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STATEMENT OF

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BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

ON

ENTERING A NURSING HOME: COSTLY IMPLICATIONS FOR MEDICAID AND THE ELDERLY

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Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss GAO's study of the problems which lead to the admission of individuals to nursing homes when, with appropriate supportive services, they could have remained in the community.

Long-term care in our study is defined as a group of health, social, income and housing services provided to individuals who have chronic physical or mental conditions which permanently impair their ability to perform essential activities of daily living such as bathing, eating and shopping. These services can be provided in a variety of settings including the individual's home, outpatient facilities, sheltered or congregate housing, and institutions such as nursing homes.

The use of nursing home care, however, when community-based care would have been preferred or appropriate, has serious implications. Premature or avoidable institutionalization results in high human costs for those individuals who must give up their independence and accustomed way of life when they enter a nursing home. It also represents an ineffective use of Medicaid funds.

Medicaid has become the major payer for the long-term care of the chronically impaired elderly in nursing homes. In 1978 Medicaid financed 46 percent of the total $15.751 billion national nursing home bill. In contrast, Medicaid's home health benefits in FY 1978 represented an outlay of $221 million. Medicaid costs for nursing home care are expected to increase to $9.5 billion by 1984.

Avoidable use of nursing homes is partly a result of problems in the admissions process. We reviewed this process, particularly in respect to the effect Medicaid and other public policies have on the decisions of

the elderly and their families to use nursing home care even when community based long-term care is preferred and appropriate. The elderly are the focus of the study because they are the primary users of nursing home care; in 1977 86 percent of all nursing home residents were 65 or older.

THREE CAUSES OF AVOIDABLE NURSING HOME ADMISSIONS

Three areas which contribute to avoidable nursing home admissions were addressed in our analysis:

--Medicaid's eligibility policies, which create financial incentives to use nursing homes rather than community services

--Barriers encountered by the elderly and their families who atempt to obtain community services

--Medicaid assessment procedures for determining the elderly's need for nursing home care.

Medicaid's Eligibility Policies

The first problem that I would like to discuss deals with Medicaid's eligibility policies and benefit package which create a financial incentive to place the chronically impaired elderly in institutions. Medicaid, Medicare and other public programs provide little or no financial coverage for the community-based long-term care services needed to prevent or postpone institutionalization. At the same time Medicaid provides full or partial coverage for long-term care in a nursing home.

For many chronically impaired elderly the only adequate source of financial assistance for long-term care is Medicaid's nursing home benefit. The following examples identify common situations which affect the elderly in the community who cannot purchase the care they need to remain at home and must consider entering a nursing home to receive support.

1. Some Medicaid-eligible elderly cannot obtain the in-home or community-based services needed to help them cope with their chronic impairments because the State has placed tight limits on these services under its Medicaid benefit package. However, if these individuals enter a nursing home, Medicaid will provide full or partial coverage for the individual's long-term care, including room, board and services.

2. Another segment of the population who may have to enter a nursing home to receive long-term care is the elderly poor who are ineligible for Medicaid but who cannot afford to purchase the services they need to remain safely in the community. Many of these individuals may become eligible for Medicaid if they enter a nursing home because the State has set a different income standard for Medicaid eligibility for institutional residents. For example, certain States may set a higher income eligibility standard for institutionalized persons as long as this standard does not exceed 300 percent of the Federal Supplemental Security Income Standard. Consequently, an individual with an income of $590 a month would be ineligible for Medicaid if residing in the community but would become eligible for Medicaid upon admission to a nursing home.

3. A third group of elderly who become Medicaid-supported nursing home residents are those who enter as private patients and subsequently turn to Medicaid after they have become impoverished, either by transferring their assets to their relatives or by depleting their resources on costly nursing home bills.

An increasing proportion of the Medicaid nursing home population is composed of residents who entered as private pay patients and converted to Medicaid

after depleting their resources in the facility. In addition, because of the high cost of nursing home care, many of these conversions occur within a short time after admission. In 1978 two-thirds of the Medicaid nursing home residents who converted to Medicaid in one county in New York had been private pay patients a year or less. Our analysis of the data from the 1976 Survey of Institutionalized Persons conducted by the Census Bureau showed that the longer an individual is in a nursing home the more likely it is that he or she is receiving Medicaid. This means that a large number of residents currently supported by Medicaid in nursing homes were ineligible for Medicaid assistance in obtaining community-based long-term care services.

The lack of adequate financial assistance for community-based long-term care services also has a detrimental impact on families who provide the vast majority of long-term care support and are often the key factor in preventing institutionalization of their elderly relatives. Because they receive little or no assistance from Medicaid or other public programs, they may experience serious financial and emotional strain. Many families can obtain substantial help only by placing their elderly relatives in a nursing home where Medicaid will often assume the financial burden.

