Special Report

An overview of long-term care

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Long-term care (LTC) refers to health, social, and residential services provided to chronically disabled persons over an extended period of time. Especially during the last 20 years, State and Federal Governments have played an increasing role in the financing of long-term care. The aging of the population underlines the future importance of this topic. This article provides background data on need, supply, and expenditures; discusses government financing programs; and addresses quality of care concerns and options for LTC reform.

Background: Disabilities, demographics, supply, and expenditures

The need for and utilization of long-term care services is largely determined by the incidence of chronic disease and disability. Elderly persons, by virtue of their high risk of chronic disease and disability, are the primary recipients of long-term care. The aging of the U.S. population will increase the demand for long-term care in the future. While nursing-home care is the most visible form of long-term care, in fact the bulk of the disabled are cared for at home by friends and relatives. Public funding, primarily by Medicaid, is predominately for institutional services.

Growth of the elderly population

The elderly population increased more rapidly from 1950 to 1980 than the U.S. population as a whole. More importantly, the population 75 years of age or over increased more rapidly than the population 65-74 years of age. The population 75 years of age or over are at high risk of chronic disease, disability, and institutionalization in a nursing home. This aging of the population will continue into the future.

Overall growth

- The elderly population doubled from 12.4 million persons in 1950 (8.1 percent of the U.S. population) to 24.9 million persons in 1980 (9.9 percent of the U.S. population) (Table 1).
- The number of elderly will more than double again by 2030, accounting for almost one-fifth of the U.S. population.

Table 1

U.S. population 65 years of age or over and percent of total population: Selected years and projections 1950-2030

Year	Population 65 years or over in thousands	Percent of U.S. population
1950	12,397	8.1
1970	20,087	9.9
1980	24,927	11.2
2000	31,822	12.2
2010	34,837	12.7
2020	45,102	15.5
2030	55,024	18.3

SOURCE: U.S. Bureau of the Census.

Table 2

Percent increases in U.S. population for 10-year intervals, by age groups: Selected years and projections 1950-2010

Year	All ages	65-74 years	75-84 years	85 years or over
1950-1960	18.7	30.1	41.2	59.3
1960-1970	13.4	13.0	31.7	52.3
1970-1980	8.7	23.4	14.2	44.6
1980-1990	10.0	13.8	26.6	20.1
1990-2000	7.1	-2.6	15.6	29.4
2000-2010	6.2	13.3	-2.4	19.4

SOURCE: U.S. Bureau of the Census.

Changes in age structure

- The elderly population is becoming older (Table 2). For example, between 1980 and 1990, while the 65-74 age group will increase by 13.8 percent, it is projected that the 75-84 age group will increase by 26.6 percent, and the 85 years of age or over group, by 20.1 percent.
- In the next two decades, 1990-2000 and 2000-2010, the 85 years of age or over group will increase three to four times as fast as the general population.

Need for long-term care

Long-term care is characterized by medical, personal, social, and psychological care over extended time periods. The need for long-term care is not necessarily identified with particular diagnoses, but rather physical or mental disabilities that impair functioning in activities necessary for daily living. Although such conditions affect individuals of all ages, the need for long-term care strongly increases with age.

Table 3

Percent distribution of helpers and helper days, by sex and relationship to individuals 65 years of age or over with limitations to activities of daily living

Age and relationship	Helpers		Helper days	
	Male	Female	Male	Female
	Percent			
All persons 65 years or over				
Spouse	37	10	53	17
Offspring	24	34	19	37
Other relative	23	35	18	30
Formal	16	21	11	16
65-74 years				
Spouse	45	18	61	31
Offspring	21	29	15	27
Other relative	21	33	15	28
Formal	13	20	9	14
75-84 years				
Spouse	35	8	53	14
Offspring	23	35	18	38
Other relative	25	36	18	32
Formal	17	21	11	15
85 years or over				
Spouse	20	2	31	3
Offspring	34	39	31	47
Other relative	27	36	22	30
Formal	19	23	16	19

SOURCE: Preliminary data from the 1982 National Long-Term Care Survey, Department of Health and Human Services, 1982.

