BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Entering A Nursing Home-- Costly Implications For Medicaid And The Elderly

Medicaid has become the chief support of nursing home care for the chronically impaired elderly. However, many of these recipients could have remained in their own homes or communities if long-term health and social services were available to them.

Factors leading to premature or avoidable institutional care include:

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

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

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

This report recommends to the Congress several changes to reduce avoidable nursing home use. .

PAD-80-12
NOVEMBER 26, 1979

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

To the President of the Senate and the
Speaker of the House of Representatives

This report analyzes the impact of Medicaid policies and other factors on the decision to place the chronically impaired elderly in nursing homes when this level of long-term care is neither preferred nor necessary. Avoidable or premature institutional care is of critical concern because of its impact on the elderly and on Medicaid, which currently pays for nearly half of the nation's $15.7 billion nursing home bill.

Copies of the report are being sent to the Director, Office of Management and Budget; the Secretary of Health, Education and Welfare; and the Chairmen of Congressional Committees which have primary responsibilities for matters concerning health and the aging.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

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

D I G E S T

Medicaid is the chief support for the long-term care of the chronically impaired elderly in nursing homes. In FY 1978 it financed, at a cost of $7.2 billion, 46 percent of the total national nursing home bill. Individuals paid 45.6 percent of the bill out-of-pocket while other private funds paid 1.4 percent and other public funds paid 7.1 percent. Medicaid costs for nursing home care are expected to increase to $9.5 billion by 1984.

A widely recognized problem with Medicaid's extensive support is that many elderly (who represent 86 percent of the nursing home population) neither need nor prefer nursing home care. Generally, admission to a nursing home is regarded as avoidable for those residents who could have remained in the community if the necessary long-term care services had been available.

Three issues contribute to the nursing home placement of the chronically impaired elderly even when community-based long-term care is preferred and appropriate:

--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 attempt to obtain community services,

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

Medicaid's Long-Term Care Benefits

Medicaid's eligibility policies and benefit packages create a financial incentive to care for the chronically impaired elderly in nursing homes because:

--Medicaid, Medicare and other public programs provide little or no financial coverage for long-term care services in the community;

--Medicaid, at the same time, offers full or partial coverage for long-term care in a nursing home.

Medicaid programs vary widely throughout the country because each State has considerable discretion, within broad Federal guidelines, in setting eligibility standards, benefit packages and reimbursement rates for its plan. Most States have placed restrictions on community-based Medicaid services as a means of containing costs. (See pp. 16-23.)

Medicare, the Federal health insurance program covering the majority of the elderly, is designed primarily to relieve beneficiaries of a large portion of their medical bills associated with hospitalization and surgery. It provides less coverage for long-term care services and is, therefore, of limited benefit in meeting chronic needs. In addition, many poor elderly do not use their Medicare benefits because they cannot afford to pay the copayments and deductibles, yet they are ineligible for Medicaid. (See pp. 23-29.)

For many chronically impaired elderly, the only adequate source of financial assistance for long-term care is Medicaid's nursing home benefit:

--The Medicaid eligible elderly who cannot obtain community services because of restrictive State benefit packages receive full long-term care coverage under Medicaid if they enter a nursing home.

--The elderly poor who are ineligible for Medicaid in the community but cannot afford to purchase the long-term care services they need may become eligible for Medicaid if they enter a nursing home because the State has a different income standard for nursing home residents.

--The elderly not eligible for Medicaid outside of a nursing home may also: 1) transfer their assets to relatives and become eligible for Medicaid coverage of nursing home care, or 2) enter a nursing home, deplete their resources on costly bills, and become eligible for Medicaid's nursing home benefit. (See pp. 29-33.)

An increasing proportion of all Medicaid nursing home residents convert from private pay to Medicaid after depleting their resources in the nursing home. 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. A major number of nursing home residents whose care is paid for by Medicaid were, in most cases, ineligible to participate in the program outside of a nursing home. (See pp. 33-44.)

The lack of adequate financial assistance for community long-term care services has a detrimental impact on the elderly who do not want to enter a nursing home and on their families. Families are often the key factor in preventing nursing home admission because they provide the vast majority of long-term care to the elderly. Since they receive little or no financial or social assistance from Medicaid or other public programs, they may experience severe financial and psychological strain. Frequently, the only way families can obtain relief is to place their elderly relatives

in a nursing home where Medicaid will often assume the financial burden. (See pp. 43-53.)

Difficulties in Obtaining Community Long-Term Care Services

In addition to inadequate financial resources, other factors discourage or prevent the chronically impaired elderly and their families from obtaining community-based long-term care services. These factors include:

--a lack of information about noninstitutional long-term care options;

--the fragmentation and problems in coordination among public and private community service providers;

--varying eligibility requirements for services;

--the tendency of professionals to recommend nursing home placement because they do not have the expertise and time to arrange for community care; and

--the lack of essential community services. (See ch. 3.)

Medicaid's Assessment and Placement Mechanisms

Because the long-term care needs of the chronically impaired elderly are often complex, assessment procedures are required to identify whether institutional or community-based services are more suitable. The most appropriate long-term care decisions are made on the basis of an assessment of the individual's medical, psychosocial, financial, and housing needs, and the family's willingness and ability to provide care. (See pp. 88-96.)

Medicaid's current assessment procedures have not been adequate in preventing avoidable admissions because:

--Most of the reviews occur after admission when it is difficult to discharge the resident to the community.

--The two preadmission reviews focus primarily on medical conditions. They do not provide information on other factors which are critical in determining the most suitable long-term care placement. (See pp. 96-103.)

If comprehensive preadmission screening procedures were carried out for all Medicaid eligible nursing home applicants, Medicaid still would not be able to eliminate its support for avoidable care because many Medicaid residents are initially admitted as private pay patients. Because nursing homes can charge private pay residents a higher rate than the Medicaid reimbursement rate, private pay applicants generally are admitted over Medicaid applicants regardless of who has the most critical need for care. Once private pay residents apply for Medicaid coverage, it is unlikely that it would be denied because they now lack sufficient resources to return to the community. Due to the nursing home industry's preference for private pay applicants, Medicaid, and in some areas, Medicare applicants 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 is a costly and growing problem. (See pp. 103-112.)