Inaccessible or Unavailable Community Services

In addition to inadequate financial resources the chronically impaired elderly and their families often face a number of other barriers in trying to obtain community-based long-term care services. Many chronically impaired individuals require a package of health and social services to help them cope with activities of daily living. For example,

an individual may need home health care, homemaker services, meals on wheels and transportation assistance. Yet, these services often are provided by a maze of public and private service providers. Consequently an impaired elderly person may be required to locate and travel to several agencies to apply separately for each service. Typically each agency performs its own assessment to determine whether the individual meets its eligibility criteria. Thus, even with a great deal of time and effort, it may be impossible to assemble the required package of services because the individual is found to be ineligible for one or more types of assistance.

Many elderly and their families have no one to turn to for assistance in planning and obtaining community-based long-term care services. In fact, community services may never even be considered before an elderly person is admitted to a nursing home because of a lack of information about these services among consumers and the professionals assisting them--the physicians, hospital discharge planners, and social service department case workers. There is a tendency among these professionals to recommend nursing home placement because they lack the time to plan, arrange and coordinate community services. For example, even though hospital discharge planners are responsible for developing the most appropriate care plan for a patient who no longer needs acute care, they often lack the time or the staff to explore community service options. One study of the role of hospital social workers in the discharge planning process found that the social worker spent an average of 5 hours arranging each nursing home placement, of which 1 hour was actually spent with the patient. The social worker had little time to do anything other than locate a nursing

home and arrange for the patient's transfer.

One of the major barriers faced by many elderly and their families who seek an alternative to nursing home placement is the lack of essential services. For example, critical in-home services may not exist in the community or may be unavailable on a 24-hour, 7-day-a-week basis. Support services for family members who care for their impaired elderly members are generally not provided under any public programs. A variety of services are needed to help relieve the strain on family caretakers including: counseling on emotional, financial and legal matters; adult day care programs; and respite care services which permit the family to place the elderly person in a supervised setting while they take a break or go on vacation.

Medicaid's Assessment and Placement Mechanisms

Because the present system of financing and delivering long-term care creates strong incentives to use nursing care services, assessment procedures are required to identify whether institutional or community-based services are most appropriate to the individual's and the family's conditions and preferences. However, most chronically impaired elderly are placed in a nursing home without a comprehensive needs assessment. The physician typically is the only person to examine the elderly and advise them and their families about the need for nursing home placement. Yet a medical examination alone cannot adequately differentiate the impaired elderly who require nursing home placement from those who have the potential to remain in the community.

The most appropriate long-term care decisions are made on the basis of a comprehensive preadmission assessment of the individual's medical,

psycho-social, financial; and housing needs, and the family's ability and willingness to provide care. Assessment is also a more effective tool if it is used prior to admission rather than after an individual has been placed in a nursing home. Some of the difficulties involved in efforts to safely discharge elderly nursing home residents who have been identified as being inappropriately admitted are the following:

--They have no place to go because they gave up their homes and severed their ties with the community upon entering a nursing home.

--They have depleted their resources on costly nursing home bills and cannot afford to reestablish a home.

--They could not withstand the trauma of being transferred to another environment. For many elderly, relocation to a new residence, particularly if it is an involuntary move, can have deleterious effects such as severe depression, memory defects, confusion and unusual behavior.

Medicaid's current assessment procedures under the utilization control program (section 1903 (g) of the Social Security Act) have not been adequate in preventing avoidable institutionalization because:

--most of the reviews occur after admission when it is difficult to discharge the resident to the community, and

--the two preadmission reviews focus primarily on medical conditions and do not provide information on other factors that are critical in determining whether an institutional or community setting is the most suitable long-term care placement.

The inadequacy of Medicaid's utilization control program in reducing avoidable nursing home admissions has been a source of widespread concern. The steady increase in Medicaid's nursing home bill has intensified interest in designing better procedures for assessing a client to determine whether a nursing home is the most suitable long-term care placement. Changes in the utilization control program have been proposed at the Federal and State level and several States have taken steps to improve their procedures for assessing Medicaid nursing home applicants. In 1978 the State Medicaid Directors' Council recommended several revisions in the utilization control program. The Council urged that greater emphasis be placed on preventing inappropriate institutional placement. It suggested the establishment of a new Preadmission Review Program designed to actively explore whether community-based services could meet an individual's needs in place of nursing home care.

Professional Standards Review Organizations (PSROs) also have a role in reviewing the long-term care of Medicaid patients, primarily in skilled nursing facilities. But neither the Social Security Act nor HEW guidelines require these organizations to perform comprehensive pre-admission assessments of the recipient's need for institutional care.

PRIVATE PAY ADMISSIONS

Another problem in the nursing home admissions process is that private pay applicants are not required to go through any assessment procedure. While many of these applicants and their families may consult a physician about the need for institutionalization, most are admitted without any formal assessment. These patients also have preferred access

to nursing home beds because the rates charged private pay residents are higher than the Medicaid reimbursement rate. Generally private pay patients will be admitted over public patients regardless of who has the most critical need for care.

Ironically, many of these private pay admissions, after using up their savings, convert to Medicaid for coverage of the remainder of their stay in nursing homes. Although these residents are subject to Medicaid's assessment procedures when they apply for their coverage, it is unlikely their applications would be denied since they now lack sufficient resources to return to the community.