Subgroups and indicators of need for long-term care

- Major long-term care subgroups are the:
  - Elderly disabled
  - Nonelderly disabled (under age 65)
  - Developmentally disabled (primarily the mentally retarded)
  - Mentally ill
- Indicators of need for long-term care include requiring assistance in:
  - Activities of Daily Living (Personal Care Needs)
    - Eating
    - Toileting
    - Mobility
    - Bathing
    - Dressing
  - Instrumental Activities of Daily Living
    - Housekeeping
    - Shopping and errands
    - Food preparation
    - Laundry
    - Chores

Estimates of need

- Need for assistance with activities of daily living (ADL's) increases dramatically with age. Only 2.6 percent of persons age 65-74 need assistance with personal care compared with 31.6 percent of those 85 years of age and over.
- It is estimated that 8 million persons in the United States, two-thirds percent of whom are elderly, need assistance with personal care.

Sources of long-term care

While 29 percent of the long-term care population resides in an institutional setting (e.g. nursing homes), 71 percent are in the community. Residents of institutions are generally more disabled than dependent elderly in the community, yet for every person 65 years of age and over residing in a nursing home, there are twice as many persons living in the community requiring similar levels of care.

Institutions

- Long-term care institutions include nursing homes (primarily skilled nursing and intermediate care facilities), institutions for the mentally retarded (primarily intermediate care facilities for the mentally retarded), residential care facilities (e.g., board and care homes), and long-stay hospitals, (including psychiatric hospitals).
- In 1977, 1.3 million persons were residents of nursing homes, 89 percent of whom were over 65 years of age.
- Institutionalization rates increase dramatically with age. Only 2 percent of the elderly 65-74 years of age were in nursing homes, compared to 6 percent of the elderly 75-84 years of age and 23 percent of those 85 years of age or over.
- Only 24 percent of the elderly 45-64 years of age with ADL dependency reside in institutions, but by 85 years of age, 61 percent of those with ADL dependency are in nursing homes.
- In addition to age, major predictors of institutionalization include: mental disorders, severe functional dependencies, and weak social support systems.

Home and community care

- Informal care, primarily by family, constitutes the bulk of care to the disabled elderly requiring assistance in activities of daily living (Table 3).
- Formal sources of care (paid providers of home health, homemaker/chore services, adult day care programs, etc.) provide a minority of the care to the disabled elderly. In 1982, formal services accounted for less than 15 percent of all "helper days of care" in the community.

Projections of the need for long-term care

- Based on the projected growth of the elderly population and the current utilization patterns of institutional and community long-term care services, major increases in the demand for long-term care can be anticipated.

Table 4

Projections of daily volume of long-term care assistance, by source of assistance: 1980-2040

Year	Source of assistance				
	Institution[1]	Spouse[2]	Offspring[2]	Other relative[2]	Non-relative[2]
	Number in thousands				
1980	1,187	1,442	1,436	1,213	655
1985	1,411	1,612	1,701	1,414	771
1990	1,623	1,801	1,950	1,610	880
1995	1,861	1,953	2,232	1,814	1,003
2000	2,081	2,049	2,484	1,989	1,110
2020	2,805	2,976	3,392	2,728	1,530
2040	4,354	3,900	5,172	4,028	2,298

[1]These projections refer to a full day of care in an institution.
[2]These projections refer to the number of episodes of caregiving on a given day.

SOURCE: Preliminary data from the Department of Health and Human Services, 1982 National Long-Term Care Survey, 1977 National Nursing Home Survey, National Center for Health Statistics, and Social Security Administration projections.

- For example, for the period 1980-95, the nursing home population is expected to grow from 1.2 million to 1.9 million, an increase of 57 percent. By 2040, 4.3 million elderly are expected to be institutionalized (Table 4).

Supply of nursing home beds

The number of nursing-home beds, which exceeds the number of hospital beds, has been growing at a modest rate.

Supply in 1980

- As of 1980, there were approximately 1.4 million nursing-home beds, or 54 beds per 1,000 elderly, in the United States.
- There is a great deal of interstate variation in the number of nursing-home beds per 1,000 elderly, ranging from a low of 22 per 1,000 elderly in Florida to a high of 94 per 1,000 elderly in Wisconsin.