The excess demand for nursing home care, as shown in long waiting lists, may reflect a real shortage of beds in some areas. However, in many communities it is the result, instead, of a lack of in-home and community-based care and the financing to pay for it. Overbuilding of hospital beds and the

growing backup of nursing home applicants in hospitals has led in recent years to a push to convert some of these beds to long-term care. Yet, problems in the current use of nursing homes coupled with the lack of adequate information have meant there are insufficient data to identify accurately the number of beds needed. (See pp. 112-113.)

State and Local Projects

State and local long-term care demonstration projects have indicated that several project elements are needed to offset the causes of preventable nursing home use and spiralling Medicaid costs. These elements are: 1) a gatekeeping mechanism, 2) a comprehensive needs assessment, 3) a coordinating mechanism, 4) a funding source, and 5) controls over cost and utilization. Five State and local long-term care projects which are testing these elements are reviewed. (See pp. 123-147.)

The success of State and local projects in reducing avoidable institutional care is hindered by serious obstacles, including:

--Fragmentation and limitations in current funding sources for long-term care, and

--Lack of control over private pay nursing home admissions. (See pp. 147-152.)

Recommendations to the Congress

Because of the strong Congressional interest expressed in recent years for legislative recommendations concerning all aspects of the delivery of home health and other in-home services, GAO proposes the following approach aimed at providing the elderly with a viable option to nursing home care, increasing the choices older people have when they need long-term care, and assuring that Medicaid expenditures for avoidable nursing home care are minimized.

The proposed approach includes establishing a Preadmission Screening Program with the following components:

--Comprehensive needs assessments for all applicants to nursing homes,

--Assistance in planning and obtaining services to help individuals stay in the community,

--Coordination and monitoring of community care,

--Payment for services outside a nursing home, and

--Control over costs and utilization. (See pp. 162-163.)

The Preadmission Screening Program could be located in HEW with responsibility assigned to public health departments at the State and local levels. Data obtained from the needs assessments should be used in developing a more reliable basis for projecting nursing home bed needs. (See pp. 163-164.)

This approach has been developed to focus on those individuals who would be directly admitted to a nursing home if they did not receive supportive in-home or community-based services. Controls on costs for each individual served could be maintained at the comparable level of 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.

Because 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 concrete information on costs, people who could be served, service utilization, and systemwide effects.

Tear Sheet

AGENCY COMMENTS

The Department of Health, Education and Welfare had no disagreement with the report's findings or conclusions. In their response they noted that "no issue is of greater interest and concern to HEW's Health Care Financing Administration (HCFA) at this time." HEW concurred with some of the recommendations or agreed to consider them in a long-term care demonstration project. (See apps. I and II.)

Contents

ABBREVIATIONS

SNF	Skilled Nursing Facility
ICF	Intermediate Care Facility
HRF	Health Related Facility
SIP	Survey of Institutionalized Persons
NNH	National Nursing Home Survey
GAO	General Accounting Office
DHEW	Department of Health, Education and Welfare
NCHS	National Center for Health Statistics
SMI	Supplementary Medical Insurance
SSI	Supplemental Security Income
AFDC	Aid to Families with Dependent Children
HCFA	Health Care Financing Administration

ABBREVIATIONS

PSRO	Professional Standards Review Organization
PHS	Public Health Service

TABLES

policy evaluation standards eval.

Nursing homes Medicaid programs Medicare " Health care costs ~~for the~~ Elderly persons Cost analysis

CHAPTER 1

INTRODUCTION

Medicaid, authorized by Title XIX of the Social Security Act, is a Federal/State program in which the Federal Government currently pays for 50 to 78 percent of State costs of providing health services to the poor. 1/ The program's purpose, as stated in the 1965 legislation, was to enable States, "as far as practicable under the conditions in such State," to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 2/ Another objective was to assist recipients to "attain or retain capability for independence or self-care" through the provision of rehabilitation and other services. 3/

When it was created, Medicaid substituted a single program of medical assistance for an ongoing, yet more limited system of vendor payments. The Department of Health, Education and Welfare estimated that if all States fully adopted the provisions in the new legislation, Medicaid would increase Federal expenditures in 1966 by $238 million over the $1.3 billion cost of the vendor payment program. The error in this initial cost estimate was evident after only a few years. Expenditures in FY 1968, with 37 States operating Medicaid programs, were $3.5 billion; 4/ in FY 1978 they increased to $18.6 billion. 5/ Categorized as the "sleeper" of the Social Security Amendments of 1965, Medicaid today is an extensive and costly program.

NURSING HOME COSTS AND UTILIZATION HAVE A SIGNIFICANT IMPACT ON MEDICAID

One of the primary factors which explain the expense of Medicaid is the program's coverage of nursing home care. Davis and Schoen cite "the high cost of institutionalization for an impoverished elderly and disabled population that is unable to meet the demands of daily living without nursing assistance" for a major source of the cost increase. 6/ These costs consumed nearly 41 cents of each Medicaid dollar in FY 1978 or a total of $7.6 billion. 7/ By FY 1984 payments are expected to increase to over $9.5 billion. 8/

Medicaid's funding of nursing home care involves several complex issues. Nursing home costs dominate Medicaid expenditures as more money is spent on this care than on any other medical service. However, only 6 percent of those who received any service under Medicaid in FY 1976 used nursing home services. 9/ Medicaid has also become the predominant payer nationally of nursing home care. In 1976, approximately 60 percent of all days spent in nursing homes were financed either totally or in part by Medicaid. 10/

Finally, payments are being made for some nursing home patients who would have preferred and could have remained in a more independent setting if necessary supportive services had been available. Medicaid funding of community-based services (e.g., home health care), however, was 1 percent of total expenditures in FY 1978. 11/

Medicaid has become the major payer of nursing home care

The impact of Medicaid's nursing home coverage on its budget has been profound. While only a small percentage of all Medicaid recipients are in nursing homes, its high costs make it the service requiring the largest expenditures. As shown in figure 1, in FY 1978, 74 percent of the States (37) spent 40 percent or more of their total Medicaid expenditures (Federal and State) on nursing home care; in 19 States at least half of their budgets went for these services. 12/ These figures underestimate all Medicaid expenditures for patient care in nursing homes because they do not include the cost of physician services, drugs, medical equipment, and other medical services which are also reimbursable for patients in nursing homes.

