What You Will Learn

• Decisions made by the government in the form of policy can affect numerous groups and classes of individuals. Strategic decisions made in private organizations may also hinge on public policy.
• Public policy can take many different forms. Policies can come from all three branches of government.
• 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 a nursing home industry that has remained mostly private. 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 has been directed toward moving people out of nursing homes into the community.
• 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.
Introduction

Long-term care (LTC) 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. 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 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, hospitals, manufacturers of medical technology, or employers in the American industry. The Affordable Care Act (2010), also known as Obamacare, is a prime example of a major health policy that also extends into the broader domain of public policy because of its tax consequences on individuals and businesses.

LTC policy is specifically crafted to address issues pertaining to access, financing, delivery, quality, and efficiency of LTC services. These 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; and manufacturers and purveyors of technology and medical supplies.

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.

The term policy is also sometimes used in the context of private policy. More appropriately, however, private policies are strategic decisions that senior managers in private organizations make to better serve their markets. For example, the increased prevalence of dementia among the elderly has prompted the growth of specialized Alzheimer’s care facilities in response to a rising market demand. 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. Hence, in addition to market demand factors, policy considerations can play a critical role in strategic decisions.

Types 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. Thus, in the process of interpretation and implementation of laws, administrative bodies also end up creating 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 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 for Congress to act on. 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 care. Examples in all three areas follow.

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 State Children’s Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (MedPAC, 2002).

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. In 2012, the U.S. Supreme Court upheld part of the Affordable Care Act to be constitutional, but also ruled that the federal government could not coerce the states into expanding their existing Medicaid programs as required by the act.

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**).

These examples 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, withholding of payments by the government, and prison terms for criminal offences.
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.

LTC policies in the United States had three major effects:

1. The government became the largest payer for services provided by nursing homes. This encouraged the growth of a private nursing home industry.
2. The government implemented policies to regulate nursing homes.
3. For several decades, long-term care policy actually promoted institutionalization because there was little financial incentive to develop community-based services. As rising costs put strains on federal and state budgets, it was not until the 1980s that policies promoting community-based services were crafted.

Welfare Policies and Long-Term Care

The history of LTC policy in the United States goes back to the building of poorhouses in the late 17th century. A poorhouse (or almshouse) was a government-operated institution during colonial and postcolonial 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, also 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. Between 1894 and World War I, the State Care Acts were passed. Each state built its own mental asylum and took financial responsibility for the care of mentally ill patients. These reform efforts even spread 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 fueled a reform movement...
to move people out of poorhouses. An Old Age Assistance (OAA) program was included in the Social Security Act. The OAA program made federal money available to the states to provide financial assistance to needy elderly persons. 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, n.d.). The new law purposely prohibited payments to anyone living in a public institution (i.e., a poorhouse), and was instrumental in putting an end to the poorhouse system (Wagner, 2005, pp. 132–133). An unintended side effect of this policy, however, was that it started a private for-profit nursing home industry in the United States because many elderly now were able to pay for services in privately run homes for the aged and boarding homes (Eustis et al., 1984, p. 17). Private nonprofit homes for the aged did not grow at the same rate as for-profit homes because the nonprofit facilities were established to care for members of particular religious, ethnic, or fraternal groups and thus restricted whom they would admit (Doty, 1996).

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. By public policy, nursing homes now became recognized as institutions of medical care rather than social welfare. 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 rules (Phillips, 1996). It is estimated that by 1960 there were over 10,000 nursing homes with 400,000 beds in the United States (Vladeck, 1980).

**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 in the American health care landscape. Medicare and Medicaid are two major public health 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.

With the creation of Medicare and Medicaid, LTC became more fully integrated into the U.S. health care delivery system. Also, the federal and state governments became the largest payers for LTC services, and the politics of long-term nursing home care took root. 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 need to be 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 regulations for skilled nursing facilities were finalized, and their enforcement began in earnest. Compliance with standards, known as conditions of participation, in areas 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 (U.S. Department of Health, Education, and Welfare, 1975).

Interestingly, licensing of health care professionals and hospitals was initiated by the professionals themselves and by hospitals, 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 lapses in care. 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).

Policies Favoring 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.” 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.

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 called, 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.

**Deregulation Averted**

In the early 1980s, nursing home regulations came under the broader sweep to deregulate the 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.

**Legislation to Address Quality Issues**

The nursing home industry remained fraught with scandals about 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 mechanism 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 presented 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 as follows (Castle, 2001; Turnham, 2001):

- Emphasis on residents’ 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 for nursing assistants
- Right to remain in the nursing home absent nonpayment, dangerous resident behaviors, or significant changes in a resident’s medical condition
- Procurement of services both 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 one’s own 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 that OBRA had produced positive outcomes. 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
The final rules were published at the end of 1994 to be effective in July 1995, more than 8 years after the law had been passed (Phillips, 1996, p. 35).

