance protection in an amount commensurate with their assets. Thus, an individual with \$25,000 in assets might buy \$25,000 in insurance protection while another individual with \$150,000 in assets might buy \$150,000 in insurance protection. Insurance payments for long-term care services would be considered as equivalent to the spending of assets for the purpose of establishing Medicaid eligibility. Once on Medicaid, individuals would be able to keep control of assets up to the amount that insurance paid; income would still have to be applied toward long-term care expenses.

The opportunity to avoid impoverishment by buying long-term care insurance is an incentive intended to help those who are most at risk of depleting their resources when long-term care is needed. Middle-income elderly (\$20,000-\$40,000 per year) generally have less assets to protect and are least able to afford currently offered private insurance "lifetime" protection (four years or more) that would minimize the risk of impoverishment. Yet when they need long-term care, the cost of Medicaid (spending down assets and income to the poverty level) can very well be catastrophic. In order to have enough protection to cover the risk of an average length of stay, middle-income elderly in the current market must buy insurance benefits that often substantially exceed their assets. Consequently, the market for this type of insurance is unlikely to extend to this group without the impoverishment protection incentive offered by the Partnership. This incentive makes purchases of one to three years of protection both more meaningful and more affordable to those in the middle-income group, who are most at risk for spending down their resources and requiring Medicaid.

The asset protection model used by New York bases its incentive on time rather than the dollar amount of coverage purchased (Holubinka, 1992). Partnership policies in New York are required to pay three years of nursing home care, six years of home care, or some combination (with two days of home care equaling one day of nursing home care), after which all remaining assets are protected. A high priority of the New York approach is to offer a viable alternative to asset transfers (Nussbaum, 1992). With about 80 percent of its nursing home residents on Medicaid compared to a national average of about 60 percent, New York feels this approach is best suited to keeping people with significant financial means from using Medicaid unnecessarily. Transfer of assets is thought to be quite common

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in New York and such a growing phenomenon that any strategy which encourages individuals to take financial responsibility for their own care could yield savings to the state.

Program Analysis

Arguments in support of the Partnership

The Partnership states selected the strategy of linking the purchase of long-term care insurance to Medicaid eligibility after considering several alternatives (Meiners, 1988). The Partnership has a number of strengths. The program is fiscally conservative, helps middle-income people avoid impoverishment, serves as an alternative to Medicaid estate planning, promotes better-quality insurance products and consumer protection efforts, enhances public awareness regarding long-term care needs and options, and helps maintain public support for the Medicaid program (Meiners & Goss, 1994).

The Partnership provides a fiscally conservative form of premium subsidy in that only those who buy a policy and use the benefits receive the special protection. Program-related expenditures occur well after program initiation, and savings would be accruing to cover future costs. In contrast, traditional premium subsidies (including tax breaks) entail public expenditures at the time of purchase for all purchasers. Under the Partnership, middle-income people may obtain assistance with catastrophic long-term care expenses without becoming impoverished. Under special arrangements with the state, participating insurance companies can assure policyholders they no longer have to be impoverished to qualify for Medicaid. Assets protected under the Partnership can mean the difference between autonomy and dependence if a policyholder exhausts his or her insurance and still needs assistance.

Policymakers in recent years have devoted significant attention to the practice of Medicaid estate planning. Partnership purchasers have less reason to resort to legal maneuvering to hold on to their savings. The Partnership policies are an alternative to transferring assets to relatives or friends to avoid spending savings on long-term care. Participants can control their funds instead of worrying about how someone else might be handling their money. Policyholders also do not have to be concerned about state and federal government efforts to stop Medicaid estate planning. The states can pursue regulations to minimize Medicaid estate planning with less controversy, knowing people are being given a reasonable alternative.

The Partnerships bring the states into a close working relationship with insurers, providing both the means and the incentive to monitor insurer performance. Partnership policies are subject to a rigorous review beyond that conducted for non-Partnership policies and carry a stamp of approval from the states indicating they have meet rigid state certification requirements. Further, regulatory oversight is strengthened to help consumer protection and confidence. All participating insurers are required to provide the state with extensive data for program monitoring. The data will make possible a variety of special studies, including analysis of underwriting rules, utilization patterns, and insured event criteria.

As part of the program, educational campaigns are increasing public awareness about what long-term care is, risks of needing long-term care, and the limited financing options. The public information campaigns are multifaceted, directed at persons for whom long-term care insurance may be especially beneficial. This component of the Partnership has been successful in each of the states.

Finally, the Partnership program can help mitigate concerns about means-testing--that programs for the poor are poor programs because they lack broad-based political support. By linking the Partnership incentive to Medicaid and by including middle-income persons as potential Medicaid recipients, the constituency for the means-tested program can be enhanced rather than eroded.

Concerns about the Partnership program

In the early stages of program development, arguments against the Partnership were raised primarily by social insurance advocates, who viewed the program as an incremental step that would erode support for more ambitious reform (Meiners, 1993). As the Partnership was implemented, insurers voiced their dissatisfaction with certain aspects of the program design because it deviated from some of the standard approaches used to market this coverage and required extra attention beyond that for non-Partnership products.

As long-term care insurance began to emerge as a viable reform instrument, it was viewed by some as more an obstacle than a help with long-term care reform since it did not provide universal insurance. It was argued that any further growth of the private long-term care insurance market would both relieve public pressure for reform and build opposition to social insurance reform from private-sector advocates whose stake in future long-term care insurance policymaking increased. For advocates of

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social insurance, Medicaid, as a means-tested program, was viewed as part of the problem crying for a social insurance solution. The linking of long-term care insurance with Medicaid as a way to address financing problems of long-term care was philosophically unacceptable, if not damaging to the cause, for some advocates.

Concerns about the link to Medicaid also resonated with the Partnership insurers and their agents, as well as the program developers. The applicability of the model is limited because many state Medicaid programs do not offer comprehensive home and community benefits or a system of care management that supports the continuity of care desired in such a partnership. States that have not developed strong programs for the poor will have trouble justifying asset protection models. With discussion of block grant programs and cutbacks in federal funding, the future form and substance of Medicaid is uncertain.

This uncertainty surrounding Medicaid reinforces the standard marketing practice of insurance agents selling against Medicaid. A basic message from many insurance agents is to not depend on Medicaid, in fact, to avoid it at all reasonable cost. Compatible with this message has been the emphasis on lifetime coverage to assure avoidance of Medicaid. Over this early period of market development, the standard product has increased from three years (designed to cover the average of two and half years in a nursing home) to lifetime coverage.

These complexities have made getting insurance agents to understand and buy into the Partnership message more difficult than initially anticipated. Though lifetime coverage only assures avoidance of Medicaid if the product is inflation-protected and covers both nursing home and home care, these features are often relegated to secondary consideration in the marketing presentation. The bottom-up message of the Partnership—everyone should have some coverage, trading lifetime coverage for shorter, comprehensive, inflation-protected benefits, and then, if necessary, accessing Medicaid coverage without being impoverished—has been difficult to integrate into mainstream selling practices.

Equally important is the fact that the primary target audience for Partnership policies differs from the market agents have customarily worked with. Selling to the high end of the income and asset spectrum is easier than targeting sales to those most in need of the Partnership products. The problem is compounded by the fact that agent commissions are directly related to the size of the premiums they sell.

An additional factor that may work against Partnership sales is that the Medicaid rules under which the Partnership operates do not waive income

rules along with asset rules. As a result, income must be applied to the cost of care once insurance runs out. People expecting to have high income when they exhaust their insurance may not need the extra asset protection because their income will cover the entire bill. This tends to be a greater issue at the high end of the market, but can make the decision to choose Partnership coverage less attractive.

The lack of portability of the asset protection feature has also been cited as a barrier to sales. Since only a few states have Partnership programs and the details of each state's Medicaid program vary, reciprocity agreements that allow asset protection outside the home state have not been established at the time of this writing. While this has no effect on the value of the insurance benefit payment itself, it is a concern for those who feel they might move and depend on the asset protection feature as the primary motivation for choosing a Partnership policy.

The participating insurers have also cited state-by-state differences in Partnership program details as being too costly and time-consuming. Nearly all insurers participating in the Partnership maintained their regular product offerings. The Partnership policy development, approval process, and data reporting is an additional set of responsibilities they are required to carry out in order to participate in the program. Only in the case of the data reporting system have the participating states agreed to do things in a uniform way. In nearly every other aspect, even when states use the same asset protection model, knowledge of differences in program details are required for insurers participating in more than one state.

Another concern raised about the Partnership is that increased Medicaid costs could result because the extra protection offered by the states would be available to those who would have purchased long-term care insurance even without the Partnership incentive. The concern is that the program could not be targeted only to people who would otherwise not have bought long-term care insurance without the Partnership incentive (Nyman, 1994). Because there is an emerging market for long-term care insurance that has significant growth potential, the merits of this targeting problem have been debated (Meiners & Goss, 1994).

A related concern has to do with crowding out segments of the private market that might have emerged if the government-supported asset protection incentive were not offered. For example, this could happen if someone who would have bought lifetime inflation-protected coverage instead buys a shorter, less expensive Partnership policy because of the asset protection.

In summary, there are essentially three perceived drawbacks of the Partnership approach. The first is political in nature, that is, this incremental

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step takes the wind out of radical, comprehensive reform of long-term care. The second is somewhat process-oriented. Getting both the insurers and agents to truly buy in to the concept and promote it effectively can be challenging. Finally, there are issues of economic efficiency having to do with targeting the incentive and possible crowding out private responsibility for financing care.

Experiences in Partnership Implementation

Most of the arguments for and against the Partnership share common elements viewed from different perspectives. Central to the strategy is the fact that Medicaid is the primary public payer for long-term care, that states are the key decision-makers regarding Medicaid rules and insurance regulation, and that the states must determine that programs are budget-neutral before undertaking efforts to provide incentives for insurance purchase. At the time when the Partnership programs were initiated, two countervailing forces clashed. First, state interest in the Partnership grew well beyond the four states funded by the Robert Wood Johnson Foundation. In fact, twelve states passed enabling legislation to create programs modeled on the RWJF program.

