Chapter 2

Long-Term Care Policy: Past, Present, and Future

What You Will Learn

- Public policy can take many different forms and can come from different governmental sources.
- There is no single process or model that can describe how policies are made, except that legislative policymaking follows a well-defined process.
- Policies do not always achieve their intended objectives and sometimes produce unintended side effects that can be positive or negative.
- In the United States, long-term care policy and general welfare have been closely intertwined. The Social Security Act of 1935 and the creation of Medicare and Medicaid in 1965 were landmark policies that indirectly started the nursing home industry. Regulation of the industry soon followed.
- Quality of care issues in nursing homes took center stage during the 1980s. The Nursing Home Reform Act of 1987 provides current nursing home regulations dealing with patient care, but the regulations also have some serious drawbacks.
- Most of the current activity in long-term care policy is at the state level. Community-based services and purchase of private insurance are receiving various degrees of state-level attention.
- The complex interaction of financing, access, utilization, and expenditures is critical to current and future long-term care policy.
- Future policy initiatives are necessary in the areas of prevention, financing, workforce development, health information systems, mental health, and evidence-based practices.

Policy Overview

Long-term care (LTC) policy is specifically crafted to address issues pertaining to access, financing, delivery, quality, and efficiency of LTC services. Long-term care policy is a subset of broader health policies that fall within the domain of public policy.

Public policy refers to decisions made and actions taken by the government that are intended to address current and potential issues that the government believes are in the best interest of the public. As with other types of decisions, policy is intended to accomplish certain defined purposes. However, the intended objectives of public policy are not always achieved. On the other hand, public policy can produce some unintended consequences, even though such unintended results are not always bad.

When the intended goals of public policy pertain to health care, the government's decisions and actions are referred to as ***health policy***. Health policies pertain to health care in all aspects, including production, delivery, and financing of health care services. Health policies affect groups or classes of individuals, such as physicians, the poor, the elderly, or children. They can also affect various types of organizations, such as medical schools, managed care organizations, nursing homes, manufacturers of medical technology, or employers in the American industry. Health policy can have a major effect on access to services, shifts in utilization, market competition, availability of an adequate and qualified workforce, and development and use of technology.

Long-term care policies particularly affect the recipients of services such as the elderly or disabled; provider organizations such as nursing homes, home health agencies, and senior centers; caregivers such as physicians and certified nursing assistants; managers such as nursing home administrators; manufacturers and purveyors of technology and medical supplies; and, sometimes, potential consumers of long-term care. For example, favorable tax policies adopted by many states are intended to provide financial incentives so that more consumers can buy long-term care insurance to enable them to cover high LTC expenses later on. However, research shows that tax incentives have not induced the purchase of LTC insurance any more than other factors such as income, health status, and family support (Nixon, 2007). This is one example in which public policy may not produce the intended effects.

The term *policy* is sometimes also used in the context of private policy. More appropriately, however, private policies are strategic decisions that various private organizations make to better serve their markets. In the health care sector, public policy is often an important consideration when private organizations make strategic decisions. For example, a strategic decision by a skilled nursing facility to convert some of its beds to deliver subacute care may be driven by a public policy to increase reimbursement for subacute care. This would be an important consideration in addition to market demand factors.

Forms and Sources of Policy

Commonly, policy takes the form of laws passed by legislative bodies such as the U.S. Congress or state legislatures. Administrative bodies, such as the Centers for Medicare and Medicaid Services (CMS) or state health boards, interpret the legislation and formulate rules and regulations to implement the laws. In the process of interpretation and im-

plementation, the administrative bodies also end up creating public policy. The term ***policymakers*** is generally applied to legislators and decision makers in regulatory agencies who become actively involved in crafting laws and regulations to address health care issues. The two sources of policymaking just mentioned are the most common. Less frequently, certain decisions rendered by the courts and executive orders issued by the President of the United States or state governors also become public policy. The president often plays an important role in policymaking by generating support of his agenda in Congress, by appealing to the American people as to why certain issues are important, and by proposing legislation. Hence, all three branches of government—legislative, judicial, and executive—can make policy. The executive and legislative branches can establish health policies; the judicial branch can uphold, strike down, or modify existing laws affecting health and health care. Examples in all three areas follow. (1) Legislation contained in the Balanced Budget Act of 1997 required Medicare to develop a prospective payment system (PPS) to reimburse skilled nursing facilities. This legislative policy triggered several rounds of policymaking. First, the Health Care Financing Administration (now called Centers for Medicare and Medicaid Services) developed and implemented a new payment methodology in 1998. Subsequently, to address concerns from nursing home operators, Congress instituted a series of temporary payment increases through two pieces of legislation—the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (MedPAC, 2002). (2) A 1999 decision by the U.S. Supreme Court in *Olmstead v. L.C.* directed states to provide community-based services for persons with disabilities—including persons with developmental disabilities, persons with physical disabilities, persons with mental illness, and the elderly—when such services were determined to be appropriate by professionals responsible for rendering health care to these people. (3) The 2004 Executive Order 13335 provided incentives for the use of health information technology (HIT) and established the position of a National Health Information Technology Coordinator. One of the main objectives of this executive order was to develop a nationwide HIT infrastructure that would allow a patient's electronic health records to be portable and available to different health care providers (i.e., make electronic health records ***interoperable***). The LTC profession has been actively participating to ensure that it is included in this national policy. These examples also illustrate that public policy can take many different forms that can have far-reaching consequences. When policies require that certain individuals or organizations perform or behave in a certain manner, the policies carry the force of law. Violations can result in various kinds of penalties that can include monetary fines, expulsion from participation in public programs, and prison terms for criminal offences.