Policies to Regulate Other Services

It is interesting to note that although 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; all states now require licensing of assisted living facilities. State regulations for adult day care centers vary. 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 also 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 care had become the fastest growing 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.

In 2001, President George W. Bush announced the New Freedom Initiative and signed Executive Order 13217 to expedite the implementation of the Supreme Court’s ruling in Olmstead v. L.C. that required individuals with disabilities to have community living options.

The Deficit Reduction Act of 2005 authorized the Money Follows the Person program. It was a 5-year demonstration project that provided $1.75 billion in federal grants between 2007 and 2011 to the states to help strengthen their Medicaid programs to move people out of nursing homes into the community. 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. By the end of 2010, almost 12,000 people nationwide had transitioned to the community (Denny-Brown et al., 2011). This program experienced a slow start, but, as discussed in the next section, it has been bolstered through additional federal funding.

Current State of Long-Term Care Policy

Public policy in long-term care has evolved in three main directions: financing, utilization, and quality; all three go hand in hand.
Utilization is the actual use of health care that 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 affects financing negatively as total expenditures rise. Reduced levels of financing, however, affect quality negatively.

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 to pay for services. Consequently, access and utilization become uneven. People face financial obstacles in a system that is complex and nonintegrated. For example, middle-income people who require nursing home care for a long period of time can face a financing nightmare. Medicare pays only for postacute 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.

Shift in Financing to Favor Community-Based Care

Medicaid remains the largest source of financing LTC services. In 2011, 40% of the $357 billion spent nationally on all types of LTC services was attributed to Medicaid (Kaiser Commission on Medicaid and the Uninsured, 2013).

Today, all states provide 1915(c) waiver services to the elderly, working-age people with disabilities, and those with developmental disabilities. In addition, 44 states and the District of Columbia participate in Money Follows the Person program. As Figure 2–1 illustrates, total Medicaid expenditures between 2006 and 2011 increasingly shifted from financing nursing home care to home- and community-based services (HCBS) so that in 2011 Medicaid spent 23% more on HCBS than on nursing home care.

To date Money Follows the Person program remains far less effective than 1915(c) waivers. The former accounted for less than .05% of Medicaid spending on HCBS in 2011, whereas 1915(c) waivers accounted for 59% (Eiken et al., 2013). An insufficient supply of appropriate and affordable housing has been cited as the most common problem in transitioning people under Money Follows the Person (Denny-Brown et al., 2011). Nevertheless, the Affordable Care Act has expanded the program for another 5 years through 2016 and appropriated $2.25 billion in grants to the states (CMS, 2014).

The Affordable Care Act also created a new program, Community First Choice.
Under this program, states have the option to provide home- and community-based attendant services and supports. A 6% increase in the federal matching payments under Medicaid is available to the states to implement this program.

There is some evidence that services received under HCBS waivers result in cost savings over receiving care in a nursing home (Shapiro et al., 2011). Conversely, when HCBS programs are cut back the overall LTC costs to states increase (Howes, 2010). Further evidence shows that the amount of services received by individuals in community-based settings is important for reducing the risk for nursing home placement (Sands et al., 2012). For example, Sands and colleagues found that every 5-hour per month increase in attendant care services reduced the risk of nursing home placement by 5%; every 5-hour per month increase in homemaking services reduced the risk by 13%.

**Reimbursement to Providers**

Nursing home operators have long contended that payments from public payers, particularly Medicaid, have been inadequate to support quality services. Independent experts have also voiced opinions that reimbursement levels should be raised, and research shows that reimbursement levels have ramifications for nursing home quality—increased Medicaid payments result in improvements in clinical quality (Mor et al., 2011). However, Medicaid and Medicare regulators have been concerned about rising expenditures, whereas 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.

Some states have experimented with pay-for-performance (P4P) reimbursement models for Medicaid under the assumption that P4P would improve quality. However, research shows that P4P does not result in consistent improvements in nursing home quality of care (Werner et al., 2013).

Incentives for Private Insurance

Private LTC insurance is particularly expensive if a plan is purchased in the later years of a person’s life. People in younger age groups, for whom the cost of LTC insurance would be more affordable, face other financial priorities, such as saving for retirement, children’s college education, life insurance, and buying a home. The need for LTC in the distant future is considered a much lower priority.

In 2009, only 7 million Americans (7% of those over age 50) had LTC insurance coverage (National Health Policy Forum, 2011). 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.