Growth

- For the United States, the annual growth rate for nursing-home beds was 2.9 percent between 1976-80. This growth rate represents a considerable decline from the decade 1963-73 when the rate of growth was 8.1 percent per year.
- The annual bed-growth rate between 1976-80 varied dramatically across States. For example, beds in three States (Hawaii, Kentucky and Nevada) grew at more than 15 percent per year, beds in five States (California, Michigan, Nebraska, New York and Washington) and the District of Columbia had a growth rate of one percent or less.
- States have become increasingly concerned about Medicaid expenditures for nursing-home care, and have initiated actions to stabilize expenditures for nursing homes. A widely used approach is to limit the construction of beds by setting stricter certificate of need standards (e.g., Georgia and Washington). Six States (Kentucky, Minnesota, Mississippi, North Carolina, Virginia and Wisconsin) have simply imposed moratoria on the addition of new beds.

Long-term care expenditures

Most of the national expenditures for long-term care are for nursing home or other institutional care. However, expenditures for noninstitutional services have been increasing rapidly.

Institutional long-term care

In calendar year 1982, $27 billion were spent for nursing-home care, accounting for 8.5 percent of total national health expenditures. Expenditures for nursing-home care have quadrupled since 1972 when the $6.5 billion that were spent comprised only 6.9 percent of total national health expenditures (Table 5). The 1982 expenditures were almost equally divided between public and private sources.

- Almost all of the $13 billion spent from private sources was out-of-pocket, with insurance payments accounting for less than 1 percent of the total national expenditures.
- Medicare spent $465 million on skilled nursing facility (SNF) services in fiscal year 1982. Medicare SNF expenditures accounted for only two percent of total national expenditures for nursing homes and one percent of total Medicare expenditures.
- Medicaid is the major public source of payments for institutional care, accounting for 49 percent of the total national expenditures. This figure gives a misleadingly low impression of the number of nursing home residents whose care is at least partially financed by Medicaid, since income that Medicaid recipients must contribute to the cost of their care is counted as private, out-of-pocket expenditures.

Table 5

U.S. total expenditures for nursing home care and annual percent change: Calendar years 1960-82

Year	Expenditures in billions	Annual percent change
1960	$ .5	—
1965	2.1	64.0
1970	4.7	24.7
1971	5.6	19.1
1972	6.5	16.1
1973	7.1	9.2
1974	8.5	19.7
1975	10.1	18.8
1976	11.4	12.9
1977	13.2	15.8
1978	15.2	15.2
1979	17.6	15.8
1980	20.6	17.1
1981	24.2	17.5
1982	27.3	12.8

SOURCE: Health Care Financing Administration, Office of Financial and Actuarial Analysis.

Noninstitutional long-term care

Private expenditures for home health are also increasing rapidly, but are small relative to expenditures for nursing-home care. Expenditures for home health under Medicare and Medicaid have grown rapidly over the past decade, but still comprise only a small fraction of total Medicare and Medicaid expenditures. Since 1981, States have been allowed to apply for waivers under Medicaid to provide various types of nonmedical home and community-based long-term care services such as homemaker chore and adult day care services.

- Industry estimates of private insurance and out-of-pocket expenditures for home health care were $1.7 billion in 1979, $2.0 billion in 1980, and $2.3 billion in 1981.
- Medicare home health payments were $1.1 billion in fiscal year 1982 and accounted for 2.6 percent of total Medicare expenditures in that year.
- Medicaid home health expenditures of $496 million accounted for 1.7 percent of total Medicaid payments in fiscal year 1982. Approximately three-quarters of Medicaid home health expenditures are for personal care services and three-quarters of all personal care expenditures are made in New York.

Government long-term care financing programs

The Federal Government funds several different programs that finance a wide array of medical and social services. The bulk of the funding, primarily through Medicaid, is for institutional services.

Medicare

Medicare, as originally enacted, is an acute-care program with services designed to support this concept. Medicare's skilled-nursing facility (a type of nursing home) and home-health benefits are oriented toward a need for skilled care. The benefits are designed to be part of the continuum of care in an acute episode, either following hospital care or as an economical substitute for an extended hospital stay. Since there is a strong incentive under Medicare hospital prospective payment to discharge patients earlier than in the past, utilization and costs in skilled-nursing facilities and home-health agencies may increase in the future.