Second, the Omnibus Reconciliation Act of 1993 (OBRA 93), enacted the same year as the RWJF Partnership was implemented, contained language with both indirect and direct impact on the expansion of Partnership programs. Indirectly, the act closed several loopholes in the Medicaid eligibility process, thereby providing further incentives for persons to purchase private insurance for long-term care. The act also makes specific mention of Partnership programs. The statute contains a grandfather clause that recognizes as approved the four initial states, plus a future program in Iowa and a modified program in Massachusetts (protecting only the home from estate recovery). These states were allowed to operate their partnerships as planned since the Health Care Financing Administration had approved their state plan amendments before May 14, 1993.

While states obtaining a state plan amendment after that date are allowed to proceed with Partnership programs, they are also required to recover assets from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the Partnership is in effect only while the insured is alive. After the policyholder dies, states must recover what Medicaid spent from the estate, including protected assets. With participating insurers already concerned about variability in state-by-state approaches, this has had the effect of stifling the growing interest in replicating the Partnership in other states.

Partnership policy sales

Partnership policy sales at the time of this writing indicate steadily growing interest in public-private long-term care insurance policies. However, the numbers also reveal that the public is still wary about the need for such policies. The following are highlights from Partnership policy sales in four states (California, Connecticut, Indiana, and New York) as of June 30, 1996. At that time, the programs had between two and four years of experience, with Connecticut first (1992) and California last (1994) to implement.

More than 26,000 applications had been received for the purchase of Partnership policies by mid-1996 across the four participating states. From these applications, almost 20,000 Partnership policies were purchased (there is a lag between application and purchase). Of these purchases, there are currently more than 15,000 policies in force in the four states. Three of the four states (California, Connecticut, Indiana) allow the sale of one- and two-year Partnership policies. The proportion of purchasers in these states buying one- and two-year policies remains high (California: 91%, Connecticut: 49%, and Indiana: 40%). The majority of Partnership policy purchasers are first-time buyers. The proportion of first-timers ranges from a high of 95 percent in California to a low of 79 percent in Indiana. A significant proportion of Partnership policy purchasers are under age sixty-five, ranging from a high of 56 percent in Connecticut to a low of 31 percent in California.

Variations on the Partnership theme

Several states decided to proceed with Partnership programs in the aftermath of the OBRA 93 restrictions. Believing that access to Medicaid coverage without impoverishment was a major benefit for citizens, Maryland and Illinois secured state-plan amendments to offer Partnership programs modified to meet the OBRA 93 requirements. Both states modified the programs developed and implemented by their predecessors.

Maryland decided to make state-certified long-term care insurance policies eligible for asset protection rather than have special rules associated with Partnership policies. This approach made the Partnership strategy more visible and eliminated marketing against the Partnership. Though targeting concerns might be exacerbated by this approach, it was also a way to develop widespread knowledge concerning the Partnership incentive among the middle-income people who need the protection most.

One major change implicit in this model was that Maryland did not

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require inflation protection. In the development of the RWJF Partnership program, inflation protection was a major point of contention with the insurers and the agents, who preferred that inflation protection not be required since the related significant price increase reduces demand. However, all the RWJF Partnership states require inflation protection because they feel it is important to the budget neutrality of the program. It also helps assure the states' promise of protection of assets. Without inflation protection, the growing cost of deductibles and co-pays could impoverish a policyholder before much asset protection can be secured. Maryland planned to deal with the inflation issue through consumer education campaigns, leaving the choice to consumers.

As the Maryland approach has not been implemented, this Partnership strategy has not received a market test. Maryland tabled its program because of concerns about the estate recovery language in OBRA 93. The definition of the estate is broader than currently in use in Maryland, which would have the potential of penalizing insurance purchasers relative to those who had not purchased insurance—quite the opposite of the intent of the program (McKay, 1995).

Illinois, the other state approved after OBRA 93, did not share this concern with Maryland and has implemented its program. Although initially Illinois chose the dollar-for-dollar model, the state recently revised the program, developing a hybrid approach that switches to total asset protection for those who buy \$200,000 of protection. The required inflation protection is optional. These changes were made to stimulate sluggish insurer interest. At this writing, it is too soon to tell whether the changes will overcome the perceived problems.

Colorado took yet a different approach in the face of the OBRA 93 estate recovery provisions. The state legislature requires that any insurer certified to sell insurance in Colorado must also actively market a basic and a standard policy that meets specific requirements, using the insurers' normal sources and methods of distribution. The basic plan was to be one that would be affordable to purchasers of moderate income, while the standard plan was to reflect the features most commonly sold in the existing market (middle- or high-income purchasers). No special asset protection provisions were made. The Colorado strategy combines the dissemination of a shopper's guide along with a consumer education campaign and relatively simple comparable product offerings to focus attention on long-term care insurance and help consumers make an educated purchase decision.

Another model of note has been implemented by the California Public Employees Retirement System (CalPERS) in cooperation with the Cali-

foria Partnership program. The CalPERS long-term care insurance program is a group offering for active public employees, retirees, and their dependents designed to achieve lower premiums through group marketing economies. A range of ten options was offered, which included a one-year and a two-year Partnership policy. Through this initiative, California took the lead in encouraging employer-group offerings as a way to mainstream this type of protection at younger ages, when it is especially affordable. CalPERS is self-funding and relies on its own investment expertise, thereby freeing itself from a number of regulatory and reserving requirements normally exercised by the State Insurance Department.

In a span of only eighteen months over seventy thousand policies were sold (about 5 percent were Partnership policies). A new open period offering will be launched during 1997 so the self-funded CalPERS program may soon be among the largest group long-term care programs in the country. This initial success has been attributed to three key ingredients (Mahoney, 1995). First, CalPERS' solid reputation for managing health care costs without sacrificing quality of care gave it special credibility with this completely new program. Second, the design of the product was based on elements members had identified as essential and simplicity was emphasized. Third, CalPERS and United Health Care (the private contractor administering the program) made a serious commitment to member education and marketing efforts.

Finally, the Partnership insurance strategy has also captured international attention. Great Britain, faced with long-term care gaps in its public funding systems similar to those in the United States, is in the early stages of debating the details of a national version of the RWJF Partnership program (HM Secretary of State for Health, 1997). It appears the favored scheme is the pound-for-pound, modified to provide a greater incentive (pound and a half or even two pounds of asset protection) and greater assurance that protection of the home will be accomplished for those at the low end of the resource spectrum.

Movement to a National Partnership

The idea of a uniform nationwide public-private partnership approach that uses extra asset protection as an incentive to buy long-term care insurance is not new. It has been suggested by representatives of both political parties. In 1990, then Senators Packwood and Dole took the lead in proposing such an approach, along with a revised Medicaid program designed to be more uniform across the states (Packwood & Dole, 1993). More recently,

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to complement the Clinton long-term care proposals, Senators Kennedy and Wofford proposed a self-funded public insurance program for nursing home care very much modeled on the RWJF Partnership for Long-Term Care (Kennedy & Wofford, 1994). The voluntary program included a special incentive of asset protection from Medicaid rules of \$30,000 to \$90,000, depending on the amount of insurance purchased. The proposed program was to be publicly run, with more liberal enrollment rules than private insurance. It would have allowed all individuals to enroll during an open period at each of ten-year intervals, beginning at age thirty-five, regardless of preexisting conditions.

Because state-by-state development is costly and dependence on Medicaid as the basis for the stop-loss protection does not easily allow for reciprocity agreements between states, the idea of uniform national partnership has prompted discussions among the states and insurers who have been most active in the current RWJF Partnership effort. However, consensus on how to implement a national partnership program that would simplify the implementation and operation for states and insurers has been difficult to achieve. Two approaches have emerged from these efforts.

One approach is to determine a set of insurance features that would comprise a Partnership policy approved by all participating states. From this cafeteria of features, insurers could choose the details of their Partnership product and receive timely approval in those states. The set of features and approval process would be independent of what the participating state did with non-Partnership products. The strength of this approach is that it achieves uniformity across the states in all basic Partnership policy features. The weakness is that insurers offering Partnership and non-Partnership policies would still have two separate products with separate filing requirements. One suggestion to further simplify this approach is to have the Partnership product reflect a limited set of options (e.g., a two-year and a four-year policy only) with the features fully standardized.

The second approach is to distinguish a Partnership policy by requiring a limited set of features such as inflation protection and uniform data reporting. The remaining features would be the same as those for non-Partnership policies in the participating states. The approval process would be expedited and paperwork minimized by allowing companies to use their current policy as the base, with the option of including the Partnership requirements if they wanted it to qualify for the special asset protection. Although both approaches require agreement on Partnership features, the second approach requires agreement on a smaller set of features. The second model may also be easier for states to accept, as it fits with the current

insurance regulatory environment, where states have considerable control over what gets sold.

None of this addresses the issue of Medicaid as the backup (payer of last resort). The asset insurance model and a more uniform means-tested long-term care program in the states would be mutually complementary. Yet improvements to the means-tested program can only be sustained as affordable and appealing private-market financing options serve to prevent people from using those benefits except as a legitimate last resort.

By linking the Partnership incentive to Medicaid (or a new means-tested long-term care program), the constituency for the means-tested program may be enhanced rather than eroded. As noted earlier, this strategy is intended to help secure middle- and upper-class support for a viable and quality means-tested program by making it part of what they may also need to depend on in the face of otherwise catastrophic long-term care expenses. However, insurance agents often find it easiest to market against Medicaid. This basic conflict has yet to be resolved in the Partnership program.

One approach to this problem would be to separate the asset protection from Medicaid. This could be done by creating a new entitlement under Medicare that would require the purchase of a certified private long-term care insurance policy in exchange for a commitment to protect some level of assets. A less ambitious alternative step in this direction would be to create a new optional benefit in which states could choose to contribute to a backup pool (perhaps with federal matching funds like with Medicaid) with reciprocity arrangements for participating states. The key to either of these approaches is that the stop-loss incentive is removed from its direct link to Medicaid, which would eliminate concerns about variability across states and over time. It could also serve to allow for some combination of income and assets to be protected. The recent movement toward product standardization under the tax qualification requirements of the Kassebaum-Kennedy legislation might serve to facilitate agreements on the qualifying features.