Health policy may be made at the national, state, or local level of government. For example, national building and fire safety codes govern the construction, design, and safety features for LTC facilities. State policies govern licensure of facilities and health care professionals. States also establish guidelines that insurance companies must follow in the design and sale of LTC insurance. Local governments establish zoning laws specifying where LTC facilities may be built. Local governments may also decide on the availability of certain community-based services on the basis of budget constraints.

Policymaking

There is no single process or model that can describe how policies are made because there are different sources of policy. Hence, policymaking is difficult to describe, and the process can be obscure (Cockrel, 1997). On the other hand, policymaking does not occur in a vacuum. In a representative democracy, the policymaking process must insure that all relevant viewpoints are heard and that the rights of individuals are protected. The larger and more diverse the constituency, the more difficult policymaking becomes (MRSC, 1999).

The formation and implementation of legislative policy generally occurs in a policy cycle that has six main stages: (1) issue raising, (2) policy design, (3) building of public support, (4) building of policy support, (5) legislative decision making, and (6) policy implementation. The enactment of a new policy is generally preceded by a variety of actions that first create a widespread sense that a problem exists and that it must be addressed. The actions are intended to bring issues to the forefront with some degree of importance and urgency. At the second stage, specific policy proposals are designed in the form of a ***bill***, which is simply a proposed piece of legislation. If the bill is crafted at the federal level, the proposal is reviewed by various committees and subcommittees in Congress. Amendments may be added. At the third stage, to build public support, policy proposals are sent to organizations and interest groups that may be affected by them. ***Interest groups*** are an organized sector of society—such as a business association, citizen group, labor union, or professional association—whose main purpose is to protect its members' interests through active participation in the policymaking process. Hearings are held and testimonies, both in favor of and in opposition to the proposed policy, are given by citizens, business representatives, labor groups, interest groups, professional associations, and experts in the field. At the fourth stage, internal support of the policy becomes critical for it to pass. Influential members of Congress meet with members of their own party, influential leaders from the opposition, and with the president in an effort to gain support. At the fifth stage, the issues are debated on the congressional floor. In the end, a majority vote is needed, and subsequently the bill becomes law if the president signs it. At the sixth stage, once legislation has been signed into law, it is forwarded to the appropriate administrative agency, such as the CMS, for implementation. The agency publishes proposed regulations in the *Federal Register* and holds hearings on how the law would be implemented.

Policymaking can be triggered by events such as natural disasters, growing social problems such as crime, severe economic shocks such as the Great Depression (started in 1929 and ended in the late 1930s), increasing burden on taxpayers such as the rising cost of health care services, demand from consumers such as product safety, etc. For example, the Social Security Act of 1935 was passed during the Great Depression. Widely reported events such as fires and cases of food poisoning in nursing homes during the early 1970s prompted development of nursing home regulations in 1974.

Policy and Politics

Policymaking and politics are often closely intertwined because most policymakers are politicians. The danger is that policymaking often becomes highly politicized and be-

comes hostage to the ideologies of a political party. The primary concern of politicians is to get elected or reelected. Hence, certain public policies are driven by the desire to keep campaign promises or to please some powerful constituent group. For example, politicians pay attention to powerful organizations, such as the AARP, that represent the growing population of the elderly. It was in this political context that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was passed. Going against the wishes of the elderly would have been political suicide for some.

The policy-for-politics approach generally does not ask for or consider the cost benefit of a proposed policy. It is pushed through mainly for ensuring votes. For example, no one cared to inquire what impact the new prescription drug program would have on reducing future disability among the elderly.

Long-Term Care Policy: Historical Perspectives

Policy evolution in the United States did not progress according to some planned design. This follows the general pattern of American health policymaking. Health care policymaking has followed an ad hoc approach to incrementally address issues as they have cropped up.

Welfare Policies and Long-Term Care

The history of LTC policy in the United States goes back to the building of poorhouses (or almshouses) in the late 17th century. A ***poorhouse*** was a government-operated institution during colonial and post-colonial times where the destitute of society, including the elderly, the homeless, the orphan, the ill, and the disabled, were given food and shelter, and conditions were often squalid. The first poorhouse in the United States is recorded to have opened in 1660 in Boston (Wagner, 2005, p. 10). The poorhouse program was adopted from the Elizabethan system of public charity based on English Poor Laws. In the United States, cities, counties, and states operated these facilities, which were often located on farms and, hence, referred to as poor farms. The poorhouses were part of a very limited public relief system that was financed mainly by local governments. These facilities admitted poor and needy persons of all kinds, including those released from prison, and the ill who did not have family or relatives to take care of them. In response to the growing concerns about abuse and squalid living conditions, some states created state-run Boards of Charities in the mid-1800s to oversee and report on the local poorhouse operations. The Boards' efforts led to some improvement in living conditions and to separation of the insane from the sane and the dependent elderly from the able bodied (Stevenson, 2007). The tireless efforts of Dorothea Lynde Dix (1802–1887), a social reformer, were particularly instrumental in convincing Massachusetts' legislature to pass laws that would put the mentally ill in separate facilities. These reform efforts spread to other states and even abroad to Canada and Europe.

Passage of the Social Security Act in 1935 was a landmark piece of legislation. The elderly were particularly hard hit during the Great Depression as many of them saw their lifetime savings disappear. Hence, the federal government specifically addressed the needs of America's elderly. Simultaneously, deplorable conditions in the poorhouses fueled a reform movement that favored community-based care over institutionalization.