Skilled-nursing facilities (SNF's)

- The Medicare skilled-nursing benefit covers only short-term, post-acute care (3 days prior hospitalization required) for persons needing skilled-nursing or rehabilitative services in an inpatient setting. The Medicare SNF benefit as mandated by statute sets specific and relatively stringent requirements regarding the level of skilled care necessary for Medicare SNF services. In 1980, the average Medicare coverage of a SNF stay was 30 days, much less than the average stay of 456 days for all nursing home patients.
- Medicare services in skilled nursing facilities are reimbursed on a retrospective, reasonable-cost basis, subject to limits applied to routine costs (e.g., nursing, meals, laundry). Ancillary costs (e.g., physical therapy and drugs) and capital expenses are not included in the limits. HCFA has prepared a Report to Congress on converting Medicare SNF to a prospective payment system.
- The Medicare SNF benefit is relatively small both as a percentage of Medicare expenditures and as a proportion of total national nursing home revenues. Medicare SNF expenditures totaled $520 million in fiscal year 1983 (Table 6).
- As a result of flat utilization trends and per diem increases that track the SNF market basket (the cost of input prices), total Medicare expenditures have increased at a modest rate (Table 6).

Home health

- Under the Medicare home-health benefit, the following types of services are covered:

  Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

  Physical, occupational or speech therapy;

  Medical social services which contribute significantly to the treatment of a patient's health condition;

  Part-time or intermittent services from a home-health aide; and

  Medical supplies (other than drugs and biologicals) and medical appliances.
- The Medicare law limits payment for home-health services to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician,

Table 6

Medicare long-term care expenditures and percent change, by type of service: Fiscal years 1974-83

Fiscal year	Total expenditures in millions	Long-term care		Skilled nursing facilities		Home health care	
		Expenditures in millions	Percent change	Expenditures in millions	Percent change	Expenditures in millions	Percent change
1974	$10,680	$343	38.8	214	19.6	119	48.8
1975	14,118	476	32.1	273	27.6	203	70.6
1976	16,938	629	32.1	308	12.8	321	58.1
1977	20,771	778	18.5	351	11.0	427	25.6
1978	24,267	872	12.1	352	0.3	520	21.8
1979	28,157	982	12.6	358	1.7	624	20.0
1980	33,937	1,100	12.0	365	2.0	735	17.8
1981	41,254	1,343	22.1	404	10.7	939	27.8
1982	49,150	1,686	25.5	465	15.1	1,221	30.0
1983[1]	55,589	2,005	18.9	520	11.8	1,485	21.6
				Percent			
ACRG 1974-80	20.3		20.5		8.9		33.8
ACRG 1980-83	17.9		22.2		12.5		26.4

[1]1983 data are preliminary figures.

NOTE: ACRG = annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy.

confined to their homes (homebound), and in need of part-time skilled-nursing care or physical or speech therapy on an intermittent basis.

- Home-health agencies (HHA's) are reimbursed on a reasonable cost basis, subject to limits.
- Even though home health expenditures constitute only about 3 percent of overall Medicare costs, they are growing rapidly. From 1974-80 Medicare expenditures for home health increased at an annual rate of 34 percent (Table 6). Since 1980, Medicare home health expenditures have doubled from $772 million in 1980 to $1.5 billion is 1983, at an annual compound rate of 26 percent.
- Only about one-third of the Medicare expenditure increases from 1976-80 were due to price inflation. Increases in utilization accounted for the bulk of the increase in Medicare expenditures. The factors accounting for increased expenditures are:

  An increased proportion of beneficiaries utilizing home-health services, which accounted for almost half of the growth in expenditures;

  Increased visits per person served, which accounted for 8 percent of the growth in expenditures; and

  The growth in the number of Medicare beneficiaries, which accounted for 10 percent of increased expenditures.

Passage of the Omnibus Reconciliation Act (P.L. 96-499) in 1980 expanded the home health benefit by removing the limit on the number of covered home-health visits, eliminating the requirement for a prior hospital stay, eliminating the deductible, and allowing more proprietary home-health agencies to participate in the Medicare program.

Medicaid

Although adults and children in dependent families constitute the large majority of recipients, Medicaid expenditures are largely for long-term care for the elderly and disabled. States have flexibility in what they cover and how they reimburse LTC services. Many Medicaid nursing-home recipients were not poor prior to being institutionalized, but became Medicaid-eligible because nursing-home care is so expensive.

Coverage

- States must cover services provided in skilled nursing facilities (SNF's), the most intensive form of nursing home care, for persons 21 years of age or over. In addition, States may cover the following optional services:

  SNF's for persons under age 21 (44 States and the District of Columbia).