Next steps in program development

A key question in research and program development is identifying the problem that needs to be solved. Even among those actively involved in the development and implementation of the Partnership program, there is disagreement about the nature and scope of the long-term care financing problem. The original goals of the Partnership program centered on helping consumers take more personal responsibility for paying for long-term

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care by increasing the value and affordability of long-term care insurance. The intervention needed to be at least budget-neutral and work from existing state and federal financial and administrative structures so as to allow for incremental learning and acceptance. Furthermore, the program needed to be an effective vehicle for educating consumers about the probability of needing long-term care, as well as the availability and benefits of quality long-term care insurance coverage for individuals with middle and modest levels of income and assets.

These are ambitious goals, particularly since they did not completely coincide with the goals of some of the key partners, the insurers and the agents. Throughout the development and implementation of the Partnership program, tax clarification was the primary public policy goal of the long-term care insurance industry. It was viewed as a way to show that the government supported the role of private insurance in protecting against this risk. Equally important was that tax clarification signaled that the government was not going to pursue a broad-based new entitlement. However, since these were also reasons for supporting the Partnership program, a cooperative working relationship has emerged, with potential for further development.

As the market matures and the effect of the Kassebaum-Kennedy legislation becomes clear, it is likely that there will be renewed interest in finding ways to reach the broader market. The lessons learned in the Partnership program will be valuable to that renewed interest. At least two possible options fit within the framework of incrementalism. One option is to revise the product design to make it as identical to that offered in the market as possible, given the goals of the program. This would relieve the burden of creating and receiving approval for two separate products. The other option is to develop selective partnering strategies along with distribution channel innovations that emphasize lifetime protection as the top priority in a marketing approach.

Bottom-up marketing would convey that everyone needs some protection against the risk of long-term care and should buy as much as possible, using their resource base as a guide. This message would be targeted to groups of potential purchasers of middle and modest means at risk of impoverishment if they needed long-term care. Prospective purchasers would be coached to make their purchase decision by assessing the level of resources that they would like to have at their disposal while still qualifying for Medicaid's help.

As the next steps unfold, some version of both these strategies may be tried. However, without the repeal of the OBRA 93 restrictions on

Partnership-style asset protection, it may be difficult to stimulate the multistate interest necessary to justify the commitment of resources by insurers and their agents to support these alternative marketing strategies. But there is growing recognition that states need flexibility in dealing with the pressures on the Medicaid system and that private long-term care insurance is a needed alternative to public financing. The National Governors' Association has recently called for elimination of federal barriers to public-private insurance Partnerships like those in the RWJF states and the expansion of authority to all states to implement such programs (National Governors' Association, 1997). Future efforts will also involve investigation of strategies that do not depend on direct links to Medicaid. For example, the growing interest in managed care for both Medicare- and Medicaid-eligible populations has promoted greater recognition of the potential value of integrating acute and long-term care. Minnesota, Colorado, Florida, New York, and Wisconsin, to name a few states, are developing managed care programs for those eligible for both Medicare and Medicaid. These programs have as their goal better, more cost-effective care through the integration of provider systems and the coordination of care. Though the initial focus is on public-pay clients, the delivery system development lessons are equally relevant to long-term care insurance links that might be made with Medicare managed care products as the private-market alternative for those not eligible for Medicaid.

Conclusions

Strategies for enhancing the market for private long-term care insurance abound. The menu of options originally suggested as the impetus for the Partnership program remains relevant today (Meiners, 1988). Options can be categorized into the following four distinct, but related, target categories.

The first category focuses on general public policy interventions. It includes educational campaigns to enhance public awareness, regulatory review to encourage market flexibility while promoting consumer protection, support for improved data development and sharing to minimize uncertainty, and coordination of public cost and care management mechanisms (e.g., preadmission screening, utilization review, case management, benefit coverage, and rate regulation) with those of the private market. The second category focuses on consumers. It includes tax credits or deductions, deductible or co-pay subsidies, and inflation protection in addition to liberalized asset spend-down requirements. The third cate-

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gory focuses on insurers and premium tax relief and public reinsurance. The fourth category focuses on special populations and notes buy-in of Medicaid-eligible and special risk pool subsidies. The dilemma faced in moving forward with long-term care reform is that different approaches—universal social insurance versus means-testing—make compromise difficult (Meiners & McKay, 1990; Mahoney & Meiners, 1994). During the development of the Clinton long-term care plan, there was clear tension between the preference for universal social insurance and the realities of budget constraints. The Clinton plan, on the one hand, supported private action and preparation through tax clarification and national insurance regulations. On the other hand, the plan proposed a home and community care benefit that leaves the impression that government programs will be sufficient to meet individual needs even though the details really suggest a “capped entitlement” to states, a more limited policy. There was considerable concern on the part of the states regarding the proposal’s implementation, given their fiscal constraints.

To have effective private financing options, a clear delineation of where the public role ends and personal responsibility begins is required. This is especially the case if individuals are expected to plan for and bear some of the risk of chronic disability. If planning does not occur, more people will be dependent on public support. There is a need to commit to a vision for the future, because long-term care is a risk that will require prefunding if it is to be affordable either privately or publicly. Incremental solutions would seem to make sense both in terms of the cost and the experience necessary for solid progress to be made.

References

- Clinton Administration. (1993, September 7). *Description of President's Health Security Act of 1993*. Bureau of National Affairs, Washington, DC.
- Freudenheim, M. (1996, November 17). Deductions coming for long-term care: Incentives to buy insurance may not entice many boomers. *New York Times*.
- HM Secretary of State for Health. (1997). *A new partnership for care in old age*.
- Holubinka, G. (1992). New York Partnership for LTC Insurance. *LTC News & Comment*, 3, 9-10.
- Kennedy, E. M., & Wofford, H. (1994). Senate Bill 1833, 103d Cong., 2d Sess.
- Mahoney, K. J. (1992). Financing long term care with limited resources. *Journal of Aging and Social Policy*, 4, 35-50.
- Mahoney, K. J. (1995, November 6-7). Strategies for making private long-term care insurance more accessible to the middle class: Lessons from the California experience. Prepared for the Florida Commission on Long-Term Care's Legislative Symposium.

- Mahoney, K. J., & Meiners, M. R. (1994). Private and social insurance—the feasible option. *Western Journal of Medicine*, 160, 74–76.
- Mahoney, K. J., & Wetle, T. (1992). Public-private partnerships: The Connecticut model for financing long-term care. *Journal of the American Geriatrics Society*, 40, 1026–1030.
- McCall, N., Knickman, J., & Bauer, E. J. (1991, Spring). Public/private partnerships: A new approach to long-term care. *Health Affairs*, 164–176.
- McKay, H. (1995, August 23). *Partnership implementation post OBRA '93*. Partnerships for Long-Term Care memo.
- Meiners, M. R. (1988). Enhancing the market for private long-term care insurance. *Business and Health*, 5, 19–22.
- Meiners, M. R. (1993). Paying for long term care without breaking the bank. *Journal of American Health Policy*, 3, 44–48.
- Meiners, M. R. (1996). The financing and organization of long-term care. In R. H. Binstock, L. E. Chaff, & O. von Meiring (Eds.), *The future of long-term care*. Baltimore, MD: Johns Hopkins University Press.
- Meiners, M. R., & Goss, S. C. (1994). Passing the "laugh test" for long-term care insurance partnerships. *Health Affairs*, 13, 225–228.
- Meiners, M. R., & McKay, H. L. (1989). Developing public-private long-term care insurance partnerships. *Pride Institute Journal*, 8.
- Meiners, M. R., & McKay, H. L. (1990). Private versus social long-term care insurance: Beware the comparison. *Generations*, 14.
- Merrill, J. C., & Somers, S. A. (1989). Long-term care: The great debate on the wrong issue. *Inquiry*, 26, 317–320.
- National Governors' Association. (1997). Executive committee winter meeting recommendations.
- Nussbaum, S. (1992). The New York State Partnership for Long-Term Care. *The Bulletin—Official Publication of the New York City Association of Life Underwriters*, 72, 27–36.
- Nyman, J. A. (1994). The economic and political feasibility of long-term care insurance partnerships. *Health Affairs*, 13, 220–224.
- Packwood, R., & Dole, R. (1993). Senate Bill 1600, 103d Cong., 1st Sess.
- Somers, S. A., & Merrill, J. C. (1991). Supporting states' efforts to provide long-term care insurance. *Health Affairs*, 10, 177–179.



ADMINISTRATION ON AGING

The Ombudsman Program: Investigating Complaints About Nursing Home Care

Professional ombudsmen, working with citizen volunteers, have made a dramatic difference in the lives of nursing home residents since the Long-Term Care Ombudsman Program was started by the Administration on Aging (AoA) 25 years ago.

Through periodic visits to nursing homes and response to telephone complaint lines, ombudsmen have exposed problems hidden from public view, resolved specific complaints, protected residents' rights, and given emotional support to lonely older people.

State Ombudsmen Programs

Originally a demonstration program funded by the AoA, the Ombudsman Program was incorporated into the Older Americans Act in 1978, the law that provides for home-delivered meals and a wide range of other services for older Americans. Over the years, the program was expanded to cover not only the nation's 18,900 nursing homes, but 35,000 board and care homes, plus other long-term care facilities.

The AoA and its nationwide network of 57 State and Territorial Units on Aging, 655 Area Agencies on Aging (AAA's), 221 Tribal Organizations, and some 27,000 service providers have always been concerned about the care received by the elderly in long-term care facilities, and with the growth in the older population this will become increasingly important.

Ombudsman--Who or What Is It?

According to *Webster's Dictionary*, an ombudsman, originally a Swedish word, is "a public official appointed to investigate citizens' complaints against local or national government agencies that may be infringing on the rights of individuals."

In 1995, 6,400 certified volunteer ombudsmen, backed by 900 paid staff, investigated 218,455 complaints from residents of long-term care facilities, family members, and professionals. Seventy percent of these were fully or partially resolved. One-third of these complaints were about poor resident care--ranging from cold food and enforced early bedtimes to verbal abuse, medical neglect, and even wrongful death.