An Old Age Assistance (OAA) program was included in the Social Security Act. However, instead of providing direct community-based services, the OAA program made federal money available to the states to provide financial assistance to needy elderly persons. The Social Security program, even though it left out a relatively large number of Americans (including many elderly and disabled people) was instrumental in putting an end to the poorhouse system (Wagner, 2005, pp. 132–133). For the fiscal year that ended on June 30, 1936, Congress authorized the sum of $49,750,000 under Title I of the Act in the form of matching grants, meaning the states participating in the program would share in the total cost of the program (Social Security Administration, undated). Prior to this, several states had their own old age assistance programs. The new law purposely prohibited payments to anyone living in a public institution (i.e., a poorhouse). An unintended side effect of this policy was that it started a private nursing home industry in the United States because many elderly now were able to pay for services in homes for the aged and boarding homes (Eustis et al., 1984, p. 17).

The Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act, provided federal funds to states for the construction of new hospital beds. An unplanned result of the Hill-Burton legislation was that many of the old hospitals that were being replaced were converted to nursing homes (Stevenson, 2007).

Policies during the 1950s provided federal funds for the construction of nursing homes while, at the same time, OAA payments were increased, and a 1950 Social Security Amendment required payments for medical care to be made directly to nursing homes rather than to the recipients of care. Nursing homes could now contract directly with the state governments and get reimbursed for services delivered to the elderly poor. Also, at this time, nursing homes were required to be licensed by the states. The legislation contained no specific standards for licensure; hence, each state set its own standards (Phillips, 1996).

Financing and Growth of Nursing Homes

The creation of Medicare and Medicaid in 1965 as Title 18 and Title 19 amendments, respectively, to the Social Security Act brought about the most transforming changes on the American health care landscape. Medicare and Medicaid are two major public insurance programs. ***Medicare*** covers health care services for the elderly, certain disabled people, and those who have end-stage renal disease (kidney failure). ***Medicaid*** covers health care services for the poor. These programs are more fully discussed in Chapter 7.

With the creation of Medicare and Medicaid, LTC became a part of the health care delivery system in the United States. Also, the federal and state governments became the largest payers for LTC services, and the politics of long-term nursing home care took roots. Medicare and Medicaid funding for nursing homes also attracted Wall Street investors and real estate developers to a fast-growing nursing home industry dominated by chains—that is, multifacility systems that own and operate nursing homes in several states (Hawes et al., 2007). Medicare and Medicaid policies favored payments to nursing homes that lawmakers could regulate rather than payments for community-based services that would be difficult to regulate. These policies led to the institutionalization

of a large number of people, many of whom did not belong in nursing homes.

Nursing home utilization and government expenditures exploded shortly after Medicare and Medicaid went into effect. The massive infusion of dollars into the nursing home industry, which had already acquired a tarnished image, prompted regulations to hold individual nursing homes accountable for meeting minimum standards of care. In 1968, Congress passed legislation, commonly known as the Moss Amendments (named after Senator Frank Moss), that paved the way for comprehensive regulations to improve care in the nation's nursing homes. It was not until 1974, however, that final regulations for skilled nursing facilities were promulgated, and their enforcement began in earnest. Compliance with standards such as staffing levels, staff qualifications, fire safety, and delivery of services now became a requirement for participation in the Medicare and Medicaid programs. Later, these regulations were widely criticized that they concentrated on a facility's capacity to give care, not on the quality of services actually delivered (DHEW, 1975).

Interestingly, licensing of health care professionals and hospitals was initiated by the professionals themselves and by the institutional providers, respectively. In contrast, licensing of nursing homes and of nursing home administrators (NHAs) came about through federal laws. As mentioned earlier, the 1950 amendments to the Social Security Act required that states license nursing homes in order to participate in the OAA program. Licensing of NHAs was a major exception to the general trend of requests from professionals that anyone practicing in their respective professions be licensed. The demand for qualified persons to manage nursing homes was not initiated by the industry, but came about as a result of public outcry over fraud and abuse. As a result, the 1967 amendments to the Social Security Act included a provision that, for states to participate in the Medicaid program, they had to pass laws to govern the licensing of NHAs. In contrast, hospital administrators were not required to be licensed. One key characteristic of licensure is that it is a responsibility of each state, not the federal government. Licensure by the state permits an institution to begin and continue operations and health care professionals to begin and continue to practice (Eustis et al., 1984, pp. 143–145).

Financing of Community-Based Services

Social Security amendments in 1974 authorized federal grants to states for various types of social services. These programs included protective services, homemaker services, transportation services, adult day care, training for employment, information and referral, nutrition assistance, and health support (Lee, 2004). The Social Security Amendment of 1975 created Title 20, which consolidated the federal assistance to states for social services into a single grant. Under Title 20, one of the goals for the states was to prevent or reduce "inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care."[1] In 1981, Title 20 was amended to create Social Services Block Grants. The single block grants actually reduced federal funding to the states for social services. Also, Title 20 covered services for all ages, not just the elderly. Consequently, block grants have provided relatively little money for LTC services.

[1]Title XX appears in the United States Code as §§1397-1397f, subchapter XX, chapter 7, Title 42.

Also in 1981, the Home and Community Based Services waiver program was enacted under Section 1915(c) of the Social Security Act. The 1915(c) waivers, as they are commonly referred to, allow states to offer LTC services that are not otherwise available through the Medicaid program, which had authorized payments for institutional care only. The waivers have been particularly successful, and states have increasingly used them to expand community-based LTC services, thus saving money on institutional care. Today, all states provide waiver services to the elderly, working-age people with disabilities, and those with developmental disabilities. Some states also serve people with AIDS and those with serious mental health problems (Miller et al., 2006). Between 1987 and 1997, spending on waiver programs soared from $451 million to $8.1 billion (Coleman, 1999), an increase of 1,696%. By 2006, there were 329 waivers, and the expenditures amounted to $25.6 billion in state and federal Medicaid dollars (Acosta & Hendrickson, 2008).