Medicaid's role in financing nursing home services nationally is significant because it spends more on this care and supports more individuals in nursing homes than any other public or private source. Thirteen percent of nursing home residents (97,000) in 1969 used Medicaid funds as their primary source of payment; 13/ by 1977 this had increased to 48 percent of all residents (623,300). 14/ During this same period there were declines in the proportion of residents using Medicare, their own income, or other public assistance or welfare as the primary source of payment. Most of the decrease in the number of residents supported by "other public assistance or welfare" resulted from the transfer of intermediate care facility services from cash assistance programs to the Medicaid program on January 1, 1972. These changes are shown in figure 2.

Figure 1

Nursing Home Expenditures As a Percentage of Total Medicaid Expenditures by State, FY 1978 (note a)

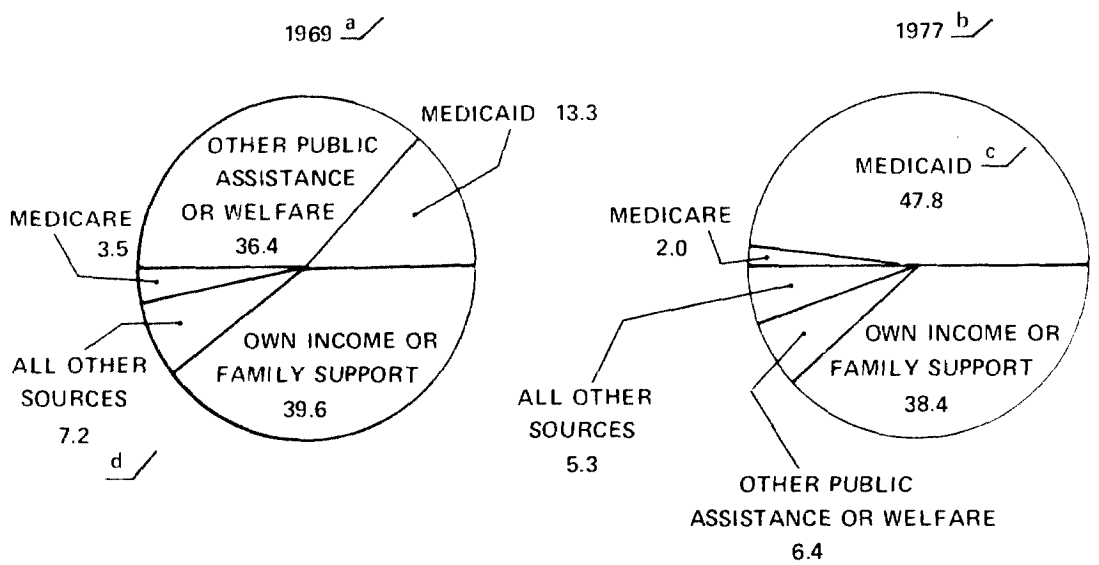
South Dakota	67.8	Alabama	45.8
Minnesota	64.2	Vermont	45.2
Alaska	63.2	Georgia	44.7
New Hampshire	62.2	South Carolina	44.6
Colorado	60.5	New York	44.3
Wyoming	60.5	Kansas	44.2
Iowa	58.1	Hawaii	43.8
Texas	58.1	Rhode Island	43.3
Nebraska	57.8	Kentucky	41.7
Wisconsin	56.9	Mississippi	41.1
Idaho	56.7	Florida	40.3
Arkansas	55.5	Ohio	40.0
Montana	54.0	North Carolina	39.8
North Dakota	53.8	Delaware	39.7
Connecticut	53.1	Michigan	39.3
Indiana	53.1	Missouri	38.8
Oklahoma	52.8	Massachusetts	38.7
Utah	52.5	Washington	38.4
Nevada	51.0	New Jersey	36.4
Oregon	48.9	Maryland	34.3
Maine	48.4	New Mexico	31.3
Pennsylvania	47.6	Illinois	29.5
Louisiana	47.0	California	23.9
Virginia	46.3	West Virginia	22.5
Tennessee	46.0	District of Columbia	13.1

a/Arizona does not have a Medicaid program. Guam, Puerto Rico and the Virgin Islands are not included.

Source: Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, DHEW Publication No. (HCFA) 78-03154, Research Report B-5 (FY 78) (Preliminary), June 1979, Table E.

Figure 2

Percentage Distribution of Nursing Home Residents by Primary Source of Payment



a/ DHEW, National Center for Health Statistics, Charges for Care and Sources of Payment for Residents in Nursing Homes, Series 13, Number 32, August 1973-April 1974, (DHEW Publication No. (PHS)78-1783), p. 23. (Data adjusted to exclude residents of personal care homes).

b/ DHEW, National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, Series 13, No. 43, (DHEW Publication No. (PHS) 79-1794), July 1979, p. 99.

c/ Most of the increase in residents supported by Medicaid resulted from the transfer of intermediate care facility services from "other public assistance or welfare" to the Medicaid program on January 1, 1972.

d/ This segment includes religious organizations, foundations, volunteer agencies, Veterans Administration contract, initial payment-life funds, and other sources or no charge.

Total national expenditures for nursing home care more than doubled between 1974 and 1978. The two major sources of these expenditures are Medicaid funds and individuals' out-of-pocket payments. Of the 1978 total national nursing home bill of $15.751 billion, Medicaid paid 46 percent ($7.246 billion) and individuals paid 45.6 percent ($7.179 billion); other public funds (Medicare, Veterans Administration and others) paid 7.1 percent ($1.112 billion) and other private funds (private health insurance, philanthropy) paid 1.4 percent ($214 million). 15/ Figure 3 shows a breakdown of these sources. At the national level there is limited control over the increase in Medicaid expenditures for nursing home care because the Federal Government is required to match whatever the States spend on this service.