There are 52 **State Long-Term Care Ombudsman Programs**, which support ombudsman staff and volunteers in 564 local programs. The AoA provides national leadership to the states in carrying out their ombudsman programs. The AoA also funds an Ombudsman Resource Center that offers training and technical assistance to ombudsmen throughout the country. Located in Washington, D.C., the Center is operated by the National Citizens' Coalition for Nursing Home Reform in conjunction with the National Association of State Units on Aging.

Funding for ombudsman programs totaled \$40.9 million in 1995, 60 percent of which was federal money and 40 percent, state and local funds. Although these figures indicate a sizable network, insufficient funding and staff are placing a strain on ombudsman programs everywhere as they try to meet demands for assistance from families concerned about relatives in long-term care.

A 1994 National Academy of Sciences study of the Long-Term Care Ombudsman Program recommended hiring 300 additional ombudsmen nationwide to lower the current estimated ratio of one full-time professional ombudsman for every 2,700 nursing home beds to one for every 2,000 beds.

Nursing Home Reform Law

Nearly 70 percent of nursing homes today are for-profit businesses that receive about \$20 billion in Medicare and Medicaid dollars. While federal and state funds pay 60 percent of the bills in nursing homes that accept Medicare and Medicaid patients, these homes only became subject to stringent federal standards with the passage of the Nursing Home Reform Law of 1987 and publication of regulations to implement that law in 1990.

The law's regulations cover many aspects of resident care and rights, mandate training of nursing home aides, require that nursing homes be inspected every 9 to 15 months, and direct that the state survey report on the results of this inspection be available to the public. As important as these inspections are, they usually occur annually, leaving ombudsmen to provide the only day-to-day source of protection for nursing home residents.

Ombudsmen Spot Problems

Ombudsmen often detect mood or health changes in residents that are overlooked by busy staff. "We are an outside eye, so we notice if something is strange. We get to know residents and see changes," commented Kathy Gannoe, director of the ombudsman program in Lexington, Kentucky. "The genius of our program is that first, we hire older people, and second, our people live near the nursing homes they visit."

How to Contact an Ombudsman

To find the phone number of an ombudsman who can investigate your complaint, call the AAA nearest to the nursing home or long-term care residence where you or your elderly relative lives. The AAA will know the telephone number of the ombudsman program covering that residence. AAA's are listed in the government section of the telephone directory, usually under "aging" or "elderly" services.

If you can't find the number of the AAA in the telephone directory, you can obtain it by calling AoA's **Eldercare Locator** at 1-800-677-1116.

The retired teachers, nurses and other seniors (the oldest is 83) who work part time for the Lexington program often have ties to nursing home residents and their families. Gannoe stressed that the ombudsman program "helps to reconnect the nursing home to the community."

The Lexington program has two full-time and 33 part-time employees visiting nursing homes as often as four times a week. Communities in other parts of the country, however, may only have enough staff and volunteers to visit nursing homes once a month or board and care homes once a year. Some states rely on a statewide hotline to handle complaints.

While the programs differ, the problems faced by many nursing home residents are the same--unappetizing food, call buttons that go unanswered, poorly trained staff or a shortage of staff, inadequate infection control, and unnecessary use of physical restraints or tranquilizing drugs. To quote one advocate for nursing home residents, "The public would rather not hear about the things I've seen." Nevertheless, the public needs to know more about what goes on inside nursing homes, because, according to one study, 43 percent of the 2.2 million Americans who turned 65 in 1990 will enter a nursing home at some point in their lives.

Requests from ombudsmen to change nursing home practices often carry more weight than complaints lodged by a family member. "It is in the nursing home's self-interest to do better when an ombudsman is insisting on it," commented Kathy Gannoe. "The elderly ladies who work for my program may look like apple-cheeked grannies," she remarked, "but they have spines of steel."

Ombudsmen Also Detect Medicare Fraud

Ombudsmen are also saving taxpayers millions of dollars by helping to detect Medicare and Medicaid fraud. Nursing facilities are common targets for fraudulent schemes--doctors who falsify bills to Medicare and Medicaid for services never provided and scams in which companies overcharge for nursing supplies.

One physician billed \$350,000 over a two-year period for physical examinations of nursing home residents, without ever seeing a single patient. In another case, a woman masterminded a \$7 million nursing home supply scam in which Medicare was billed \$5 each for gauze dressings that cost a penny a piece. As part of "**Operation Restore Trust (ORT)**," the Administration's two-year effort to identify and prevent waste, fraud and abuse, ombudsmen in selected states are trained to identify and report this kind of fraud and to educate families and professionals on how to spot abuses. Recent legislation will allow continuation of the training over the next several years and expand ORT to 10 more states.

Additional information is available from:

Resources for Families

Guide to Choosing A Nursing Home is an 18-page booklet available free from the Health Care Financing Administration, 7500 Security Boulevard, Baltimore, MD 21244-1850, (410) 786-7843.

Nursing Homes: Getting Good Care There is a 165-page paperback book issued in 1996 by the **National Citizens' Coalition for Nursing Home Reform** (NCCNHR). It is mainly a guide for families who already have a relative in care but would also be helpful to families in choosing a nursing home. The book tells about good care practices, residents' rights and staff responsibilities, and explains the laws and government regulations that give you the power to get good care. To order, send \$15.40 (includes postage) and make checks payable to: NCCNHR, 1424 16th St., NW, Washington, DC 20036

Administration on Aging

U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Telephone: (202) 619-0724

TDD: (202) 401-7575

Fax: (202) 260-1012

E-Mail: aoainfo@aoa.gov

Internet Web Site: <http://www.aoa.gov>

Everyone can help to end health care fraud, which also occurs in home health care services, hospice care, and in the durable medical equipment industry. **If you observe questionable practices, call the Health and Human Services Confidential Tip Line:**

1-800-HHS-TIPS (1-800-447-8477)



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The Resource Directory for Older People

A Cooperative Effort of the National Institute on Aging and the Administration on Aging

National Long-Term Care Ombudsman Resource Center

National Citizens' Coalition for Nursing Home Reform
Suite 202
1424 16th Street NW.
Washington, DC 20036
(202) 332-2275
FAX (202) 332-2949
Internet: <http://www.nccnhr.org/>

Mission

The National Long-Term Care Ombudsman Resource Center supports the ongoing development and operation of the 52 stateside long-term-care ombudsman programs. These programs function under a Federal mandate to investigate and try to resolve the problems experienced by the residents of long-term-care facilities. The mandate includes both individual and systemic advocacy to improve the quality of life for residents.

Services

- The Center provides technical assistance to State and regional ombudsman programs in the area of program development, program management, and on substantive issues as they impact residents. The Center provides consultation, training, and printed resource materials. The service is housed at the National Citizens' Coalition for Nursing Home Reform and is provided in cooperation with the National Association of State Units on Aging.

Publications

InfoBulletin, a newsletter published five times a year for the network, is available on request.

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Real People Real Problems:

An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act (Summary)

Summary

Long-term care (LTC) ombudsmen^[1] advocate to protect the health, safety, welfare, and rights of the institutionalized elderly in nursing facilities^[2] and board and care (B&C) homes. Given the dramatic changes that are occurring in the entire LTC sector, the need for such advocates is compelling. A multiplicity of factors--sociodemographic, economic, political, and clinical--are converging in ways that call for significant attention to the quality-of-care and quality-of-life needs of all persons needing LTC services.

"LTC services" is a broad term that describes a constellation of services used by people with disabilities to achieve a meaningful life according to their own expectations and yardsticks. These services include health care, social services, housing, transportation, and other supportive services. Typically, LTC is associated with the elderly, although many older persons never require such care and many who are not elderly do require LTC services. Elderly residents of LTC facilities (nursing facilities, B&C homes, and other group residential homes) are the designated constituency of ombudsmen.

ORIGINS OF THE STUDY AND REPORT

This report from the Institute of Medicine (IOM) addresses important aspects of the LTC ombudsman program--specifically the LTC ombudsmen's ability to deal with problems that affect the care provided to and the quality of life achieved by elderly residents of LTC facilities. The ombudsman program arose in response to the widespread perception of problems in nursing facility quality. The program began in 1972 through five state demonstration projects that were funded by the Department of Health, Education, and Welfare's Health Services and Mental Health Administration. The Administration on Aging (AoA) received responsibility for the program during a departmental reorganization in 1973 and has retained that responsibility over the past two decades.

Recently, policymakers--at the urging of ombudsmen themselves--concluded that a more in-depth examination of the program is warranted, with the aim of clarifying present strengths and weaknesses and assessing the program's potential for future contributions. To this end, the Congress of the United States directed, in the 1992 reauthorization of the Older Americans Act (OAA), that the Assistant Secretary for Aging conduct a study of the state LTC ombudsman programs. Through a contractual arrangement, the IOM carried out the study.

This report is the culmination of that work, which commenced in October 1993. To conduct the study, the IOM appointed a 16-member expert committee comprising individuals recognized for their expertise in LTC, medicine, medical sociology, health care policy and research, clinical research, health law, health care administration, state government policy and program administration, consumer advocacy, public health, voluntarism, and the LTC ombudsman program (for details of committee members' backgrounds and specialties, see Appendix D).

The committee's report examines four key issues:

1. the extent of compliance with the program's federal mandates, including conflict of interest issues;
2. the availability of, unmet need for, and effectiveness of the ombudsman program for residents of LTC facilities;
3. the adequacy of federal and other resources available to operate the programs; and
4. the need for and feasibility of providing ombudsman services to older individuals who are not residing in LTC facilities.

To inform itself on issues pertaining to this charge, the committee engaged in a variety of factfinding activities. These included site visits, seven commissioned papers, numerous contacts with a wide array of ombudsmen and individuals with whom they interact, a one-day invitational symposium, and two meetings of a technical panel.

THE LONG-TERM CARE OMBUDSMAN PROGRAM

Concerns with the quality of nursing facilities, the care provided in them, and the government's ability to enforce regulations in them led to the creation of the LTC ombudsman program in the early 1970s. In contrast to regulators, whose role is to apply laws and regulations, ombudsmen are supposed to help identify and resolve problems on behalf of residents in order to improve their overall well-being. The ombudsman program works alongside other programs, groups, and individuals engaged also in efforts to improve the quality of care and quality of life of residents in LTC facilities.