Deregulation Averted

In the early 1980s, nursing home regulations came under the broader sweep to deregulate industry and downsize the federal bureaucracy. Rumors leaked out that a task force on regulatory reform in the Reagan administration was planning to downgrade sanitation standards, eliminate staff development requirements, reduce physician visits, delete medical director requirements, reduce social work programs, and ignore certain staff qualifications (Trocchio, 1984). Various interest groups such as consumer advocates and professional associations representing medical directors, social workers, and activity personnel lobbied Congress. In the end, interest group politics and congressional opposition derailed any attempts to deregulate the nursing home industry.

Efforts to Address Quality Issues

The nursing home industry remained fraught with scandals about severely substandard quality of care and an ineffective regulatory system to enforce compliance with standards. At the request of Congress, the Institute of Medicine (IOM) conducted a comprehensive study that culminated in a scathing report on the state of nursing homes in the United States. The study found that residents of nursing homes were being abused, neglected, and given inadequate care. Sweeping reforms were proposed (IOM, 1986). The IOM's prestige lent scientific credibility to its recommendations, and the report triggered the most comprehensive revision of the federal standards, inspection process, and enforcement system for nursing homes since the creation of Medicare and Medicaid in 1965 (Hawes et al., 2007). National organizations representing consumers, nursing homes, and health care professionals worked together to create consensus positions on major nursing home issues and supported them before Congress. Their consensus positions on most IOM recommendations laid the foundation for a new federal law (Turnham, 2001). Although the IOM report has been widely credited to be the impetus for the Nursing Home Reform Act of 1987, it has also been observed that the *Estate of Smith v. Heckler* (1984) class-action lawsuit in Colorado may have played a role. The suit was brought on behalf of all the Medicaid beneficiaries in the state's nursing homes. In essence, the suit charged that the constitutional rights of the nursing home residents were violated because the federal and state governments failed to enforce its laws

and regulations. The district court judge, Richard T. Matsch, ruled against the plaintiffs, but his decision was later overturned on appeal. The appeals court ruled that the Secretary of the Department of Health and Human Services (DHHS) did have a duty to establish a system that could determine whether a nursing facility was providing the high-quality care required by the Social Security Act (Phillips, 1996, pp. 10–14).

In 1987, President Reagan signed into law the Omnibus Budget Reconciliation Act of 1987 (OBRA-87), which contained the Nursing Home Reform Act. OBRA-87 brought enormous changes to nursing home operations. The most important provisions of the law are summarized (Castle, 2001; Turnham, 2001) as follows:

- Emphasis on a resident's quality of life as well as quality of care.
- New expectations that each resident's ability to walk, bathe, and perform other activities of daily living will be maintained or improved absent medical reasons.
- A resident assessment process leading to development of an individualized care plan.
- 75 hours of training and testing of paraprofessional staff, such as nursing assistants.
- Right to remain in the nursing home absent nonpayment, dangerous resident behaviors, or significant changes in a resident's medical condition.
- New opportunities for services inside and outside a nursing home to address the needs of residents with mental retardation or mental illnesses.
- Right to safely maintain or bank personal funds with the nursing home.
- Right to return to the nursing home after a hospital stay or an overnight visit with family and friends.
- Right to choose a personal physician and to access medical records.
- Right to organize and participate in a resident or family council.
- Access to an ombudsman to resolve disputes and grievances.
- Right to be free of unnecessary and inappropriate physical and chemical restraints.
- New remedies to be applied to certified nursing homes that fail to meet minimum federal standards.

OBRA-87 also changed the way state inspectors approached nursing home inspections. Inspectors were to no longer spend their time exclusively with staff or with facility records, as was the case in the past. Conversations with residents and families and observation of dining and medication administration became critical steps in the inspection process (Turnham, 2001).

Ironically, OBRA-87 reforms were nearly repealed in 1995 as part of a larger attempt to reform Medicaid. This time, part of the nursing home industry supported repeal of the OBRA reforms, particularly the enforcement provisions. But consumer advocates, aided by researchers, were able to use empirical evidence about the positive effects of OBRA provisions to effectively oppose the dilution of federal regulations. Once consumer advocates redefined the issue as one of quality of care, Congress opposed the repeal of the Nursing Home Reform Act (Hawes et al., 2007).

OBRA-87 altered the regulatory landscape in a significant way. Even though substantial funds were allocated to carry out the legislative mandate, it was a complex

piece of legislation, and numerous hurdles were encountered in developing regulations. The final rules were published at the end of 1994 to be effective in July 1995, more than eight years after the law had been passed (Phillips, 1996, p. 35).

Oversight for Other Services

It is interesting to note that while the nursing home industry has been under the spotlight from federal policymakers for more than half a century now, the same policymakers have shown little interest in the assisted living industry. The latter has been one of the fastest growing areas of LTC delivery in recent years, and the aging-in-place philosophy has raised the level of clinical acuity of residents in these facilities. The absence of direct federal reimbursement to assisted living facilities is perhaps the reason any federal regulatory oversight is unlikely, unless at some point crises and failure of care similar to those encountered during the long history of nursing homes become apparent (Edelman, 2003). Most regulatory efforts for assisted living facilities have occurred at the state level. Similar variations in state regulations exist for adult day care centers. Medicaid-funded adult day care services must meet applicable state licensing and regulatory requirements such as minimum staff-to-participant ratios. The majority of states have instituted inspections (O'Keeffe & Siebenaler, 2006).