Medicaid is supporting predominantly elderly residents in nursing homes

Along with rising outlays for nursing home care there has been a corresponding rise in the number of individuals using these institutions. The National Nursing Home (NNH) survey shows that there were about 1,303,100 residents in 18,900 homes in 1977, a 21 percent increase over the 1,075,800 residents in the 1973-74 survey. 16/ The number of nursing home beds has also increased from 1,177,300 in 1973-74 17/ to 1,402,400 in 1977. 18/

As shown in table 1, 86 percent of the nursing home residents in 1977 were elderly: 19/

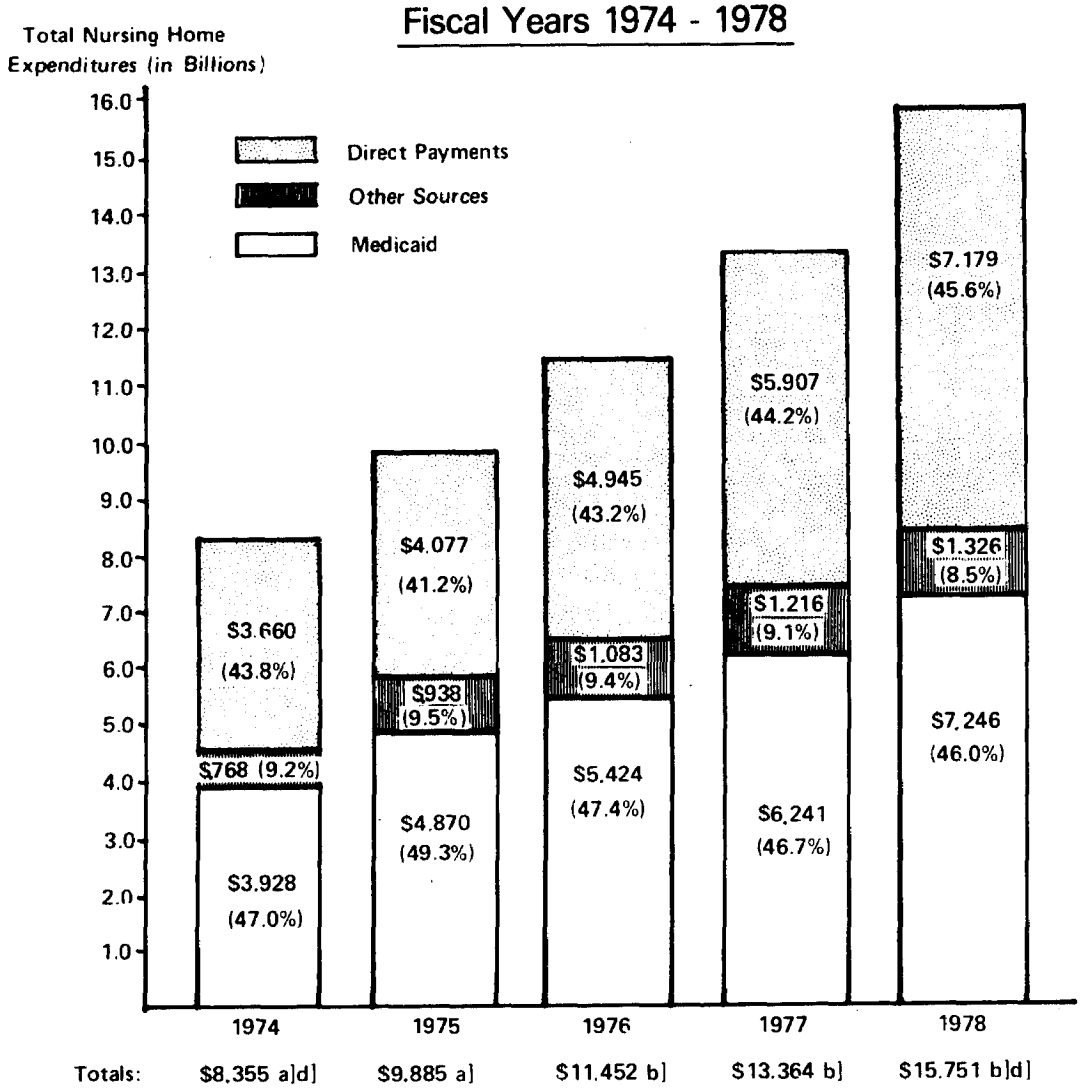
Table 1

Age Distribution of Nursing Home Residents

Nursing home residents (1977 NNH survey)	Number	Percent
Under 65 Years	177,100	13.6
65-74 Years	211,400	16.2
75-84 Years	464,700	35.7
85 Years and Over	449,900	34.5
Total	1,303,100	100.0

Figure 3

Proportion of Nursing Home Expenditures by Source of Payment, Fiscal Years 1974 - 1978



a] Unpublished data obtained from DHEW, Health Care Financing Administration, Office of Research, Demonstrations and Statistics, Washington, D.C.

b] DHEW, Health Care Financing Administration, Health Care Financing Review, Summer 1979, pp. 26 - 28.

c] Other sources of payment: Medicare, Veterans Administration and State and local payments, private health insurance, philanthropy and industrial inplant services.

d] Numbers do not add due to rounding.

The proportion of elderly who are using nursing home services has grown from 2.3 percent of all elderly in 1960 20/ to 5 percent in 1977. 21/ However, these data underrepresent the actual number of elderly admissions. Because the NNH survey is based on a sample of residents in nursing homes on a particular day, it undercounts total utilization during a year's period. It is estimated that 20 to 25 percent of the elderly population will spend some time in a nursing home even though only 5 percent are residents on a given day. 22/

The fact that the elderly are the predominant users of nursing homes is also reflected in the distribution of expenditures by age group for this care. Of total FY 1977 expenditures for nursing home services, 2.7 percent was spent for individuals under 19, 13.8 percent for the age group 19 to 64, and 83.5 percent was spent for the 65 and older age group. 23/ The elderly are also the primary users of Medicaid-supported nursing home care. In FY 1975, 79.1 percent of Medicaid expenditures for skilled nursing home facility (SNF) services and 67.2 percent of expenditures for intermediate care facility (ICF) services were spent on elderly recipients who were 65 or older. 24/*

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* Medicaid pays for intermediate care facility services and skilled nursing facility services which are defined as follows:

--Skilled nursing facility services are services which are required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.

--Intermediate care facility means an institution which is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. 25/

AVOIDABLE INSTITUTIONALIZATION IS COSTLY IN HUMAN AND FINANCIAL TERMS

A critical problem with the elderly's use of nursing homes is that many admissions could have been avoided or were unnecessary. Lawton, in a review of research on utilization, estimated that between 10 and 18 percent of the institutionalized older persons surveyed could live in the community if appropriate support services were available. 26/ Baltay assessed 14 studies of appropriateness of placement in nursing homes and estimated that 10 to 20 percent of skilled nursing facility patients and 20 to 40 percent of intermediate care facility patients were receiving unnecessarily high levels of care. 27/

Placing elderly persons in nursing homes when they have the potential to remain in the community is problematic because:

--It is contrary to the wishes of most elderly and their families.