Although the classic model of the ombudsman stresses neutrality and mediation, the role of the LTC ombudsman is considered a hybrid, since it was designed to encompass both active advocacy and representation of residents' interests over those of other parties involved. Additionally, in the classic model the ombudsman intervenes between the government and individual citizens. In the case of the LTC ombudsman program, however, intervention usually also includes a private third party--the nursing or B&C facility.

Today the LTC ombudsman program operates in all 50 states, the District of Columbia, and Puerto Rico. No single model can accurately describe these multifaceted programs. Variability in organizational placement, program operation, funding, and utilization of human resources has given rise to at least 52 distinctive approaches to implementing the program. The Office of the State LTC Ombudsman program is most often housed within the state unit on aging (SUA); 42 states have this arrangement. The SUAs in these states themselves vary in their organizational placement: some are housed in independent, single-purpose agencies; some reside in larger, "umbrella" agencies in which several other agencies report to a head office. Others are housed in independent state-run ombudsman agencies. Some even operate completely outside state government. Recent estimates of LTC ombudsman staffing put the number of full-time equivalent (FTE) paid staff at about 865. Volunteer ombudsmen number about 6,750, excluding volunteers who serve chiefly on advisory committees.

Funding for LTC ombudsman programs is patched together from multiple sources at the federal, state, and local levels. Most federal funding comes from the OAA. Sources for other funding include state and local governments, area agencies on aging (AAAs), the United Way, and foundations.

The primary activity required of LTC ombudsmen by the OAA is the identification, investigation, and resolution of individual complaints relating to the residents of LTC facilities. The program clearly performs

this function. In 1993, LTC ombudsmen received more than 197,800 complaints, lodged by more than 154,400 people.

Ombudsmen are required to address and attempt to rectify the broader, or underlying, causes of problems for residents of LTC facilities. When working on the systemic level, ombudsmen's responsibility to advocate for policy change includes evaluating laws and regulations, providing education to the public and facility staff, disseminating program data, and promoting the development of citizen organizations and resident and family councils.

STATE COMPLIANCE WITH PROGRAM MANDATES

If a state is operating a LTC ombudsman program in compliance with congressional mandates, the program will perform several functions. For purposes of reviewing the extent of compliance, the committee collapsed the several statutory functions of the LTC ombudsman program into two primary services: (1) direct, individual advocacy services, which should be accessible, available, and meet the needs of residents of nursing and B&C facilities, and (2) systemic advocacy services.

Findings

Although in some states and locales elements of the ombudsman programs are vigorously implemented, the ombudsman program as a whole has not been fully implemented with regard to the provisions of the OAA that call for ombudsman services to be available and accessible to residents of LTC facilities. The committee finds the following:

- Not all residents of LTC facilities in need of advocacy assistance have meaningful access to the services of an ombudsman.
- Given the lack of a frequent visitation pattern to LTC facilities by ombudsmen in many parts of the country and little, if any, evidence that other methods are used effectively to build an awareness in the community of the availability of ombudsman services, large numbers of residents of LTC facilities are unaware of, and thus would probably not be able to use, the ombudsman programs' services.
- For the most part, ombudsmen provide timely responses to complaints. However, serious problems exist in some locales. For example, some state programs serve a large proportion of their LTC residents largely through one central toll-free telephone service. In such cases, it is not unusual for ombudsmen to investigate complaints through telephone inquiries only. Those residents most in need of an ombudsman to assist in protecting their health, safety, welfare, and rights may be reluctant or simply unable to initiate complaints to the ombudsman by such means as telephone calls because they are too frail or cognitively impaired.
- Implementation of the ombudsman program for residents of nursing facilities has been uneven among and within states.
- Implementation of the ombudsman program for residents of B&C homes has not been achieved in any significant way except in a small number of states.
- The ombudsman program activities of too many states are piecemeal, fragmented, and focused primarily on responding to complaints that relate to individual residents of nursing facilities. These

states are not in compliance with the spirit of the program provisions as stated in the OAA; the Offices of the State LTC Ombudsman programs do not function as a whole, statewide, unified, integrated program delivering a range of individual, systemic, and educational efforts.

- AoA has not mandated any level of implementation for the legislated LTC ombudsman program, nor has the agency monitored the states' efforts at implementation. Although ombudsman programs vary in the amount of staff and volunteer resources being expended to serve the residents of LTC facilities, no agreed-upon level of effort exists to signify that an ombudsman program has been implemented at a minimum acceptable level in a state. States do not uniformly comply with the essential requirements for operating statewide ombudsman programs, and neither AoA nor any other federal agency employs mechanisms to require such compliance.
- AoA has not developed technical guidance materials that inform states of the federal government's operational definitions of a fully implemented Office of the State LTC Ombudsman program.
- Ombudsman programs need competent legal advice and backup, including, when the circumstances call for legal interventions, assistance to LTC facility residents in pursuing issues in the courts and in regulatory hearings. The availability of these services is extremely uneven across the country.
- Except in a very few states, SUAs have not fulfilled their responsibility to ensure that adequate and independent legal counsel is available to the ombudsman programs for the purpose of providing advice and counsel related to LTC residents.

Recommendations on Compliance

The committee considers the mission of the LTC ombudsman program to be worthy in purpose and deserving of support from public funds. Accordingly, the programs should operate throughout the country in compliance with federal mandates. The committee proposes eight recommendations as a result of this part of its review.^[3]

3.1. The committee recommends that Congress amend the Older Americans Act to allow state ombudsman programs to serve younger individuals who reside in long-term care facilities in which primarily elderly individuals reside. However, state ombudsman programs should strive to comply fully with their current mandates before using Older Americans Act resources to serve residents who are younger than 60 years of age. When applicable, the state long-term care ombudsman should coordinate activities and advocacy efforts with other organizations that serve as advocates for nonelderly residents.

3.2. The committee recommends that the Department of Veterans Affairs (VA) institute an agreement with the Administration on Aging (AoA) to ensure that long-term care ombudsman services are available to all veterans residing in nursing and domiciliary homes operated by the VA. The agreement should include the transfer of adequate funds from the VA to the AoA to support the provision of ombudsman services to VA-owned or VA-managed facilities.

3.3. The committee recommends that the Assistant Secretary for Aging develop and distribute a policy statement detailing the sanctions the AoA is authorized to use to enforce state compliance with statutory mandates of the long-term care ombudsman program. The statement should describe the sanctions and explain which conditions require or justify invoking each sanction.

3.4. The committee recommends that the Assistant Secretary for Aging issue clearly stated policy and program guidance that sets forth the federal government's expectations of state long-term care ombudsman programs. Such guidance should articulate operational principles in terms of basic elements of the program, including:

- **definitions, criteria, and standards to determine whether a state ombudsman program is operating as a unified entity throughout the state;**
- **designation and de-designation process(es) of all host agencies and all individual representatives within the ombudsman program;**
- **process(es) by which the state ombudsman program provides assistance (including training) to local ombudsman programs;**
- **method(s) by which the state ensures that its ombudsman program has suitable access to facilities, records, and residents;**
- **method(s) by which the state ensures that its ombudsman program provides meaningful annual reports; and**
- **method(s) by which the state ensures that adequate legal counsel is an integral part of the ombudsman program both in representing the ombudsman program itself and in providing advice and counsel in matters related to long-term care facility residents.**

3.5. The committee recommends that Congress direct the Secretary of the Department of Health and Human Services to implement the statutory provisions set forth in Public Law 102-375 that require a federal Office of Long-Term Care Ombudsman Programs in the Administration on Aging and that Congress explicitly provide an adequate appropriation in the Older Americans Act for the position of Director of the Office of Long-Term Care Ombudsman Programs.

3.6. The committee recommends that the Assistant Secretary for Aging explicitly operationalize the federal government's responsibility for oversight of the long-term care ombudsman program. This should include (at a minimum) the following elements of program oversight: (1) active monitoring of programs by regional offices or the central office of the Administration on Aging; (2) effective technical assistance to the state programs; and (3) standards and procedures for training representatives of the Office of the State Long-Term Care Ombudsman.

3.7. The committee recommends that the Assistant Secretary for Aging develop plans of action and cooperative agreements with the Legal Services Corporation, the National Association of Protection and Advocacy Systems, the National Association of Medicaid Fraud Control Units, and the Office of the Inspector General of the Department of Health and Human Services to foster and encourage a variety of legal assistance resources for residents of long-term care facilities.

3.8. The committee recommends that the Assistant Secretary for Aging require that each state unit on aging include in its state plan a description of how the state has funded and ensured the provision of adequate and independent legal counsel to the ombudsman program, including how all designated representatives of the Office of the State Long-Term Care Ombudsman are afforded legal counsel so that all their mandated duties and services can be and are performed.

CONFLICTS OF INTEREST

Legislative and Conceptual Aspects

The determination of whether actual or potential conflicts of interest in the administration and operation of the LTC ombudsman programs exist depends primarily on two factors: (1) the definition of or parameters describing occurrences of conflicts of interest and (2) the circumstances of the situation under review. Without a doubt, most state and local ombudsman programs are subject to one or more of the conflicts of interest reviewed by the committee.

Of particular concern to the committee is the prevalence of potential and real conflicts of interest that arise from the structural location of many of the Offices of the State LTC Ombudsman programs. Situations in which real, potential, and perceived conflicts of interest exist may be more prevalent than is typically understood, and perceived conflicts of interest may be as detrimental to operating the ombudsman program as real conflicts of interest. All conflicts of interest work to the disadvantage of the vulnerable client.

Ombudsmen--particularly state ombudsmen--operate in a politically charged environment accentuated by the fact that most often the state ombudsman is a state employee. Government cannot function efficiently if its employees work in opposing directions. All levels of government in the United States have formal and informal standards that govern chains of command. Every executive branch of government justifiably exercises some control over its employees' contacts with the legislative branch and media.

By federal statute, the ombudsman is required to speak out against government laws, regulations, policies, and actions when the circumstances justify such action. Taking such steps, however, is antithetical to the hierarchical rules of government. It is not surprising, therefore, that conflicts occur. The imposition of a state's routine chain-of-command rules on the ombudsman can significantly constrain his or her independence, although no person in such situations may intentionally act to interfere with the work of the ombudsman.