Because the nursing home industry prefers private pay applicants, many Medicaid and in some areas Medicare applicants have trouble being admitted. Some wait a long time in the community and in acute care hospitals for a nursing home bed. The backup of public pay nursing home applicants in acute hospital beds has become a costly and growing problem. A one day census of New York State hospitals in 1979 found 3,961 Medicaid and Medicare patients awaiting transfer to a lower level of care at an estimated annual cost of almost $217 million in unnecessary hospital expenses.

This excess demand for nursing home care, as expressed in long waiting lists and the backup of patients in acute care hospitals, represents a complex problem. In some areas it may reflect a real shortage of beds. However, in many others it is the result of a lack of in-home and community-based care and the financing to pay for it. Because there is no mechanism to assure that these individuals receive a comprehensive assessment of

their needs, it is not known how many of these patients should receive community-based care and how many should be in nursing homes. It is clear, however, that many of these patients are referred for nursing home placement primarily because Medicaid is available to pay for it.

STATE AND LOCAL PROJECTS

There have been several long-term care demonstration projects designed to test and demonstrate the effectiveness of community services in preventing unneeded institutionalization. The experiences of these projects in organizing, delivering and financing long-term care services have indicated that several elements are required for success. These key elements are: 1) a gatekeeping mechanism, 2) a comprehensive needs assessment, 3) a coordinating mechanism, 4) a source of funding, and 5) controls over cost and utilization.

In the past few years many States and local communities have established demonstration projects and small-scale permanent programs designed to reduce avoidable institutionalization using these project elements. However, they have experienced difficulty in testing the programs' effectiveness within the existing system of financing and delivering long-term care. Some of the problems include:

--The fragmentation and gaps in current Federal sources of funding for long-term care impede efforts to initiate amd maintain these projects.

--The absence of a stable funding source creates difficulties in developing and expanding the range of community-based long-term care services which are needed to prevent institutionalization.

--The lack of control over private pay nursing home admissions makes it difficult to reduce avoidable utilization.

After struggling to become operational most of these demonstrations must either terminate or sharply reduce their services when their grant expires because there is no source of permanent funding available from either the Federal or most State governments.

RECOMMENDATIONS TO THE CONGRESS

Specific changes are needed to assure that the elderly who are at risk of institutionalization are offered a viable alternative to nursing home placement. We recommend an approach designed to intervene in the nursing home admissions process to offer individuals community-based long-term care options. This approach--a Preadmission Screening Program--should have the following components.

First, comprehensive needs assessments ought to be mandatory for all individuals applying to nursing homes whose care would be reimbursed by Medicaid or Medicare. Such assessments should also be available on a voluntary basis to all private pay nursing home applicants. To achieve the broadest coverage of these services for elderly persons, these assessments could be covered as an additional benefit under both Parts A and B of Medicare without a coinsurance requirement.

Second, plans of care should be developed, based on the needs assessment and in consultation with the elderly and their families, for those individuals who have the desire and the potential to remain in the home or community setting. These plans should identify the services needed to support in-home or community-based care.

Third, the required community services, as identified in the plans of care, should be assembled, coordinated, and monitored to assure that clients receive care that is both appropriate to their needs and of high quality. These services could be financed out of general revenues based on a Federal-State cost-sharing arrangement comparable to the Medicaid Program. The Preadmission Screening Program could pay for those services which are not available under an existing program or which are available under a program for which the client is not eligible. Clients could share the costs of these services based on their ability to pay.

Fourth, control over the cost and utilization of the community services provided as an alternative to institutionalization could be achieved by placing some type of cap on reimbursement. For example, reimbursement could be limited to some percentage of the cost of the appropriate level of institutional care.

The Preadmission Screening Program could be administered by a new or existing agency. One option would be to locate the program in HEW with responsibility for its administration assigned to the public health departments at the State and local levels. The advantages of using public health departments are that these agencies serve the entire community rather than the welfare population alone, and they provide a range of public education, health-related and social services rather than medical or social services only.

If the public health departments were designated as responsible for administering the Preadmission Screening Program they should be given discretion in determining the most appropriate organization in their

community for carrying out the program. They should also be responsible for assuring that data obtained from the comprehensive needs assessments are collected as part of an ongoing information system and coordinated with the planning efforts of the local Health Systems Agency.

This approach is designed to begin improving the long-term care options available to the elderly who are at risk of institutionalization. It would also provide a means of gaining the data and experience needed to develop a broad national long-term care policy. Controls on costs for each individual served could also be maintained at a comparable level to expenditures for nursing home care. Total program costs, however, are unknown because of the lack of information on the number of individuals who would participate in the program and the duration of this participation. In view of these unknown costs, the Congress may want to consider implementing this approach as a community-wide long-term demonstration project in several areas to obtain more information on costs, service utilization, persons served and total system effects.

Mr. Chairman, this concludes my prepared remarks. We will be happy to answer any questions you or other committee members might have.