--Individuals may be provided a more intensive level of care than actually needed.

--It absorbs a costly outlay of public and private funds and is an inefficient use of this service.

Elderly prefer their own homes to institutional care

The elderly, when confronted with a need for long-term health and social services as a result of impairments and functional limitations, usually prefer to receive this care in their own homes rather than entering a nursing home. Brody defines long-term care as referring to

> "One or more services provided on a sustained basis to enable individuals whose functional capacities are chronically impaired to be maintained at their maximum levels of psychological, physical, and social well-being. The recipients of services can reside anywhere along a continuum from their own homes to any type of institutional facility." 28/

A Florida survey of elderly individuals with chronic health problems living in the community and in nursing homes found that regardless of their place of residence, 85 percent of

the sampled "dependent but mentally intact elderly" preferred their own homes to institutional care. 29/

In another study, Noelker and Harel (1978) interviewed 125 ambulatory aged residents who were selected from self-care floors in 14 nursing homes and homes for the aged. Almost half (46 percent) expressed a desire to live elsewhere while 54 percent stated they would prefer to remain in their respective institutions. When residents were questioned about their reasons for wanting to live elsewhere, they responded that they preferred to live in their own homes or with a friend or that they sought more independence in their physical and social activities. Only 12 percent (6) desired to live elsewhere because of their dissatisfaction with the facility in which they lived. 30/

In addition to fearing a loss of independence, many elderly resist nursing home placement because it often means they must give up their lifelong possessions and sever their community ties; others perceive institutionalization as a prelude to death.

Some individuals are admitted to nursing homes when they have the potential to receive care in a setting offering greater independence

Institutionalization is considered appropriate or necessary "when medical or physical needs are so great that the provision of services throughout a 24-hour period is essential." 31/ Another definition adds that the determining factor in nursing home placement should be a severely or irreversibly impaired physical or mental condition which requires constant medical monitoring. 32/ Medicaid authorizes payment for nursing home care for individuals if the physician certifies that it is medically necessary.

Some individuals are admitted to a nursing home, however, not because of their need for medical and nursing home care or their level of impairment but because of insufficient economic and social resources in the community. A recent survey, for example, looked at chronically ill elderly residents of public and private nursing homes and community residents served by a home health agency. After comparing residents by their ability to perform varying functions, such as dressing, eating, and bathing, the study found that the nursing home and community populations had similar impairment levels which ranged from moderately to totally

impaired. The critical variable which explained why these individuals were residing in different settings (nursing home or home) was not level of functioning ability but living arrangement and the presence of a caring unit (primarily in the form of living with spouse and/or children.) 33/

Many elderly, even those with severe disabilities, could appropriately receive long-term care services in their own homes or in congregate settings other than nursing homes. A Texas study concluded that a large elderly population was being supported in nursing homes when in fact their basic requirement was for nonmedical supervision and management. 34/ A survey by the Virginia State Department of Health in 1976 reported that as many as 25 percent of the applicants for Medicaid covered nursing home care in Richmond could have been cared for using community-based services (if available). 35/ The elderly who are placed in nursing homes, not because they need this level of care, but because of a lack of social and economic supports, are deprived of an opportunity to obtain care in a setting which offers maximum reliance on individual potential and resources.

High cost and inefficient use of nursing home care

Nursing home admissions which could have been avoided or deferred result in a substantial commitment of public and private resources. In FY 1977, 43 percent of the $10.536 billion spent on the elderly for nursing home care was paid by private sources. Because most of these payments were met out of personal resources rather than by private health insurance or philanthropy, nursing home costs have become the primary source of catastrophic expense for the elderly.

In addition to high costs, individuals who are in nursing home beds when they could have been cared for in another setting are using a resource which is often more critically needed by other elderly. In many areas of the country there exists a chronic excess demand for nursing home care (specifically subsidized care). As a result, individuals may wait long periods in the community or in more costly acute care hospital beds for admission to a nursing home.

PROBLEMS IN THE NURSING HOME ADMISSIONS PROCESS RESULT IN AVOIDABLE INSTITUTIONALIZATION

Medicaid is directly affected by avoidable nursing home placements. Payment for this care is not only costly but it represents services to individuals which do not promote maximum independence or self-care--a program objective. Medicaid has, therefore, a direct stake in the remedying of any factors which lead to avoidable or premature use of nursing home care.

Problems in the process of admission to a nursing home--in how individuals end up as patients in these facilities--result in avoidable institutionalization. The objective of this study is to examine 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 when community-based services would have been appropriate. 36/ We analyzed three areas which impact on the admissions process:

1. Medicaid eligibility policies for individuals using institutional and noninstitutional services.

2. Factors which discourage or prevent the elderly from obtaining community long-term care services in lieu of nursing home care, and

3. Medicaid's screening and assessment procedures for nursing home applicants.

These topics are addressed in chapters 2 through 4. Chapter 5 discusses State and local efforts to counteract problems in the admissions process which lead to premature or avoidable placements and chapter 6 presents conclusions and recommendations.

In conducting this study we reviewed a large volume of literature on Medicaid and the elderly's use of institutional and community-based care services. We interviewed knowledgeable individuals in the Federal and State governments, in private social service and health organizations, and in academic institutions. We also analyzed data on nursing home residents and their relatives collected by the U.S. Bureau of the Census as part of the 1976 Survey of Institutionalized Persons (SIP).

NOTES

1/Medicaid was established by the Social Security Amendments of 1965 (Public Law 89-97) and became effective on January 1, 1966. Federal financial participation is determined by the formula prescribed in section 1905 (42 U.S.C. § 1396b(d)) which authorizes payments of up to 83 percent of State costs.

2/Public Law 89-97, Section 1901.

3/Ibid.

4/Institute for Medicaid Management, Data on the Medicaid Program: Eligibility/Services/Expenditures, Fiscal Years 1966-78, DHEW, Washington, D.C., 1978, p. 25. Expenditures for 1968 for Medicaid and Kerr-Mills and related programs have been combined.