The committee began its review of conflicts of interest with the statutory provisions of the OAA that prohibit conflicts of interest in the LTC ombudsman programs. The parameters set forth in the act to identify situations of conflicts of interest are quite limited and outdated, focusing almost exclusively on financial interests and nursing facility settings. They provide little guidance for addressing the conceptually related variations of conflict of interest--conflicts of loyalty, commitment, and control--that characterize the environments in which the ombudsman program operates in the 1990s.

The committee reviewed four major types of conflicts of interest: (1) organizational, (2) individual, (3) those arising from willful interference in the independent operation of the program, and (4) those related to the provision of legal counsel. Conflicts of interest can be dealt with either by prevention or by detection and correction. These are concepts and approaches similar to those in the quality-of-care field. Not all conflicts of interest can be prevented in the ombudsman programs, although prevention is clearly the preferred method of program administration and the most effective means of assuring compliance with the statutory provisions. Numerous mechanisms can ameliorate individual conflicts of interest, such as disclosure, ethical behavior, and accountability to the public.

Recommendations on Conflicts of Interest

The committee determined that conflict of interest problems are sufficient to warrant greater vigilance and a broader array of tactics to prevent, identify, and correct pertinent and significant conflicts. To that end, the committee offers four recommendations.

4.1. The committee recommends that Congress amend the Older Americans Act to include the following policy directive. By fiscal year 1998, no ombudsman program should be located in an entity of government (state or local) or agency outside government whose head is responsible for:

- licensure, certification, registration, or accreditation of long-term care residential facilities;
- provision of long-term care services, including Medicaid waiver programs;
- long-term care case management;
- reimbursement rate setting for long-term care services;
- adult protective services;
- Medicaid eligibility determination;
- preadmission screening for long-term care residential placements; or
- decisions regarding admission of elderly individuals to residential facilities.

4.2. The committee recommends that the Assistant Secretary for Aging adopt a clear policy that prohibits parties who provide, purchase, or regulate services that are within the purview of the ombudsman program from membership on policy boards having governance over the long-term care ombudsman program. The policy should not prohibit these parties from membership on boards and councils that serve solely in advisory capacities.

4.3. The committee recommends that the Assistant Secretary for Aging establish procedures and resources by which to identify potential conflicts of interest in the areas of loyalty, commitment, and control that are pertinent to the long-term care ombudsman and ombudsman representatives and provide guidance on how to address such conflicts of interest.

4.4. The committee recommends that each state unit on aging, in exercising its responsibility to ensure that legal counsel is available without conflict of interest to the statewide long-term care ombudsman program, adopt the following three principles to guide the selection of counsel:

- For purposes of representing the ombudsman in (a) employment, contract, or other administrative functions and (b) litigation brought against the ombudsman in connection with the performance of his or her official duties, representation by the state's office of the attorney general is appropriate and generally free of conflict of interest.
- If advice and counsel related to the rights of long-term care facility residents is provided by a government-employed lawyer, then the lawyer and agency employing the lawyer, including any "umbrella" agency, should not advise or represent other agencies or interests that could conceivably have a conflict of interest with the resident's interests or ombudsman's responsibilities.

- **If advice and counsel related to the rights of long-term care facility residents is provided by a lawyer not employed by the government, then the ombudsman should receive assurances of conformance to state rules of professional conduct for the legal profession.**

EFFECTIVENESS OF THE OMBUDSMAN PROGRAM

The committee attempted to assess the effectiveness of the state LTC ombudsman program from several perspectives. The underlying impediment to sound assessment has been the lack of reliable and valid information that could be fit into any defensible summative evaluation format. For that reason, the committee opted for a formative evaluation effort—one that would highlight program issues, strengths, and weaknesses and would point to more specific questions deserving in-depth attention in coming years.

Continuance of the Ombudsman Program

On the basis of all the information it reviewed, collected, and analyzed, the committee concludes that the ombudsman program serves a vital public purpose. Every year the LTC ombudsman program helps many thousands of individual LTC facility residents, particularly those in nursing facilities, with a wide range of problems and concerns. The committee thus takes a strong supportive stance with respect to the ombudsman program. To underscore this commitment to the mission of the program:

5.1. The committee recommends that Congress continue the long-term care ombudsman program as set forth in the Older Americans Act.

Stating such a recommendation may seem superfluous from a group empaneled to examine a program that, on the face of it, serves a worthy cause and a needy population. However, the committee took seriously the question of whether the program merited continuation in its present form (or at all). Having concluded that it does, the committee intended, through the above recommendation, to make clear that the aims of those who crafted the original program and its subsequent modifications remain consequential today.

The LTC ombudsman program can justly claim to have improved the system of LTC services. Through systemic advocacy work and educational efforts, the state programs, individually and collaboratively, have brought to the attention of state and federal policymakers, regulatory agencies, and provider organizations a host of conditions that can and should be changed to improve the health, safety, rights, and welfare of LTC residents. Examples of changes advanced or promoted by ombudsman programs (often in conjunction with other organizations) include: enactment of the federal Nursing Home Reform Law of 1987 (in particular, provisions pertaining to quality of care and quality of life); increased personal needs allowances; protections from involuntary discharge and room transfers; reduced use of physical restraints; improved building and safety standards; increased state funding for inspection and surveying of LTC facilities; reduced use of psychotropic medications; better licensing oversight of health care professionals; increased use of advance directives; stronger LTC staff competencies and sensitivities; and empowerment of residents through stronger resident and family governance structures.

In the B&C area, the ombudsman program has been partially implemented at best. Hence, evaluating national program effectiveness in this area is premature.

Exemplary Practices and Performance

The committee believes that the individual and systemic successes attributed to the ombudsman program occur despite considerable barriers in most, if not all, states. Obstacles to effective performance include inadequate funding, resulting staff shortages, low salary levels for paid staff, structural conflicts of interest that limit the ability to act, and uneven implementation among and within states. In many states, the program attempts to operate in a structural environment that expressly prohibits or, at least, does not foster its ability to carry out all federally mandated functions. The committee observed such examples as prohibitions on state and local ombudsmen from talking with any state or federal legislators about issues of concern to residents and ombudsmen who attempted to carry out additional and conflicting roles such as adult protective services officials.

As a consequence of what it perceived to be the significant drawbacks of this variation in basic program implementation and practice, the committee has developed a detailed scheme relating to the structure and activities of the program called "Elements of Infrastructure and Functions." The elements are expressed in terms of exemplary, essential, and unacceptable practices. They incorporate prerequisites for effective ombudsman program performance. The detailed elements and respective practice levels are found in tables in Chapter 5 of the committee's report. They include the following categories:

- Structure of the Office of the State LTC Ombudsman and Elements of the Host Agency(s) for the State and Local Entities;
- Qualifications of Representatives of the Office;
- Legal Authority;
- Resources (financial, information management, legal, and human);
- Office of the State LTC Ombudsman Program;
- Individual Resident Advocacy Services;
- Systemic Advocacy Work; and
- Educational Services.

Committee members underscored their belief in the value of building upon these "ideal types" of practices as a basis for objectively measuring compliance with the legislative mandate. In addition, the exemplary practices offer a standard and a challenge for ombudsman programs in terms of higher levels of effectiveness and service. Thus:

5.2. The committee recommends that the Administration on Aging build upon the committee's proposed set of exemplary, essential, and unacceptable practices to develop and implement an objective method to assess compliance of state long-term care ombudsman programs.

Data and Information Systems

As noted above, because the ombudsman program is still developing and evolving, and because data on program performance are not available, evaluating the program's effectiveness in any comprehensive way is not possible. Other barriers to adequate assessment also exist. Agreement has been lacking about the definition of goals. Implementation has been extremely varied, in part because of broad and uneven

interpretations of the OAA mandate. No formal evaluation component was ever built into the program. Finally, only recently has AoA adopted a standardized data reporting system of any complexity.

Of all these issues, the committee focused on information systems as an area that AoA could and should remedy. Accordingly, the committee developed a set of recommendations in this area.

5.3. Building on work already begun by the Administration on Aging and the National Association of State Long-Term Care Ombudsman Programs, the committee recommends that the Secretary and Assistant Secretary for Aging, Department of Health and Human Services, establish and implement an information system for the ombudsman program that provides an empirical basis for:

- **evaluating and improving complaint resolution efforts by identifying the extent to which ombudsmen have been effective in resolving complaints and issues to residents' satisfaction;**
- **identifying more precisely the kinds of problems (resolved or not) that affect the lives of residents of nursing and residential care facilities in order to provide a basis for systemic advocacy and change;**
- **documenting the key efforts made toward systemic advocacy and the results of those efforts to address priority long-term care issues; and**
- **documenting and analyzing the full range of activities of the long-term care ombudsman programs.**

To follow up this overall recommendation about information systems for the ombudsman program, and reflecting its concern about the paucity of comprehensive and accurate data to assess program activities and performance, the committee concluded that additional, more specific, or more technical points should be made with respect to data and information systems. Two recommendations pertaining to these point are as follows:

5.4. The committee recommends that the Assistant Secretary for Aging continue the efforts of the Administration on Aging to develop, refine, and implement a uniform data collection and reporting system. The committee recommends, at a minimum, that the data system should:

- **be based on a manageable number of uniform and reliable data items--each of which has precisely specified, field-tested definitions;**
- **be derived from annual statistical reports submitted by state long-term care ombudsman offices that provide information in terms of the data items in the previous point;**
- **include a clear indication of status of complaint resolution from a consumer perspective;**
- **be used to provide feedback to state and local ombudsman programs;**
- **be available for public use to foster research and inform decision making;**
- **incorporate methods and procedures for continuous revision and improvement; and**
- **be reviewed and updated no less than once every three years.**

5.5. The committee recommends that the Assistant Secretary for Aging periodically conduct audits of the data collection and reporting systems of state ombudsman programs to ensure that all states adhere to the national standards of the uniform data collection and reporting system.