  Intermediate care facilities (ICF's), a less intensive form of nursing home care (49 States and the District of Columbia).

  Intermediate care facilities for the mentally retarded (ICFMR's)(48 States and the District of Columbia).

  Institutions for mental disease for persons under 21 years of age (3 States and the District of Columbia).

  Institutions for mental diseases for persons 65 years of age or over (41 States and District of Columbia).

- States must cover home-health services to persons 21 years of age or over and to those persons under 21 years of age, if the State provides SNF services to that age group. In addition, States may cover the following optional services:

  Private-duty nursing (19 States and the District of Columbia).

  Personal care (20 States and the District of Columbia).

Table 7

Long-term care as percent of total Federal and State Medicaid expenditures, by type of service: Fiscal year 1974-83

Fiscal year	Total LTC	SNF	ICF-Other	ICFMR	Mental hospital	Home health
			Percent			
1974	40.2	20.0	13.8	2.0	4.1	0.3
1975	42.3	19.9	15.4	3.1	3.3	0.6
1976	42.6	17.6	15.7	4.5	3.8	1.0
1977	43.1	16.6	16.2	5.6	3.6	1.1
1978	46.2	17.4	17.3	6.6	3.7	1.2
1979	47.3	16.5	18.4	7.3	3.8	1.3
1980	47.0	15.8	18.0	8.5	3.3	1.4
1981	47.2	14.8	16.6	11.0	3.2	1.6
1982	48.8	15.1	16.9	11.8	3.3	1.7
1983[1]	47.7	14.3	16.6	12.0	3.0	1.8

[1]1983 data are preliminary figures.

NOTES:
LTC = long-term care.
SNF = skilled-nursing facility.
ICFMR = intermediate-care facilities for the mentally retarded.
ICF = intermediate-care facility.

SOURCE: Health Care Financing Administration, Office of Financial and Actuarial Analysis.

Noninstitutional LTC services of a nonmedical nature (e.g., case management homemaker/chore, adult day care) as part of a home and community-based waiver (86 waivers in 46 States). Services must be targeted to persons who would otherwise require Medicaid-financed nursing-home care. Importantly, average per capita costs with the waiver must not exceed average per capita costs without the waiver, States have generally proceeded cautiously with their initial waiver applications. Almost all States have requested a waiver of the "statewide" requirement for Medicaid services, meaning that they may implement the program in limited geographic areas initially.

Reimbursement

- States may use any reimbursement methodology they wish for skilled-nursing facilities and intermediate-care facilities, so long as the rates 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." As of December 31, 1983:

  10 States employed retrospective, facility-specific payment systems for SNF's; 6 States did so for ICF's.

  37 States employed a prospective payment system for SNF's; 41 States did so for ICF's.

  3 States employed hybrid systems for SNF's; 3 States did so for ICF's.
- There are no statutory or regulatory provisions prescribing how States must reimburse noninstitutional long-term care services.

Eligibility

- The average annual cost of nursing-home care exceeds $20,000 per year. Nursing-home care is a catastrophic health expenditure beyond the financial reach of most elderly.
- It is estimated that approximately half of all Medicaid recipients in nursing homes were not initially poor, but "spent down" their income and resources as a result of the high cost of nursing-home care.

  All Medicaid nursing-home recipients must contribute all of their income except for a small personal-needs allowance ($25 in most States) to the cost of their care.

  States without medically-needy programs may cover nursing home residents with incomes up to 300 percent of the supplemental security income (SSI) payment level ($933 per month).

Expenditures

- Long-term care (SNF, ICF, ICFMR, mental hospital and home health) expenditures were $15.4 billion in fiscal year 1983, accounting for 48 percent of total Federal and State Medicaid vendor payments (Tables 7 and 8). Medicaid LTC services are overwhelmingly for institutional care.

  The proportion of Medicaid expenditures attributable to LTC has been increasing over time, due almost entirely to increased expenditures for ICFMR's (Table 8).

  The proportion of Medicaid expenditures attributable to LTC varies substantially from State to State, from a low of 18 percent in the District of Columbia to a high of 73 percent in New Hampshire.