A 1988 court ruling on a class-action lawsuit, *Duggan v. Bowen*, opened up broad access to Medicare-covered home health services, and for some time, home health had become the fastest growing health care service in the United States. In August 1997, Congress enacted the Balanced Budget Act (BBA) of 1997, which mandated that Medicare's cost-based, retrospective reimbursement policy for home health agencies as well as skilled nursing facilities be replaced by a prospective payment system (PPS). This policy was part of a broader financial reform to slow down the growth of Medicare spending. A prospective reimbursement method for skilled nursing facilities was implemented in July 1998 and a home health PPS reimbursement was implemented in October 2000.

Current State of Long-Term Care Policy

The national stage for LTC policy has been largely silent as other pressing issues preoccupy politicians. Long-term care is not expected to see any major changes in the near future. States, on the other hand, continue to forge incremental policy initiatives to expand the purchase of private LTC insurance and reduce the level of institutional care in favor of community-based services. Both initiatives are intended to curtail the states' burden of nursing home expenditures and to save money overall in the LTC delivery system. A third area of state-level policymaking encompasses ongoing efforts to license alternative housing and care facilities. As pointed out in Chapter 1, the institutional continuum of LTC includes various types of living and care arrangements other than traditional nursing homes.

Public policy in long-term care has evolved in three main directions: financing, utilization, and quality. Almost all health care policy can be classified into these categories.

Financing, access, and utilization go hand in hand. ***Utilization*** is the actual use of health care occurs when people needing services have access to them. ***Access*** is the ability of a person needing services to obtain those services. Two main factors drive access: financing and availability of services. If ***financing***

(i.e., the ability to pay for services) is adequate but availability is limited, the services get rationed and access is restricted. On the other hand, if services are available but financing is not, access becomes restricted for those who cannot afford the services. Also, increased utilization negatively affects financing. Increased utilization makes total expenditures rise, and financing becomes constrained.

Financing

Financing is the means by which patients pay for the services they receive. Financing varies by the type of service, and there can be different sources of financing even for the same service. For example, care in a skilled nursing facility can be financed through Medicaid, Medicare, private insurance, Veterans Health Administration, or one's own personal funds. Hence, LTC financing is quite fragmented because no single source can be tapped on to pay for services. Consequently, access and utilization become uneven. People face financial obstacles in a system that is complex and nonintegrated. Complexities arise when people have to move from one type of service to another, such as from nursing home to the community or vice versa, or even when they have to stay within one LTC sector. For example, many who require nursing home care for a long period of time can face a financing nightmare. Medicare pays only for post-acute short-term stays, and Medicaid requires people to exhaust their financial resources to become eligible. Many elders who do not qualify for either program have to pay on a private basis either through private LTC insurance or out of personal savings. In 2005, 44% of the financing for nursing home care was derived from Medicaid, and only 16% came from Medicare. Private out-of-pocket payments financed 26%, and 7% was paid through privately purchased LTC insurance. The remainder was paid through miscellaneous private and public sources (Kaiser, 2007).

Expansion of Community-Based Services

Medicaid remains the largest source of funding for LTC services. It finances 41% of the total spending for LTC services of all types. Spending on Medicaid home- and community-based services (HCBS) has been growing, but states vary greatly in financing HCBS. In 2006, spending on HCBS accounted for 41% ($44.9 billion) of total Medicaid LTC services spending, up from 13% in 1990 (Kaiser, 2007). As mentioned earlier, lawsuits such as *Duggan v. Bowen* and *Olmstead v. L.C.* played an important role in shifting utilization from institution-based care to community-based services. More recently, the Deficit Reduction Act of 2005 provided federal funding to states to expand community-based care. As part of this legislation, Congress granted $1.8 billion over five years for states to provide 12 months of LTC services in a community setting to individuals who currently receive Medicaid services in nursing homes (Kasper & O'Malley, 2006). This legislation may be a turning point in national LTC policy because it makes rebalancing between institutional and community-based services a national priority (Mor et al., 2007) under a federal–state joint initiative referred to as Money Follows the Person. Under this program, when a person transfers from a nursing home to the community, funds that had previously paid for nursing home care are transferred to community-based services for that person.

HCBC has been viewed as a potentially more cost-effective option than nursing home

care, but research evidence remains inconclusive that expanding community-based care lowers overall LTC spending (Grabowski, 2006; Long et al., 2005). It reduces expenditures for nursing home services, but opens up access to HCBS for many who previously did not have access. On the other hand, studies do show that community-based services significantly improve the quality of life of clients. People prefer less restrictive noninstitutional settings over services received in LTC facilities.

Reimbursement to Providers

Other policy issues related to financing surround the levels of reimbursement to providers from Medicare and Medicaid. Nursing home operators have long contended that payments from public payers have been inadequate to support quality services. Independent experts have also voiced opinions that reimbursement levels should be raised. However, Medicaid and Medicare administrators have been concerned about rising expenditures, while the public is not inclined to pay more in taxes. The paradox is that, unlike many other industries, nursing home care is highly labor intensive because caregivers have to render services one on one. Hence, few options are available to increase productivity or slash operating costs.