5/Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, DHEW Publication No. (HCFA) 78-03154, Research Report B-5 (FY 78) (Preliminary), June 1979, Table E.

6/Karen Davis and Cathy Schoen, Health and the War on Poverty - a Ten Year Appraisal. Brookings Institution, Washington, D.C., 1978, pp. 57, 60. Davis and Schoen also identified two other factors which contributed to high Medicaid costs: the increase in the number of Medicaid recipients covered under the Aid to Families with Dependent Children (AFDC) program, and the rise in medical care prices.

7/Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, Fig. 1. In FY 1978, 41.9 percent of Medicaid expenditures went to nursing home services followed by: inpatient hospital care (27.7 percent), other services (13.4 percent), physician services (8.8 percent), prescribed drugs (6.0 percent), dental care (2.1 percent).

8/Testimony of Robert A. Derzon, Administrator, Health Care Financing Administration, DHEW, before the Select Committee on Population, House of Representatives, June 1, 1978, pp. 5-6.

9/Health Care Financing Administration, Medicaid State Tables FY 1976 Recipients, Payments and Services, United States Department of Health, Education and Welfare, U.S. Government Printing Office, 1979, p. 11.

10/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, Vital and Health Statistics, Series 13, No. 43, DHEW Publication No. (PHS) 79-1794, July 1979, pp. 9-10.

11/Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, Table 7.

12/Ibid. Table 8. Medicaid costs are shared by the Federal and State Governments. The Federal share ranges from 50 percent in States with high per capita income to 78 percent in Mississippi, the State with the lowest.

13/National Center for Health Statistics, "Charges for Care and Sources of Payment for Residents in Nursing Homes," U.S. National Nursing Home Survey, August 1973 - April 1974, Vital and Health Statistics, Series 13, No. 32, DHEW, (GPO), November 1977, pp. 22-23.

14/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 99.

15/Robert M. Gibson, "National Health Expenditures, 1978," Health Care Financing Review, Vol. 1 Issue 1, Summer 1979, p. 26.

16/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 8. An earlier NCHS report notes that the increase in nursing home residents is slightly exaggerated because nursing and personal care facilities are included in the 1977 NNH survey while only facilities providing some level of nursing care were included in the 1973-74 survey. See NCHS, "A Comparison of Nursing Home Residents and Discharges from the 1977 National Nursing Home Survey; United States," Advance Data from Vital and Health Statistics, No. 29, Public Health Service, Hyattsville, Maryland, May 17, 1978, p. 2.

17/NCHS, "Utilization of Nursing Homes, United States: National Nursing Home Survey, August 1973 - April 1974," Vital and Health Statistics Series 13, No. 28, Department of Health, Education and Welfare, July 1977, p. 3.

18/NCHS, The National Nursing Home Survey: 1977 Summary for the United States, p. 8.

19/Ibid., p. 43.

20/William Scanlon, Elaine Difederico, Margaret Stassen, Long-Term Care Current Experience and Framework for Analysis, The Urban Institute, Washington, D.C., February 1979, p. 3.

21/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 28. Several factors have been cited to explain the increase in nursing home beds and utilization. Brody lists the following as important: the increase in the elderly population; Federal funds to pay for care (Medicare, Medicaid, Social Security and Kerr-Mills--the forerunner to Medicaid), Federal grants and loans to build and rehabilitate facilities; and a national thrust to deinstitutionalize elderly mental patients from State hospitals to the community. Elaine M. Brody, "The Formal Support Network: Congregate Treatment Setting for Residents with Senescent Brain Dysfunction," paper presented at Conference on the Clinical Aspects of Alzheimer's Disease and Senile Dementia, Bethesda, Maryland, December 1978, p. 8.

22/Burton D. Dunlop, Need for and Utilization of Long-Term Care Among Elderly Americans, The Urban Institute, (200-975-05), Washington, D.C., August 1976, p. 85.

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24/Institute for Medicaid Management, pp. 65, 66.

25/Health Care Financing Administration, Title XIX, Grants to States for Medical Assistance Programs, Medicaid Bureau, Department of Health, Education, and Welfare, Washington, D.C., Revised, January 1979, pp. 534, 535.

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29/William G. Bell, "Community Care for the Elderly: An Alternative to Institutionalization," The Gerontologist, Part I (Autumn 1973), p. 352.

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31/Faye Abdellah, "Long-Term Care Policy Issues: Alternatives to Institutional Care," The Annals of the American Academy of Political and Social Science, 438, July 1978, p. 30.

32/Joint Committee on Long-Term Care Alternatives, Well-Being in Old Age: Essential Services, Technical Report IV, Austin, Texas, Fall 1978, p. 19.

33/Stanley J. Brody, Walter Poulshock, Carla F. Masciocchi, "The Family Caring Unit: A Major Consideration in the Long-Term Support System," The Gerontologist, Vol. 18, No. 6 (1978), pp. 558-9.

34/Joint Committee on Long-Term Care Alternatives, Final Report, Austin, Texas, 1978, p. 18.

35/Joint Legislative and Audit Review Commission, The Virginia General Assembly, Long Term Care in Virginia, Richmond, Virginia, March 28, 1978, p. 12.

36/The elderly are defined, for the purposes of this study, as 65 and older.

CHAPTER 2

MEDICAID'S LONG-TERM CARE SUPPORT PRIMARILY GOES TO INSTITUTIONAL CARE RATHER THAN IN-HOME OR COMMUNITY-BASED SERVICES

The elderly who are functionally disabled and in need of long-term care services find that Medicaid will finance all or part of institutional care but will provide only limited coverage of in-home care. Consequently frail and dependent elderly who are financially unable to purchase community-based care may enter a nursing home to obtain long-term care support. This chapter focuses on the effect Medicaid policies have on influencing nursing home admissions which could have been prevented, while chapter 3 identifies other factors which lead to avoidable utilization such as the unavailability or lack of access to community-based care.