Table 8

Medicaid long-term care expenditures and percent change, by type of service: Fiscal years 1974-83

Fiscal year	Total expenditures in millions	Percent change	Long-term care		SNF		ICFMR		ICF-Other		Psychiatric hospital		Home health	
			Expenditures in millions	Percent change	Expenditures in millions	Percent change	Expenditures in millions	Percent change	Expenditures in millions	Percent change	Expenditures in millions	Percent change	Expenditures in millions	Percent change
1974	$ 9,983	—	$ 4,023	—	$ 2,002	—	$ 203	—	$ 1,381	—	$ 406	—	$ 31	—
1975	12,242	22.6	5,174	28.6	2,434	21.6	380	87.2	1,885	36.5	405	-0.3	70	125.8
1976	14,091	15.1	5,983	15.6	2,476	1.7	635	67.1	2,209	17.2	529	30.6	134	91.4
1977	16,239	12.0	7,011	13.5	2,691	6.9	917	34.2	2,637	15.2	586	8.5	180	26.6
1978	17,992	10.8	8,296	18.3	3,125	16.1	1,192	30.0	3,104	17.7	665	13.5	210	16.7
1979	20,472	13.8	9,681	16.7	3,379	8.1	1,488	24.8	3,373	21.6	778	17.0	263	25.2
1980	23,311	13.9	10,983	13.4	3,685	9.1	1,969	33.7	4,202	11.4	775	-0.4	332	26.2
1981	27,204	16.7	12,843	16.9	4,035	9.5	2,996	50.6	4,507	7.3	877	13.2	428	28.9
1982	29,399	8.1	14,343	11.7	4,427	9.7	3,467	15.7	4,979	10.5	974	11.1	496	15.9
1983[1]	32,316	9.9	15,440	7.6	4,621	4.4	3,866	11.5	5,380	8.1	976	0.2	597	20.4
								Percent						
ACRG 1974-80		14.5		17.4		10.3		44.1		19.5		10.9		46.1
ACRG 1980-83		11.5		12.0		7.8		24.8		8.6		8.0		21.6

[1]1983 data are preliminary figures.

NOTES:
ACRG = annual compound rate of growth.
SNF = skilled-nursing facility.
ICFMR = intermediate-care facilities for the mentally retarded.
ICF = intermediate-care facility.

SOURCE: Health Care Financing Administration, Office of Financial and Actuarial Analysis.

- The rate of growth of Medicaid LTC expenditures has historically been a major concern to Federal and State officials because it has risen faster than the expenditure growth rate for Medicaid acute care. The rate of increase has moderated in recent years.

  For fiscal years 1974-80, the average compound rate of growth for Medicaid LTC services was 17 percent, compared to 15 percent for all Medicaid services.

  This higher rate of increase is largely due to expenditures for ICFMR's. Without ICFMR's, the annual rate of increase for fiscal years 1974-80 was 15 percent.

  The rate of increase for total Medicaid LTC services for fiscal years 1980-83 was 12 percent, compared to 12 percent for total Medicaid services. Without ICFMR's, the Medicaid LTC rate of increase was only 9 percent. The lower rate of increase comes largely from States tightening their reimbursement systems.

Other Federal programs

Other Federal programs also fund LTC services, although their expenditures are small relative to Medicaid and Medicare.

- The Veterans' Administration (VA) funds some nursing home and personal care for elderly veterans. Nursing-home care for nonmilitary service-related conditions is limited to 6 months.
- Many States use social services block grant funds for homemaker/chore services.
- The Older Americans Act finances home-delivered and congregate meals and some other in-home supportive services.
- Most States offer supplemental security income payments to persons residing in domiciliary care facilities (i.e., nonmedical residential long-term care services).
- The Developmental Disabilities Assistance and Bill of Rights Act provides limited funding for a variety of services for the mentally retarded or developmentally disabled, including seed money for model service programs, service coordination, and outreach.
- The alcohol, drug abuse, and mental health block grant funds a variety of mental health services, some of them for the long-term mentally ill.

Quality of care

During the 1970's, the quality of care in nursing homes was a frequent subject of Congressional and State investigations as well as news media exposés. While problems still remain, impressionistic evidence suggests that quality of care has improved since the mid-1970's. In general, public perception remains that quality of care is more of a problem in nursing homes than in hospitals.

Lack of market forces to ensure quality

In general, market forces to ensure quality of care are weaker in LTC than in acute care. Physicians are less involved in nursing home care than in hospital care. In addition, excess demand or shortage of nursing home beds means that providers need not provide good quality care in order to fill beds.