Public policy has created few incentives to stimulate the growth of LTC insurance. Subsequent to a demonstration project in four states, the Robert Wood Johnson Foundation designed a program called Partnership for Long-Term Care. 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 first have to use up their income and assets before they can qualify for benefits. Under the partnership program, exceptions are made to this rule. The Deficit Reduction Act of 2005 allowed all states to adopt the partnership program. About 40 states have adopted the policy, however, this policy has had only a modest effect in spurring the purchase of LTC insurance. The program was intended to incentivize middle-class Americans into buying LTC insurance, but the one group that has notably responded is the wealthy (Haizhen & Prince, 2013).

A recent policy initiative in the form of the Community Living Assistance Services and Supports (CLASS) Act, a self-funded voluntary program to purchase LTC insurance from the government, was made part of the Affordable Care Act but was later dropped. Officials in the Obama administration conceded that if they designed a benefits package generous enough to meet the law’s requirements, they would have had to set premiums so high that few healthy people would enroll. And without a large share of healthy people in the pool, the CLASS plan would have become even more expensive, forcing the government to raise premiums even higher, to the point of the program’s collapse (Aizenman, 2011).

In the meantime, most Americans over the age of 50 believe that the government should provide tax incentives for the purchase of LTC insurance (America’s Health Insurance Plans, 2012).
Utilization

During the 1990s, nursing home beds in the United States continued to increase whereas their utilization continued to decrease. Between 2000 and 2005, 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. Since then, there has been a continuous decline in nursing home capacity and utilization (Table 2–1). There are two main reasons for this: (1) As discussed earlier, policy initiatives have emphasized a shift away from traditional nursing home care for those who can be accommodated in the community. 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 could be met with appropriate community-based LTC services. (2) Private paying patients have found the more independent lifestyles in residential/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. Although progress has been made in improving nursing home quality, 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 outcomes 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 social and recreational programs (Hawes et al., 1997; Marek et al., 1996; Teno et al., 1997; Zhang & Grabowski, 2004).

Table 2–1 Nursing Home Utilization (Selected Years)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of nursing homes</th>
<th>Number of beds</th>
<th>Occupancy ratesa</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>16,389</td>
<td>1,751,302</td>
<td>84.5%</td>
</tr>
<tr>
<td>2000</td>
<td>16,886</td>
<td>1,795,388</td>
<td>82.4%</td>
</tr>
<tr>
<td>2005</td>
<td>15,995</td>
<td>1,724,582</td>
<td>83.3%</td>
</tr>
<tr>
<td>2011</td>
<td>15,702</td>
<td>1,703,486</td>
<td>81.6%</td>
</tr>
</tbody>
</table>

*aPercentage of beds occupied (number of residents per 100 available beds).

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 are 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, 2008).

In 2001, the DHHS announced the formation of the Nursing Home Quality Initiative, with a focus on making quality reports on nursing homes available to consumers over the Internet. Subsequently, the CMS released Nursing Home Compare as a guide for decision making by consumers. This competition-based reform has resulted in improvements in most postacute care performance measures (Werner et al., 2009).

### Policies for the Future

The Institute of Medicine (2007) projected that the number of older adults with impairments or limitations could increase from approximately 14 million in 2007 to more than 28 million in 2030. It is also estimated that older and fragile adults will outnumber those between the ages of 25 and 64, many of whom are informal caregivers (Johnson et al., 2007). 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.

The increasing prevalence of dementia is another piece in the demographic puzzle. In 2013, an estimated 5 million older Americans had Alzheimer’s disease. Although the majority of people with Alzheimer’s in the United States are white, African Americans and Hispanics are proportionately more likely to suffer from the disease (Dilworth-Anderson et al., 2008). By 2050, the number of elderly with Alzheimer’s disease in the United States could reach between 13 and 16 million. Health care costs, including those for LTC, are approximately 3 times more for those with dementia compared to those without dementia (Alzheimer’s Association, 2013).

With an aging population, not only the United States but the rest of the world also faces a looming global epidemic of
Alzheimer’s disease and other dementias. In 2006, the worldwide prevalence of Alzheimer’s was 26.6 million; it is expected to quadruple by 2050. It is also estimated that 43% of the cases would need high levels of care, equivalent to that provided in nursing homes (Brookmeyer et al., 2007). Alzheimer’s Disease International, a federation of 79 Alzheimer’s associations around the world, has called upon all governments to develop a national dementia strategy. It described dementia as one of the most significant health crises of the 21st century (Assisted Living Federation of America, 2013). It is also estimated that by 2050, 71% of all people with dementia will live in low or middle income countries (Prince et al., 2013). Of course, new developments in medical technology to prevent or control this disease could alleviate the crisis to some extent. Nevertheless, policy initiatives need to be taken before the problem gets out of control.

Long-term care faces other 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. These public insurance programs have been under growing financial pressures.