MEDICAID SUPPORT TO CHRONICALLY IMPAIRED ELDERLY IN THE COMMUNITY IS LIMITED

The elderly are at greatest risk of chronic illness which is often accompanied by disability and dependence. Approximately 18 percent (3.4 million of the noninstitutionalized elderly) have functional disabilities which require long-term assistance. 1/ Our survey of the elderly population in Cleveland (1975) which assessed impairment levels of individuals in five areas (social, economic, mental, physical and daily living activities) found that 23 percent were generally impaired or worse. Table 2 gives the results of the survey. 2/

Table 2

Elderly Impairment Levels

Assessed well-being	1975 estimate of people 65 and over	
	Number	Percent
Unimpaired	13,400	21
Slightly Impaired	13,200	21
Mildly Impaired	11,500	18
Moderately Impaired	10,300	17
Generally Impaired	5,700	9
Greatly Impaired	1,900	3
Very Greatly Impaired	2,300	4
Extremely Impaired	4,300	7
Total	62,600	100

Elderly who are 75 and older experience the highest incidence of chronic and disabling conditions. A study of physical performance in adults found that almost half of all individuals over 75 had substantial limitations in such activities as walking, climbing and bending; this was true for 20 percent of the elderly 65 to 74. 3/ Hospital and nursing home utilization also increases with age. In FY 1977, persons of all ages used an average of 1,200 days of short stay hospital care per 1,000 persons. Individuals aged 65 to 69 used approximately 3,000 days, while persons in their late 70's used 4,700 and the elderly aged 85 or older used 8,300 days. The increase in nursing home utilization is also marked; approximately 16,000 days of nursing home care are used for every 1,000 persons 65 and older, and 86,400 days are used for every 1,000 persons aged 85 and older. 4/

The vulnerability of the elderly population, particularly the age group 75 and older, to chronic disabilities is significant because of their increased need for supportive long-term care services. While nationally the number of persons 65 and older is growing, the average age within this group is also changing. It is projected that by 2020 there will be 45 million persons 65 and older; 16,975,000 of these individuals will be at least 75. 5/ Elderly with chronic illnesses or disabilities need long-term care services to assist them in maintaining their maximum levels of physical, mental and social functioning. These services are required because chronic conditions, unlike acute illness, generally cannot be cured and consequently may permanently impair an

individual's ability to function in everyday activities such as bathing, eating, and dressing.

The objectives in treatment plans for impaired elderly are to help individuals cope with their disability, reduce their dependence on others, and narrow the gap between their actual and potential function. 6/ Essential services include health, social, or income support assistance which can be provided in a variety of settings such as the home, day care centers for adults, ambulatory (outpatient) medical facilities, sheltered housing, and institutions such as nursing homes. The most appropriate mix of long-term care services varies for each individual because chronically impaired elderly respond differently to their impairments depending on their age, the extent of their impairments and the personal, social and economic resources which they have available. 7/ Furthermore, the setting in which these services should be provided often cannot be accurately determined on the basis of the individual's level of impairment.

In spite of the impaired elderly's need for social, residential, health and medical services, historically most public spending for long-term care has been through medical programs. The passage of Medicare and Medicaid in 1965 continued this trend; as a result, the medical model in long-term care has been predominant. Today the major source of public support for this care comes from Medicaid.

Medicaid's benefits vary by State

Medicaid is administered within broad Federal requirements and guidelines by State governments which have considerable discretion in setting local eligibility standards and benefit coverage. 8/ States are required to cover hospital care, physician services, laboratory and x-ray services, family planning, skilled nursing facility care and home health services for individuals aged 21 and over, and periodic screening, diagnosis, and treatment for individuals under 21. They may also cover a number of optional services. 9/ Each State may impose limits on the amount of basic and optional services covered. Most States have been restrictive as a means of containing costs. For example, some limit physician services to one visit per month regardless of how ill an individual might be. Other States limit the number of inpatient hospital days yearly. 10/

A prime example of this restrictiveness is in Medicaid's coverage for noninstitutional services which includes home health care, personal care services, and adult day health services. Home health services cover: nursing services; home health aide services; physical, occupational, and speech therapies; and medical supplies, equipment and appliances. To be authorized for payment these services must be ordered by a physician. Personal care services in a Medicaid recipient's home may also be reimbursed if the provider is deemed to be qualified and is not a relative of the recipient. These services include health-related supportive care such as help with activities of daily living. They must be prescribed by a physician as part of a plan of treatment and supervised by a registered nurse. 11/ Adult day health services are a package of medical and health-related services provided by hospitals or clinics to chronically ill and impaired Medicaid recipients on an outpatient basis. Services may include medical, nursing, diagnostic and rehabilitative services as well as personal care, social work, dietary and transportation services. 12/

Medicaid's home health care benefits, which became a covered service for every participating State in 1970, represented in FY 1978 an outlay of $211 million while nursing home expenditures for the same year equaled $7.6 billion. 13/ Of the estimated 261,331 Medicaid recipients who received home health services in 1977, almost 63 percent were residents of New York. New York also accounted for 80 percent of all national Medicaid home health expenditures. 14/ Expenditures are low because States are allowed to restrict home health care services in terms of amount, duration and comprehensiveness. A recent review of Medicaid home health care practices identified State restrictions in the number of allowable visits, the provision of supplies, equipment and appliances, and in the types of services offered. Some States added the requirement of prior authorization as a condition to receive services. 15/

Another barrier to Medicaid's home health coverage is reimbursement. Each State determines what payment level and method to use; some pay only half what Medicare pays for home health care. As a result many home health agencies will accept only a small percentage of Medicaid patients and some "not for profit" agencies accept only Medicare patients. For example, Florida's home health care industry almost exclusively serves Medicare-eligible clients ($34.3 million was spent in Medicare charges in contrast with $314,000 in Medicaid charges during 1976). One study noted that "Both

limited funding for Florida's Medicaid program and its policy of reimbursing only 1/3 to 1/2 the cost of a visit (Medicare reimburses for 100 % of cost) indicate that the poor and near-poor are greatly disadvantaged in obtaining home health care." 16/

Nine States and jurisdictions cover personal care services which they have found to be less expensive to provide than home health services purchased from home health agencies. 17/ The nine States and jurisdictions include: District of Columbia, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New York, Oklahoma, and Wisconsin. While these services could supplement home health care benefits, some States have used them instead as a replacement for home health care coverage. Oklahoma, which provided the impetus for getting these services authorized in the Medicaid regulations, has essentially no home health care program. A number of difficulties have been identified with personal care services including the questionable quality of the services; the lack of training of providers; and the lack of supervision and monitoring. Only six States reimburse for adult day services--New York, Massachussetts, Georgia, California, New Jersey and Washington. Currently, there are 90 programs in operation, 40 of which are in Massachussetts.