Incentives for Private Insurance

Coverage for nursing home care from private LTC insurance has increased slightly in recent years, but fewer than 10% of people 50 years of age and older have purchased private insurance for long-term care (Seff, 2003). The elderly population most likely to benefit from private LTC coverage also has a lower average income than the general population. Hence, LTC insurance is difficult to market because premiums must be high enough to cover costs but low enough to attract clients. Insurance is based on the principle of adequately spreading risk among a large segment of the population. However, younger healthy groups have shown little interest in buying LTC insurance because they see the need for LTC only as a remote possibility.

A few states offer tax deductions or credits for purchasing private insurance, but the incentives appear to be too small to induce many people to purchase LTC plans (Wiener et al., 2000). Another state-based policy initiative that is designed to increase the number of middle-income people who buy private insurance is the Partnership for Long-Term Care program. The program was designed by the Robert Wood Johnson Foundation, a private nonprofit organization, through a demonstration project in California, Connecticut, Indiana, and New York. Currently, about half the states have implemented the program. The Partnership program encourages individuals to purchase insurance, and, if these individuals require LTC services, they can apply for Medicaid after their insurance benefits have been exhausted. To qualify for Medicaid, these individuals would be allowed to keep all or some of their financial assets. Otherwise, under Medicaid policy, people have to first use up their income and assets before they can qualify for benefits. Under the Partnership program, exceptions are made to this rule. States have been permitted to do this under the Deficit Reduction Act of 2005. Some experts believe that the Partnership program has made progress toward meeting its goals. For example, the original four states have been modestly successful in promoting quality insurance products. As of mid-2006, about 240,000 Partnership insurance plans had been sold, and about 194,000 were being

used to obtain services. There are critics, but the program was not intended to be a comprehensive solution to all LTC needs; it was designed to fill a financial gap (Alliance for Health Reform, 2007).

Another area in which progress has been made is information to consumers. Long-term care, with its many service and financing options, is confusing for most people. People have also assumed that the government will somehow pay for their LTC needs. Government resources, however, have been shrinking and it is unlikely that public resources will be enough to meet the needs of a burgeoning elderly population. The DHHS has created the National Clearinghouse for Long-Term Care Information (see For Further Learning). The website is designed to help people understand why planning for LTC is important and how they can plan for it.

Utilization

Table 2–1 provides capacity and utilization data for nursing homes. During the 1990s, nursing home beds in the United States continued to increase while their utilization continued to decrease. Between 2000 and 2006, both the number of nursing homes and beds decreased. As a result, there was some improvement in capacity utilization as reflected in the occupancy rates. On the other hand, the utilization of nursing homes by the population, as reflected in the resident rates, has continued to decline at a rather dramatic rate.

During the 1980s, nursing homes entered the subacute and rehabilitation markets, mainly as a result of the DRG-based (diagnosis-related group) prospective payment system implemented in hospitals, which created incentives for early discharge of patients from hospitals. The trend accelerated during the 1990s because the proliferation of managed care put further pressures on reducing the length of stay in hospitals. While these trends should have increased nursing home utilization, other factors in play since the 1980s promoted the use of alternative settings such as home health care, other community-based LTC services, and assisted living facilities.

It is estimated that 5 to 12% of residents in nursing homes require low levels of care according to their functional and clinical characteristics (Mor et al., 2007). Their needs

Table 2–1 Nursing Home Utilization (Selected Years)

	1992	1995	2000	2006
Number of nursing homes	15,846	16,389	16,886	15,899
Number of beds	1,692,123	1,751,302	1,795,388	1,716,102
Occupancy rates[a]	86.0%	84.5%	82.4%	83.5%
Resident rates[b]	444.4	404.5	349.1	270.6

Sources: Data from *Health, United States* 1996–97, p. 248; *Health, United States* 2007, pp. 370–371.

[a]Percent of beds occupied (number of residents per 100 available beds).

[b]Number of nursing home residents of all ages per 1,000 population 85 years of age and over.

could be met with appropriate community-based LTC services. However, HCBS programs, being part of the state-administered Medicaid programs, have not developed uniformly across states. Also, states vary in their enthusiasm for nursing home transition programs. Some states, for example, have transitioned residents to assisted living facilities instead of home- and community-based services. Motivation of individuals and their families and the availability of a community support system to supplement formal services are viewed as key factors in determining who transitions back to the community from nursing homes. Logistical barriers may also hamper transitions. For example, hospital discharge planners find it easier to move patients from the hospital to nursing homes. Arranging for appropriate community-based services is generally time consuming and complex because it requires coordination and determination of how services will be financed. Other obstacles include shortage of housing alternatives (Mor et al., 2007) and waiting lists for community-based care in some states (Kasper & O'Malley, 2006).

Some efforts are being made at the state level to carry out evaluations of HCBS to improve the programs. In the meantime, policymakers are hesitant to broadly implement new initiatives because they have not been validated for quality and evaluated for how much they would end up costing (Acosta & Hendrickson, 2008).

Private paying patients have found the residential and social lifestyles in assisted living facilities to be much more appealing than those in skilled nursing facilities. Many people have figured that they might as well spend their personal savings in an upscale assisted living home and later apply for Medicaid if they need care in a skilled nursing facility.

Quality

Quality has been a well-recognized issue in LTC for some time. Because Medicare and Medicaid finance more than half of the nation's nursing home care, government regulations play a major role in establishing standards to ensure at least the minimum level of quality. Research has demonstrated that the overall effects of this regulation have been positive. On the other hand, little has been done to ensure quality of care in assisted living facilities and for community-based services.