The committee underscored the importance of well-defined, accurately reported, uniform data in which each item has precisely the same meaning for all state programs. Committee discussion emphasized the necessity of assuring that the burden of reporting is minimized and realistic, given the facts that staff resources are limited and that volunteers are crucial in data collection efforts. Time spent recording data is time not available for direct service. Thus, all items intended for a formal data collection instrument should be carefully examined and included only if they have demonstrated utility for AoA or state or local ombudsman programs (or, ideally, both). Preference should be given to items that are useful in documenting the nature and outcomes of the full range of ombudsman services. Committee members expressed particular interest in the value of all state ombudsmen offices commenting consistently on four specific elements of information, as noted in this recommendation:

5.6. The committee recommends that the Secretary and Assistant Secretary for Aging, Department of Health and Human Services, require that each Office of the State Long-Term Care Ombudsman include in its annual report, in addition to currently required elements, information on and comments about:

- the level of awareness of residents, their agents, and other parties regarding the ombudsman program, and the availability of ombudsmen to individual residents;
- the extent to which the complaints and concerns of residents have been satisfactorily resolved;
- the extent to which ombudsmen have provided input into activities designed to improve the overall system of care and services for long-term care residents; and
- the extent to which ombudsmen have improved the overall system of care and services for long-term care residents.

Research Imperatives

Almost no evidence exists that causally links the activities and the outcomes of the ombudsman program. For example, little, if any, empirical information relates participation in nursing facility surveys or development of an annual report with such outcomes as changes in LTC facility practices that show more respect for residents' rights or revisions in state or federal laws that provide legislative backing for residents' rights. Just as research is being conducted to assess linkages among processes, structures, and outcomes in various aspects of the U.S. health care system, so too the need exists for such research relating to the LTC ombudsman program. To this purpose, the committee offers the following recommendation:

5.7. The committee recommends that the Administration on Aging, the Health Care Financing Administration, the Agency for Health Care Policy and Research, other government agencies, and foundations support research to develop valid and reliable measures for assessing the impact of ombudsman activities on outcomes relative to the well-being of residents of long-term care facilities, at both individual and systemic advocacy levels.

Adequate Management of Volunteers

A prerequisite to effectiveness is adequate resources. Paid staff is the most crucial of all resources. To ensure that capacity exists for an effective program, staffing issues must be addressed for each state LTC ombudsman program, quite apart from funding issues. Based on site visits and other data gathered and analyzed, the committee agreed that staffing resources were minimal to inadequate from a national perspective.

The committee was particularly interested in information that suggests that many of the more "successful" programs make good use of a large number of volunteers. Use of ombudsman volunteers is positively associated with routine visitation and number of complaints made and resolved. This fact calls attention to the importance of recruiting, training, and retaining volunteers and to their singular contributions to the adequate functioning and performance of the program. Volunteers can provide a level of authenticity and consumer "grassroots" participation that is lacking in most other systems designed to protect and support the frail elderly. The continued use of well-trained volunteers is very much in keeping with the original intent and design of the program.

The committee concluded that the establishment of a standard staff-to-volunteer ratio was needed to protect and manage this resource. Thus, in setting the standard recommended here, the span of management of individuals was emphasized rather than the quantity of effort provided per volunteer (i.e., hours volunteered). The committee suggests a minimum standard for this staff-to-volunteer ratio of 1:40. It strongly encourages state LTC ombudsman programs that involve volunteers to maintain paid staff-volunteer ratios at the more robust level of 1:20.

5.8. The committee recommends that the Assistant Secretary for Aging establish a standard for ensuring the adequate management of volunteers who serve as designated ombudsmen. The committee suggests that the ratio of staff to volunteers be in the range of 1 paid full-time equivalent manager for every 20 to 40 volunteers.

ADEQUACY OF RESOURCES

Financial Resources and Program Performance

The full intent of Congress with respect to the LTC ombudsman program has not been met in all--indeed, perhaps not in any--state of the union. Some states fall short in not having expanded to B&C homes, other states do not have adequate cycles of visitation for all LTC facilities, some states operate fragmented programs and individual advocacy efforts that have no link to preventive or educational system efforts, and still others lack appropriate access to legal services.

Many factors compromise the fulfillment of congressional--and public-- expectations. A significant factor is the overriding realities of budget shortfalls and inequitable resource allocations. At the heart of many of the problems lie deficiencies of financial resources rather than any lack of interest

or basic commitment to the LTC ombudsman program or LTC facilities. In addressing the subject of adequacy of resources, the committee confined its discussions to resources for bringing the program into full implementation and compliance with today's statutory mandate for nursing facilities and B&C homes. It did not attempt to forecast the level or type of resources that might be needed to fulfill any possible expansion of the program (with respect to LTC, to the elderly, or to the nation as a whole secondary to comprehensive health care reform).

The committee approached the question of whether federal and other resources supporting the LTC ombudsman programs were adequate by identifying, first, some proxy measures of performance and, second, some levels of effort that link to resources. Its analysis included a review of such factors as the number of FTE paid staff per number of LTC beds, peer nominations of successful programs, and visibility. The available data, however, does not indicate that a straightforward relationship exists between staffing relative to LTC beds and the fulfillment of the duties of the ombudsman program.

By triangulating on data from several sources, the committee arrived at the conclusion that resources are not adequate for each state LTC ombudsman program to perform at a level that ensures compliance with even the basic, decade-old mandates of the OAA ombudsman program. In the committee's judgment, 1 FTE paid staff per 2,000 LTC beds is an essential resource standard, and it provides a measure against which the adequacy of resources can be judged. The committee concludes that, at a minimum, additional resources are needed to support an increase of about 300 FTE paid staff. Using the FY 1993 average national program expenditure of approximately \$43,240 per FTE paid staff supports the argument for an increase of \$13.2 million beyond FY 1993 total spending. If the current distribution of resources remains the same, then federal sources would have to supply approximately \$8.8 million in new dollars; state and local sources would have to supply \$4.4 million. In the committee's view, therefore, a federal appropriation within five years of about \$32.5 million (\$23.7 million plus \$8.8 million) is a defensible target. Assuming an inflation rate of 4 percent per year, estimates yield a target figure for FY 1998 of approximately \$39.5 million in federal funds.

6.1. The committee recommends that by fiscal year 1998 Congress increase the appropriations through Title VII, Chapter 2 of the Older Americans Act for the state long-term care ombudsman programs to an amount that ensures that all state Offices of the Long-Term Care Ombudsman program are funded at a level that would permit them to perform their current functions adequately. The committee further recommends that the factor of 1 full-time equivalent paid staff working as an authorized, designated ombudsman per 2,000 long-term care beds be used as a base indicator of performance and a unit of effort to determine the amount of additional resources needed.

The committee recognizes that further analysis is needed to determine more accurately the level of additional funding needed at the national level to bring each state up to a minimum level of resources.

Formula for Allocating Federal Funds and Level of State Contributions

The committee recognizes the need to distribute federal funds to states in a manner that more rationally considers the "beneficiaries" of the ombudsman programs--that is, the elderly residents of LTC facilities--and to that purpose it recommends that the distribution formula for Title VII-2 funds be changed. The formula for allocating federal funds under Title VII-2 of the OAA is based on total numbers of persons age 60 and older. This formula has several drawbacks from the perspective of need and equity in the context of the ombudsman program's mission. For example, states vary in the ratio of LTC beds to population 60 years of age and older, and some states with a high percentage of the nation's population in that age range have a low percentage of the nation's LTC beds.

Thus, in addition to arguing for a meaningful increase in federal appropriations for the ombudsman program, the committee has concluded that the major drawbacks of the current state-by-state allocation strategy must be addressed. Accordingly:

6.2. The committee recommends that Congress revise the interstate formula for allocating funds

under Title VII, Chapter 2 of the Older Americans Act and further recommends that Congress give consideration to equitably distributing funds on the basis of such factors as the number, size, and type of long-term care facilities in each state and wage and cost-of-living indices.

At present, state monetary matching is not required for federal dollars appropriated under Title VII of the OAA, as it is under Title III-B. This is a major inconsistency within even a single program. Moreover, it is one that may permit states to avoid giving the program its intended level of support, in particular if increases are made in federal appropriations through Title VII-2, as is recommended by the committee.

According to the committee, state and local governments and entities have a responsibility to provide significant financial support to the program. The committee did not examine the details of a required percentage match, in either theoretical or practical terms. It did, however, agree that a match of no less than 20 percent of federal funds would be a defensible minimum.

6.3. The committee recommends that Congress require that states match the federal funding they receive under Title VII, Chapter 2 of the Older Americans Act appropriations for the long-term care ombudsman programs and that the state match should be no less than 20 percent.

Management of Fiscal Resources

The committee makes two recommendations to enhance the management of fiscal resources. The committee believes that state ombudsman offices should have unrestricted knowledge of their own budgets and, within the boundaries permitted by state budget policy and procedures and required by federal mandates for compliance, decision making-authority among line-item expenditures. Host agencies should exercise prudent judgment regarding the use of ombudsman service monies to support administrative costs.

The committee recognizes that contracting and host agencies may need to use ombudsman program funds to offset some administrative costs. For the most part, according to information available, local host agencies tend to provide additional resources to the ombudsman programs rather than the other way around. During this study, however, the committee became concerned about the possibility that in some locales a series of host agencies may be assessing administrative charges against the earmarked ombudsman program budget to a degree that severely limits the ability of the ombudsman and designated representatives to deliver services. This practice becomes especially burdensome when the budget of a local ombudsman program administratively moves through two or more levels of host or contracting agencies, each of which assesses a fee against the ombudsman's budget.

6.4. The committee recommends that the Assistant Secretary for Aging issue program guidance to states that stresses the importance of delegating to the Office of the State Long-Term Care Ombudsman responsibility for managing all of the human and fiscal resources earmarked for the state ombudsman program within the boundaries of what is permitted by state budget policy and procedures and required by federal mandates for compliance. The Office of the State Long-Term Care Ombudsman program should in turn work with local ombudsman programs and their host agencies to assign fiscal management responsibility to appropriate managers.

6.5. The committee recommends that Congress direct the Office of the Inspector General, Department of Health and Human Services, to conduct an audit across the states of expenditure practices in the ombudsman programs to determine the extent of diversion of ombudsman program funds for administration and indirect costs and its relation to multiple sponsoring agencies. Congress should subsequently review the audit's findings to determine whether congressional or

administrative action is needed to prevent excessive use of ombudsman program resources for host agencies' administrative costs.