Federal involvement

Medicaid and Medicare funds are only available to institutions that meet Federal quality-of-care standards ("conditions of participation"). Medicare and Medicaid provide funds to State health departments to inspect LTC facilities ("survey and certification"). The bulk of the funds are for inspection of institutional providers. In addition, the Federal Government requires States to review annually the quality and appropriateness of the care given to each and every Medicaid nursing home resident ("inspections of care"). There is little formal quality assurance for nonmedical LTC services.

Areas of concern

While progress has been made in ICFMR's, the quality of care in these institutions (which are often State run) is less than optimal. For nursing homes in general, recruitment, retention, and training of nursing home staff, (especially nurses' aides); overmedication of patients (especially overuse of tranquilizers); and respect for patients' rights remain areas of concern.

Options

Many proposals have been made for reforming the long-term care financing system, most of which are designed to control Government expenditures or to increase the use of noninstitutional long-term care services. Briefly presented herein are a wide range of options for long-term care financing reform.

Private sector initiatives

This approach, which seeks to strengthen nonpublic, voluntary financing mechanisms, includes private long-term care insurance, life-care communities, and home equity conversion. Life-care communities are financially self-sufficient settings for the elderly that combine residential living with the availability of medical, nursing, and social services in specialized facilities on the premises. Home equity conversion plans convert assets in home equity into a lifetime stream of income that can be used for long-term care. These approaches may have the effect of reducing Federal expenditures by meeting the needs of middle class disabled elderly through private financing mechanisms rather than through Medicaid.

Long-term care block grant

This option would convert Federal long-term care programs into an indexed block grant. Under this proposal, Medicaid entitlement to long-term care services would end. States would be given flexibility in how they spend the funds. This approach was part of the Reagan Administration's 1982 proposal to federalize Medicaid. In addition to Medicaid, some proposals would fold in LTC services funded through the social services block grant, the Older Americans Act, and other Federal programs. A more limited block grant option would retain Medicaid coverage of nursing home care but would block grant funds for noninstitutional services. Another option would block grant only funds for ICFMR's.

Federal long-term care insurance

This option would establish a Federal LTC insurance program as an addition to Medicare. This would be a Federally administered, individual entitlement program covering an array of medical and social services. One version of this option would establish a voluntary program, analagous to Medicare supplementary medical insurance, in which Government would subsidize much of the cost of insurance purchased from carriers, but also require beneficiaries to contribute to the cost of the premiums.

Incentives for family care

A variety of options for encouraging family caregiving have been proposed. One would expand public financing of respite services for family caregivers beyond the very limited respite services currently available under the Medicaid home- and community-based LTC waivers. Respite services enable family members to take periodic time off from the demands of caring for elderly relatives and may postpone institutionalization by alleviating excessive stress on family caregivers. Another option would give families tax deductions or credits if they maintained severely disabled family members at home rather than placing them in an institution. Arizona, Idaho, Oregon, and Iowa currently do this in a limited fashion.

Case management

This option, represented by the Department of Health and Human Services "channelling" demonstration, would use case-management organizations to perform needs assessments and coordinate noninstitutional services for the severely disabled elderly at risk of institutionalization. Some legislative proposals would entitle certain low-income persons to receive a wide range of publicly funded services prescribed in the care plan developed by the assessment team.

Long-term care cash benefit

This option would provide a special SSI cash supplement for the purchase of long-term care services. Unlike most other options, this one would provide assistance to the disabled of all ages, not just the elderly. The Veterans' Administration currently provides such an LTC cash benefit.

Incremental modifications of existing programs

This strategy would make incremental changes to existing program structures to achieve such objectives as controlling costs, targeting services more effectively, or financing new noninstitutional services. These approaches would:

- Allow States to mandate that adult children contribute to the cost of care of elderly parents who are nursing home Medicaid recipients.
- Require States to perform preadmission screening on all nursing home applicants.
- Expand noninstitutional services by increasing funding for nonentitlement programs (e.g., social services block grant).
- Reduce Federal Medicaid match for institutional services and increase it for noninstitutional services.
- Encourage development of social/health maintenance organizations that would provide both acute and LTC services on a prepaid, capitated basis.