From the standpoint of quality of care delivered to nursing home residents, OBRA-87 was revolutionary. For example, the sharp decline in the use of physical and chemical restraints has been attributed to the requirements of OBRA-87. Other positive care practices since the implementation of OBRA-87 standards include improved staffing levels, more accurate medical records, comprehensive care planning, increased use of incontinence training programs and a decrease in the use of urinary catheters, and increased participation of residents in activity programs (Hawes et al., 1997; Marek et al., 1996; Teno et al., 1997; Zhang & Grabowski, 2004). OBRA-87 also mandated a comprehensive patient assessment process, which led to the development of a standardized Resident Assessment Instrument (RAI). The assessment protocols are designed to help nursing homes identify and treat or manage chronic conditions, the onset of acute illnesses, adverse effects of medications, or other factors that caused or contributed to a clinical problem (Hawes, 2003).

Although substantial progress has been made, OBRA-87 remains controversial for several reasons:

- In 2006, nearly one-fifth of the facilities were cited for violations that caused harm or presented immediate jeopardy to residents. Improvements appear to have reached a plateau (Wiener et al., 2007).
- Regulations continue to be inconsistently applied both within and across regions (Miller & Mor, 2006). Over a decade ago, Phillips (1996) had pointed out that there were significant differences in how inspectors applied the regulations and gave citations for noncompliance with the regulations. The oversight process is reliable only for assessing aggregate results, but inspectors frequently disagree on the scope and severity of problems uncovered (Lee et al., 2006).
- Phillips (1996) concluded that only 16% of the OBRA-87 regulations actually focused on clinical care and therefore did not primarily focus on high-quality care.
- Enforcement of OBRA-87 regulations takes on a punitive rather than a remedial tone. Nonflagrant violations can be better addressed with a focus on improvement rather than punishment (Willging,[2] 2008).
- Staffing levels have been relatively stable for many years, despite the increased clinical acuity in the patient population (Wiener et al., 2007).
- There is practically no available quantitative data on quality of life, which is an important component of LTC (Wiener et al., 2007).

[2]Dr. Willging was president of the American Health Care Association (AHCA) at the time OBRA-87 was passed. The AHCA was heavily involved in representing the for-profit nursing home sector, which supported the legislation.

Policy for the Future

The future of LTC will be shaped by both policy and innovation, but policy will continue to play the dominant role. Long-term care faces many serious challenges ahead. Much will depend on (1) the health status of Americans and the prevalence of disability in the population; (2) birth and mortality rates; (3) quality of education for the younger generation, innovations that generate national wealth, and quality of immigration that would be necessary for a strong economy; and (4) availability of financial resources as well as priorities for their use. These factors are critical from a broad policy perspective. The future need for LTC services is just one part of the equation; much will depend on the nation's ability to actually finance and deliver the needed services. For example, if the infrastructure for delivery (such as a skilled workforce) is inadequate, many people may have to do without the services they may otherwise need.

The complex interaction among financing, access, and utilization for LTC services would play out within a broader context of health policy for two main reasons: (1) The aging of the population will have far-reaching repercussions beyond LTC, with spillover effects for retirement, Social Security, primary health care, acute care in hospitals, and numerous other health care services. With aging, the utilization for all types of health care services increases, not just the need for LTC. (2) Financing for LTC services is an integral part of the Medicare and Medicaid programs, which also cover various types of other health care services.

Life expectancy for a newborn in the United States has risen from 68.2 years in

1950 to 78.1 years in 2006, the highest ever recorded (Heron et al., 2008). During the same time period, birth rates[3] dwindled from 24.1 to 14.2 (Martin et al., 2009). More than 75 million baby boomers are about to enter retirement age in 2011 and beyond. Between 2005 and 2050, the nation's elderly population is projected to more than double, while the number of working-age Americans and children will grow more slowly than the elderly population (Passel & Cohn, 2008).

Future growth of one population group at the expense of another group (in this case, growth of the elderly population while at the same time a contraction of the working population) is called the ***demographic imperative***. It has potentially serious consequences at two main fronts: (1) With fewer working people and a burgeoning elderly population, the financial burden for LTC on future generations is expected to be enormous. This is an impending dilemma that policymakers have been reluctant to bring up for public policy debates. (2) A labor force crisis for LTC delivery is already beginning to emerge because a smaller proportion of people from a shrinking pool of new workers are choosing employment in health care delivery settings (Stone & Wiener, 2001). Commissions have been organized at both federal and state levels to recommend solutions to address the issue of labor shortages (Friedland, 2004).

The future need for LTC will be closely associated with health and disability trends in an aging population. Actually, some research has shown that there are positive trends in the health of older Americans, thanks to advances in medical treatments. The bad news, however, is that obesity and diabetes have both increased among older people as it has in the younger age groups, and hypertension has increased in older women (Kramarow et al., 2007). Nevertheless, at least according to one source, the rise in the number of people with activity limitations is expected to moderate over time. Acosta and Hendrickson (2008) projected the number of people with activity limitations to rise 14% between 2010 and 2020, but the rate of increase would moderate to 10.5, 7.9, and 5.8%, respectively, during the subsequent 10-year periods between 2020 and 2050. Even according to this scenario, the aging demographic lends urgency to how best to restructure federal and state budgets to pay for more than 12 million older Americans who will probably need LTC services starting in 2010 (Acosta & Hendrickson, 2008). On the other hand, policymakers will continue to explore new ways for providing cost-effective LTC services without turning LTC into an expanded social program because both Medicare and Medicaid face serious cost challenges in the future. As part of these efforts, funding for community alternatives will continue, but many recipients of care in the home- and community-based settings will eventually need to be institutionalized. In addition to policies that promote community-based care, other policies can help strengthen the LTC system.