Unmet Need and Unfunded Responsibilities

The committee's report discussed the question of "unmet need"--that is, the expectations that Congress, the elderly community, and others have for the ombudsman program, which frequently go beyond the present tasks assigned through the OAA. In fact, unmet need is not confined to possible or future program mandates; it exists today in the majority of states with respect to noncompliance of their ombudsman programs in serving residents of B&C homes. Inherent in the ombudsman's advocacy role are a plethora of strategies not being consistently addressed, including interagency rapport, involvement with other community LTC and advocacy programs, administrative advocacy, and legislative lobbying--all for the purpose of influencing the care and well-being of LTC residents aged 60 and older.

With respect to adequacy of funding, the committee concludes that the present level of support for the ombudsman program is completely insufficient to allow it to expand to satisfy these unmet needs. The committee asserts unequivocally that the first priority is that the program be provided with resources commensurate with meeting all the current mandates, including those that have existed, but been neglected, since 1981. That position underlies the thrust of earlier recommendations about federal funding, the allocation formula for that funding, and the state match.

If, however, Congress or others determine that expansion of the program beyond its present mandates is desirable, then the committee wishes to go on record with respect to the fiscal realities of that movement. Specifically:

6.6. The committee recommends that, if Congress mandates additional responsibilities for the ombudsman programs, then Congress should also provide adequate additional appropriations to the ombudsman program.

NEED FOR AND FEASIBILITY OF EXPANDING THE OMBUDSMAN PROGRAM

The committee accepts the conventional wisdom that self-advocacy by consumers is the most desirable solution to many of the problems consumers face. Further, the committee also acknowledges that frail elderly people receiving health care and LTC services, ranging from skilled home health care to the wide range of in-home services funded under home- and community-based waivers and state-funded programs, may be vulnerable to neglect, abuse, and poor care. Such consumers of health care and LTC services, especially persons who cannot advocate for themselves when confronted by systems that are complex, fragmented, and cost-conscious, need an independent intermediary and advocate. Such advocates do exist in some places and in some capacities, but they cannot always act expressly on behalf of the consumer, provide both individual and systemic advocacy, or work preventively.

The 13 states that have expanded ombudsman services to health care and LTC consumers outside of LTC residential facilities have gained limited experience to date. The committee heard testimony that this circumstance arises, in large measure, from inadequate resources to implement and operate a fully viable program. The result, however, is that little empirical evidence is available to support decision making on whether and how the current ombudsman program ought to be expanded.

On the basis of what is already known, most committee members believe that some entity or individual--whether or not it is the current LTC ombudsman--is needed to answer questions, to provide systemic advocacy, and to intervene in problem situations for some consumers.

Other activities are in place ostensibly to help address the needs and interests of vulnerable people receiving community health and LTC services. These include: case management programs; the Adult Protective Services efforts available in most states; the home care complaint hotlines mandated by law in 1987, which have been variably implemented across the United States; and licensure, certification, and survey processes for home health agencies. In addition, public and private guardianship and conservatorship policies are meant to ensure that those unable to make decisions have an agent to act in their best interests. All these mechanisms have strengths and limitations. It is unclear, therefore, whether the solution to these problems is to strengthen one or more of the existing mechanisms, combine and strengthen advocacy functions into a new structure, or create an ombudsman as a superordinate, general operation.

Various arguments are marshalled for and against expanding the current LTC ombudsman program to other settings, as a means of helping to fill deficits in the present system by which people receive health care and LTC services. Opponents raise both jurisdictional and operational points. Given the status of the current program, the various philosophical and operational considerations highlighted above, and the general lack of persuasive evidence on any side, the committee takes a cautious stance about expansion. Specifically:

7.1. The committee recommends that, before any consideration is given by a state to expand its long-term care ombudsman program to serve individuals other than those mandated by the Older Americans Act, the Offices of the State Long-Term Care Ombudsman programs that are supported with Older Americans Act funds fully implement existing mandates for serving older residents of long-term care facilities.

This recommendation is intended to underscore the need to fulfill existing mandates before taking on added duties, regardless of how worthwhile they may be. The committee favors improving the operation of the current ombudsman program so that it provides a stronger base for any future expansion. Thus, the committee reemphasizes here the strong recommendations it has made about funding, program evaluation, and similar topics.

Nevertheless, the committee believes that some interim steps may be taken to clarify further the desirability and feasibility of expansion. To that end:

7.2. The committee recommends that Congress, through the Secretary of the Department of Health and Human Services, direct the leadership of the Administration on Aging, the Agency for Health Care Policy and Research, the Administration on Developmental Disabilities, and the Health Care Financing Administration to develop and support research and demonstration initiatives to determine how ombudsman advocacy services can best be delivered for consumers of health care and long-term care services. Because of the potentially significant role ombudsmen may have in ensuring quality of care in a reformed health care system, the committee also recommends that Congress require that the Secretary undertake these initiatives during fiscal years 1996-1999 and submit the accumulated results of such research to the Congress no later than January 1, 2000.

CLOSING COMMENTS

During its meetings, the committee conjectured about how a future LTC system might be configured and about the trends that might affect both the need for and nature of the ombudsman program. Consensus on

these topics was neither desired nor sought. Based on all this input and its own deliberations, the committee concluded that rather substantial changes in the very nature of LTC are likely in the next decade; it also judged that any ombudsman program will face challenges to adapt and be responsive to changing needs.

If the committee's recommendations are adopted--including those related to increasing funding, minimizing conflict of interest, developing and enforcing program compliance, and enhancing the capacity of the ombudsman program to generate information about its activities and their effects--then policymakers should be in a better position 10 years from now to make decisions about the desirable evolution of an ombudsman program to meet future needs for advocacy in whatever kind of health care system has emerged in the meantime.

ENDNOTES

1. The term "ombudsmen" carries no meaning with respect to the gender of the occupant of the position. Indeed, in the United States, the vast majority of long-term care ombudsmen are women.
2. In this report "nursing facility," the technical term for a Medicaid-certified nursing facility, is used more broadly to describe any nursing home--whether or not it is Medicaid-certified, Medicare-certified, or private-pay.
3. In this summary, recommendations are numbered to correspond to the numbering scheme used in the chapters in which they are found. For example, Recommendation 3.1 is the first recommendation that is made in Chapter 3.

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Shining A Light On Abuse

Following a TIME story, Congress reports that many nursing-home residents are beaten and starved. Who's to blame?

By MARK THOMPSON /WASHINGTON

The guilt children feel about putting a parent in a nursing home can sometimes lead them to blame others for the death of their loved one. But what Leslie Oliva saw as her mother moved through three California nursing homes during the last three years of her life is part of a bigger, shocking tale the Federal Government will tell this week. The account is based on the most detailed look in more than a decade at some of the nation's nursing homes. "My mother experienced beating, malnutrition, dehydration and neglect," Oliva says quietly. "All three of the nursing homes are responsible for her death."

In a written statement provided to the Senate Special Committee on Aging, Oliva says her mother Marie Espinoza, who was suffering from a degenerative brain disease, had bruises, bedsores and a broken pelvis within months after her 1995 arrival at the Orangetree Convalescent Hospital. Food was often left at the foot of her bed, out of her reach. She began to lose weight. "She always seemed to be starving or begging for water," says Oliva in her official account. At Extended Care Hospital, Espinoza suffered severe dehydration and bedsores. Last January she entered Palm Terrace Convalescent Center. The nursing home said she died after choking on food, but Oliva plans to tell the committee that this makes no sense: Espinoza was supposed to be fed through a tube. All three nursing homes deny any wrongdoing.

Oliva's tale will put a human face on a damning study by the General Accounting Office that will be the subject of hearings by the Committee on Aging this week. The panel has summoned two insiders--a former California nursing-home nurse and a current nursing-home inspector for the state--to offer firsthand accounts of the horrors. The women--called

"Clara B." and "Florence N." by the committee--will speak from behind a screen to shield them from retaliation by the powerful nursing-home industry and the agency that provides care to California's elderly.

"If they didn't eat fast enough, the food got taken from them," the former nursing-home employee told TIME. She says she would falsify records to show that the residents had eaten everything on their plate. Things would improve for a while when state inspectors showed up for their predictably timed annual visit. "The attitude was to put a Band-Aid on it until the state left, and then it'd go right back to the way it was," she says. The inspector, who has been visiting California nursing homes for years, told TIME her complaints are regularly ignored because of the "cronyism" that exists between the state overseers and nursing-home operators. "Once we write down violations, the nursing homes complain and our superiors keep us from going back or else they dismiss our citations," she says. This has led to "hopelessness" among inspectors like herself, she says.

And, according to the GAO, it has contributed to a litany of abuses. One resident lost a third of his body weight over seven weeks. During this time, the nursing home failed to weigh him, give him prescribed painkillers or alert his doctor to his worsening condition. Another resident had a bedsore, and the doctor ordered the bandage to be changed twice a day; it was unchanged for nearly two weeks. A third nursing-home resident was brought to a hospital, where the patient was found to have had a broken leg for at least three weeks and the nursing-home records were missing. A woman whose four bedsores were exposed to the bone and required daily cleaning was rarely given the prescribed pain medicine before the procedure.

The GAO report, following up on a story that appeared in TIME last fall, says more than half the suspicious deaths studied in California nursing homes were probably due to neglect, including malnutrition and dehydration. The study says that nearly 1 in 3 California nursing homes has been cited by state inspectors for "serious or potentially life-threatening care problems" and that the same problems probably exist across the nation. These are likely to grow as the baby boomers become grandparents and the rocketing elderly population puts even greater pressure on the nation's nursing homes. Senator Charles Grassley, the Iowa Republican who chairs the Committee on Aging, argues that much of the blame for the flawed nursing-home system can be pinned on the Federal Government, which has the economic leverage to insist on improvements. Last year the Federal Government spent \$28 billion on nursing-home care through Medicare and Medicaid. "It's been too permissive and too forgiving in its enforcement," Grassley told TIME.

In the face of such stinging criticism, President Clinton announced last week that his Administration is cracking down on abuses in the 17,000 nursing homes across the nation that house 1.6 million of the old and