Prevention

The Affordable Care Act has taken a significant step in requiring all private and public health insurance plans to include preventive care and wellness. For example, effective January 2011, Medicare included an annual physical exam (called a Wellness Exam) as part of the covered benefits without any deductibles or copayments. The main purpose of the wellness exam is to do a risk assessment and develop an individualized prevention plan. Yet, much of disease prevention requires changes in personal behaviors and policy interventions that affect other than health care. For example, enhancing community environments that can promote walking, such as repairing or building sidewalks; protecting older adults against crime; and promoting leisure...
activities can improve physical activity and promote better health. An estimated 10% of the new cases of dementia can be avoided through better public health measures, such as targeting smoking, underactivity, obesity, hypertension, and diabetes (World Health Organization, 2012).

**Financing**

Currently, most middle-class families are unprepared to meet their future LTC expenses. Most people think that Medicare would pay for their LTC needs, but Medicare covers only short-term postacute care after discharge from a hospital. Without a strong reliance on private LTC insurance coverage, the public sector will see its expenditures grow rapidly. However, despite the realization among policymakers of a potential crisis in long-term care, a comprehensive policy to address the issue has not emerged. The main dilemma is how to make LTC insurance more affordable without putting additional tax burden on younger Americans.

**Workforce**

Experts in LTC rate workforce issues at par with the aging of the population itself (Miller et al., 2008). A stable and qualified workforce has been referred to as the most important and yet the most neglected policy concern (Stone, 2003). The supply of workers appears to be cyclical, as it tends to follow fluctuations in the economy. Although a shortage of LTC workers has been predicted in the past, with high current rates of unemployment in the overall economy it is unclear whether a shortage of workers in the long-term care industry exists (McCarthy, 2013). Nevertheless, the demographic imperative strongly suggests a future workforce shortage. Ironically, the most vulnerable elderly—those on public assistance—are likely to suffer the most as the available workforce would tend to gravitate toward those who could pay for their services through private sources. The Eldercare Workforce Alliance, a coalition of 28 national organizations, has called for policy initiatives to address this impending problem. It is unfortunate that the most sweeping health care reform, the Affordable Care Act, does not touch upon this issue. Hence, under the law’s initiatives, moving a large number of the elderly and disabled out of nursing homes into the community may turn out to be a misdirected policy.

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 to 6,000 in the near future. Among nurses, less than 0.05% have advanced certification in geriatrics (Centers for Disease Control and Prevention/Merck, 2004).

Some difference in training can be made through licensure requirements for health professionals, such as graduation from programs that include a geriatric component in the overall educational curriculum, followed by clinical placement in long-term care. This can be coupled with educational assistance for a commitment and subsequent employment in long-term care.
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. Research shows a positive association between the education level and training of administrators and quality indicators (Castle et al., 2013).

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. Such transitions do not always 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. A review of the research literature by Grabowski and colleagues (2010) suggests that persons with mental illness are frequently admitted to nursing homes and their care is often of poor quality.

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 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.

Innovations in Care Delivery

Starting with the baby boomers, the next generation of elderly will demand care delivery processes in which they will seek the right to dictate their choices and preferences. Many nursing care facilities are responding by adopting practices that reflect person-centered care and culture change. Regulators will need to incorporate these evolutionary changes into their oversight policies and practices.
Case

Long-Term Care for All

The newly elected governor of a small state in which the elderly comprise 26% of the total population—twice the national average—is eager to fulfill his campaign promise. He had run for office on the slogan “long-term care for all.” The elderly in the state had overwhelmingly voted for him. Now in office about 9 months, his advisors tell him that providing long-term care services for all citizens in the state will be next to impossible because of high demand for the services. The governor, however, remains undeterred. The cornerstone of his proposed policy includes three things: (1) Develop a state-sponsored long-term care insurance plan. The insurance premiums will be income based, and will cost at least 15% less than a midlevel private long-term care insurance plan being sold in the state. (2) Make it mandatory for all citizens, old and young, to purchase LTC insurance, either from the state or from a private insurance company. (3) Place restrictions on the use of nursing home and assisted living services in favor of community-based services.

Questions

1. Give specific reasons why the governor’s policy may not work, pointing out specific problems that would likely arise.
2. Will the policy work in a large state, everything else being equal? Give reasons.
FOR FURTHER LEARNING

The National Consumer Voice for Quality Long Term Care. The website offers information on several current issues.
http://www.theconsumervoice.org

Overview of the Nursing Home Reform Act
http://www.allhealth.org/briefingmaterials/OBRA87Summary-984.pdf

U.S. Department of Health and Human Services. Basic information on long-term care, with links to resources on Medicare, Medicaid, and Alzheimer’s.
http://www.longtermcare.gov

REFERENCES


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