Prevention

LTC policy issues tend to focus on receiving and delivering care, rather than on actions that can prevent or delay the need for care. Enhancing community environments that can promote walking—such as repairing or building sidewalks, ensuring safety from traffic, protecting older adults from crime, and promoting leisure activities—can improve physical activity and promote better health. Other

[3]Birth rate is number of live births per 1,000 population.

preventive measures include a balanced diet, obesity control, smoking cessation, and vaccinations against influenza and pneumonia. Both community-based and institution-based fall prevention programs are critical because they result in high medical costs, disability, functional limitations, and diminished quality of life (CDC/Merck, 2007).

Financing

Currently, most middle-class families are unprepared to meet LTC expenses. Most people think that Medicare would pay for their LTC needs, but Medicare covers only short-term post-acute care after discharge from a hospital. Less than 10% of the elderly have private LTC insurance (Burke et al., 2005). Without a strong reliance on private LTC insurance coverage, the public sector will see its expenditures grow rapidly. Purchasing LTC insurance is both expensive and confusing. Also, current tax policies provide greater incentives to business owners and older adults than to younger people when they purchase LTC insurance. The Congressional Budget Office (CBO, 2004) recommended improving the way private markets for LTC insurance currently function, but policy initiatives are needed to expand purchase of private insurance.

Workforce

It is estimated that between 2000 and 2010 alone, when the baby boomers are about to reach retirement age, an additional 1.9 million direct care workers would be needed in LTC settings (DHHS, 2003). Stone (2003) believes that shortage of a stable and qualified workforce may be the most important and most neglected policy concern. The infrastructure can be severely restricted in its capacity to provide services without an adequate number of qualified workers. Experts in LTC rate workforce issues at par with the aging of the population itself (Miller et al., 2008). An inadequate supply of qualified workers hinders recruitment efforts. Once recruited, retention becomes equally challenging. Some health care workers have low preferences about caring for elderly people who have physical and mental incapacities. Hard work without adequate pay is another factor that makes people leave employment in the LTC sector (see Chapter 16 for details on effective recruitment and retention).

Another issue that must be addressed is training deficits in geriatrics among physicians, nurses, therapists, social workers, and pharmacists. Ironically, all 125 U.S. medical schools have a pediatrics department, but only three have a geriatrics department. Evidence shows that care of older adults by health care professionals prepared in geriatrics yields better physical and mental outcomes without increasing costs (Cohen et al., 2002). It is estimated that only about 9,000 practicing physicians in the United States (2.5 geriatricians per 10,000 elderly) have formal training in geriatrics. This number is expected to drop down to 6,000 in the near future. Among nurses, less than 0.05% have advanced certification in geriatrics (CDC/Merck, 2004).

There are also not enough well-trained administrators to provide leadership in the LTC field. Recruitment and retention of NHAs is a growing problem nationwide (Maine Department of Professional and Financial Regulation, 2004). Lack of appropriate educational standards as a requirement for licensure of NHAs no doubt contributes to the problem. In turn, the shortage of NHAs prevents the raising of national educational

standards to a minimum of a bachelor's degree in health care administration.

Health Information Technology

Leaders in the LTC field tend to look to the government for direction in health information technology (HIT) adoption (Hudak & Sharkey, 2007). Interoperable HIT can enable providers to track patients' care across hospitals, nursing homes, home health agencies, pharmacies, and physicians' offices. Interoperability is essential for an integrated system of health care that interfaces with LTC services. Long-term care needs to be fully represented in all future interoperable electronic health records. Such systems are particularly critical because the elderly frequently make transitions between LTC and non-LTC settings. Currently, such transitions rarely occur smoothly because of high rates of missing or inaccurate information (Miller & Mor, 2006). HIT can also help reduce isolation among seniors and caregivers through electronically enabled social networks and online training for caregivers (Martin et al., 2007). HIT applications can also improve staff efficiency, interface with quality measures, reduce billing errors, improve clinical accuracy, and improve communication among providers.

Mental Health

The quality of mental health services in LTC settings remains a challenge. There are concerns that patients are not receiving the mental health care they need or that they are receiving inappropriate, and sometimes unnecessary, mental health services. Even though certain aspects of mental health and psychiatric care are addressed in the OBRA-87 legislation, outcome evaluations have presented challenges (Streim et al., 2002).

Evidence-Based Practices

As pointed out earlier, quality improvement in LTC has come to a standstill. Also, there is little evidence that merely increasing the amount of spending improves quality. To the contrary, quality improvement often reduces costs. Evidence-based practices will drive the future of quality improvement in all types of health care delivery settings. Best practices in the form of clinical practice guidelines have been developed for long-term care. However, no policy initiatives have emerged to provide incentives for their use.

For Further Thought

1. Why is it important for administrators in the long-term care field to understand policy and policymaking?
2. What lessons in U.S. policymaking can be learned from the passage of the Nursing Home Reform Act in 1987 and its near-repeal in 1995?
3. Do interest groups help or hinder the policymaking process?
4. Should policy be made only after due consideration of its cost-benefit?

For Further Learning

Clearinghouse for the Community Living Exchange Collaborative: A joint effort of the Institute for Rehabilitation and Research and Rutgers Center for State Health Policy. The Exchange is a vital hub of information collection, sharing, and dissemination.

http://www.hcbs.org

National Clearinghouse for Long-Term Care Information. U.S. Department of Health and Human Services

http://www.longtermcare.gov/LTC/Main_Site/index.aspx

Overview of the Nursing Home Reform Act

http://www.ltcombudsman.org/uploads/OBRA87summary.pdf

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