Summary

Long-term care is required for persons with chronic disabilities that impair their ability to perform activities necessary for daily living. An estimated 8 million individuals in the United States require long-term care assistance in performing daily functions such as bathing, dressing, eating, and moving about. The likelihood of chronic disability increases with advancing age. The elderly 65 years of age or over are 4½ times more likely to suffer some degree of activity limitation due to a chronic condition than persons under 65 years of age. The elderly 75 years of age or over are 20 times as likely to require assistance with activities of daily living than persons under 65 years of age. The projected rapid growth of this group 75 years of age or over foreshadows major increases in the demand for long-term care. This population group is projected to grow twice as fast as the general population in the next 20 years.

While nursing homes are the most visible sources of long-term care, in fact they provide care to only 29 percent of the total population in need. Families and friends are the primary sources of long-term care for disabled individuals residing in the community; formal, noninstitutional care accounts for only about 15 percent of total helper days. Elderly residents of institutions are generally more disabled than the dependent elderly in the community, yet for every

person 65 years of age or over residing in a nursing home, there are twice as many persons living in the community requiring similar levels of care.

Total national nursing home expenditures were $27 billion in 1982, accounting for most of the national health expenditures for long-term care. Nursing home expenditures were shared equally by public and private sources. Medicaid is the principal source of public payments (49 percent of total), while almost all of private spending was "out-of-pocket."

Neither Medicare (2 percent of total) nor insurance payments (1 percent of total) are significant sources of payment for nursing home care. Currently, Medicare and Medicaid expenditures for noninstitutional long-term care are small relative to those for institutional care. For example, Medicare ($1.2 billion) and Medicaid ($0.5 billion) collectively spent only $1.7 billion for home-health care in 1982.

Government programs

Medicare's SNF benefit is designed to cover a maximum of 100 days of post-acute, restorative care. Medicare reimbursement to SNF's is currently based on a retrospective, reasonable cost basis subject to limits applied to routine costs; ancillary and capital costs are not included in the limits. Expenditures have increased only at a modest rate.

Medicare's home-health benefit covers skilled nursing, physical, speech, and occupational therapy as well as home-health aide and medical social work services provided in the home, so long as the beneficiary requires skilled-nursing care on an intermittent basis and is homebound. Reimbursement is on a retrospective, reasonable cost basis with limits. Although Medicare home-health expenditures account for only a fraction of total Medicare spending, they have the fastest growth rate of any covered service, due primarily to expanding use of home-health care. There are a variety of other Federal programs that provide limited funding for LTC services.

Medicaid programs, the principal sources of public expenditures for long-term care must cover services in skilled-nursing facilities, but States also have the option of providing less intensive care in intermediate-care facilities for the mentally retarded and in institutions for the mentally ill, except for persons age 22 to 64. States are also required under Medicaid to cover home-health services and may, at their option, also provide personal care and medical day care. Since 1981, States have also had the option under certain limited circumstances to provide nonmedical long-term care services (e.g., homemaker/chore) as a means of providing a lower cost alternative to recipients who might otherwise be institutionalized. Total Medicaid LTC expenditures amounted to $15.4 billion in fiscal year 1983.

Medicaid allows States to use any reimbursement methodology for SNF's and ICF's, as long as reimbursement rates are reasonable and adequate to meet costs. While some States have retrospective facility-specific payment systems, the vast majority employ prospective payment systems (37 States for SNF's and 41 States for ICF's). There are no statutory or regulatory provisions prescribing how States must reimburse for noninstitutional long-term care.

Nursing-home care tends to be a catastrophic health expense beyond the financial reach of most elderly. As a result, many Medicaid nursing home recipients, are admitted as private-pay patients and only "spent down" to Medicaid eligibility after their assets are depleted.

Quality of care

The quality of long-term care services financed by Medicare and Medicaid is regulated primarily by means of Federal minimum standards known as "conditions of participation". The Health Care Financing Administration provides funds to State health departments to inspect LTC facilities for compliance with the conditions of participation ("survey and certification").

Options

In light of the escalating expenditures for long-term care, which are expected to continue in the next 20 years because of the aging of the U.S. population, many proposals have been made for reforming the long-term care financing system. Most of these options are designed to control Government costs or to increase the use of noninstitutional long-term care services. Proposals to increase private-sector financing include development of private long-term care insurance, life-care communities, and home-equity conversion. Proposals to increase public financing include public long-term care insurance. Other options include terminating the open-ended entitlement to Medicaid services and substituting a closed-ended block grant.