The restrictions on benefits, low reimbursement rates and the limited implementation of in-home services under Medicaid have been due in part to the reluctance of States to invest in the development of noninstitutional long-term care services when they are not convinced that these services will serve as a substitute for expensive nursing home care or hospital care. 18/ Instead, some believe it will result in another uncontrollable cost added to their Medicaid budgets.

Medicaid's benefits do not cover all elderly poor

While Medicaid benefits are not comprehensive nor uniform across States, the covered services are critically important to the health and continued independence of many chronically impaired elderly. However, Medicaid coverage does not extend to all the poor in need of these services. Since each State has some discretion in setting its eligibility standards, the resulting variation contributes to one of the major problems in Medicaid, that "it does not treat people in equal circumstances equally." 19/ The primary reason

for this is that eligibility for Medicaid is linked to welfare. States must cover individuals eligible under the Aid to Families with Dependent Children program (AFDC) and all aged, blind, and disabled recipients of the Supplemental Security Income (SSI) program unless they elect an option permitted under Federal law to restrict Medicaid coverage to those SSI recipients who meet the more restrictive Medicaid eligibility requirements established by the State.* These requirements cannot be more restrictive than those in force on January 1, 1972, prior to implementation of SSI.

In addition, States may provide Medicaid coverage to the medically needy who are individuals who would be eligible for cash assistance except for their income level. States set the income eligibility levels for the medically needy but they may not exceed 133-1/3 percent of the State's Aid to Families with Dependent Children payment. The States' medically needy may have all or part of their expenses paid for under Medicaid; however, if their incomes and resources are above a State-prescribed level they must first incur a certain amount of medical expense which lowers their income to the medically needy levels. This is often referred to as the "spend-down requirement." As of January 1978, 33 States and jurisdictions had medically needy programs; the majority had income levels for eligibility below the poverty levels determined by the Bureau of Census in 1976. 21/

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*SSI was established by the 1972 Amendments to the Social Security Act and implemented in 1974. Before SSI, all aged, blind and disabled cash assistance recipients were eligible for Medicaid. When SSI was implemented States were given three options. 1) The Social Security Administration would determine eligibility for Medicaid using SSI criteria. This is known as the "1634" agreement and applies to 28 States. 2) States would determine eligibility for Medicaid using SSI criteria (known as Title XVI) and applies to seven States. 3) States would determine eligibility for Medicaid using pre-SSI more restrictive criteria known as 209(b) and applies to 15 States. If the States adopted the more restrictive eligibility standards they were required to provide for a "spend-down" for all aged, blind, and disabled persons which would establish eligibility for Medicaid after deducting any medical expenses from the individual's income. 20/

Due to differences in eligibility requirements, persons who would receive benefits in one State would not in another. 22/ In addition, individuals in the same State with similar incomes, because of welfare rules, may not be equally eligible for benefits. These variations across and within States have resulted in gaps in coverage of the poor. How many poor are uncovered is unknown since there are few estimates of the proportion of Medicaid recipients who have incomes which place them above or below the poverty level. Also, the number of individuals who are eligible for Medicaid is unknown at the national level.

Feder and Holahan developed a measure of the ratio of the aged persons receiving Medicaid services to the aged below the poverty line (as defined by the Bureau of Census in 1974). The estimates are approximate because they compare 1974 Medicaid recipient data (in the numerator) and 1970 census data (in the denominator). In addition, the recipient data do not show all those eligible for Medicaid but only those who reportedly used a service during 1974. The ratios may reflect some individuals above the poverty line who used a service and may not show persons below the line if they did not. The ratios presented in figure 4 reflect the variance by State in the percentage of elderly poor covered by Medicaid. In 1974 this variance ranged from 0.24 in West Virginia and Indiana to 2.82 in California. 23/ Other estimates place Medicaid coverage for recipients of all age groups at 50 to 60 percent of the poor population when the movements in and out of Medicaid are adjusted over time. 24/

Figure 4

Ratio of Medicaid Recipients to the Aged Population Below the Census Poverty Line*

Alabama	1.25	Missouri	0.54
Alaska	0.62	Montana	0.35
Arizona	N/A	Nebraska	0.31
Arkansas	0.51	Nevada	0.58
California	2.82	New Hampshire	0.55
Colorado	0.69	New Jersey	0.40
Connecticut	0.52	New Mexico	0.33
Delaware	0.44	New York	0.97
D.C.	0.87	North Carolina	0.41
Florida	0.36	North Dakota	0.38
Georgia	0.73	Ohio	0.33
Hawaii	0.82	Oklahoma	0.70
Idaho	0.27	Oregon	0.33
Illinois	0.38	Pennsylvania	0.45
Indiana	0.24	Rhode Island	1.36
Iowa	0.26	South Carolina	0.46
Kansas	0.30	South Dakota	0.30
Kentucky	0.63	Tennessee	0.38
Louisiana	0.74	Texas	0.72
Maine	0.56	Utah	0.37
Maryland	0.70	Vermont	0.74
Massachusetts	2.09	Virginia	0.54
Michigan	0.59	Washington	0.57
Minnesota	0.45	West Virginia	0.24
Mississippi	0.71	Wisconsin	0.68
		Wyoming	0.49

Medicare coverage is focused on relieving the elderly of high hospital and surgical bills

The other major program which reimburses for health services for the elderly is Medicare which was established under Title XVIII of the Social Security Act. Congress enacted Medicare to reduce the financial burden of expensive medical bills on the elderly. It is available to nearly all people aged 65 and over without regard to income.

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*Judith Feder and John Holahan, Financing Health Care for the Elderly, Medicare, Medicaid and Private Health Insurance, The Urban Institute, Washington, D.C., February 1979.

The Medicare program consists of: hospital insurance (Part A) and supplementary medical insurance (SMI, Part B). As of January 1, 1977, 98.1 percent of the aged (22.8 million) were enrolled in hospital care and 96.8 percent (22.5 million) were enrolled in Part B. 25/ To receive Medicare Part A benefits during the first 60 days of hospital care, the elderly must pay a $160 deductible; patients also must pay $40 per day for the 61st through the 90th day in the hospital. Under Part B, Medicare enrollees pay a portion of the cost of the program in the form of premiums; as of July 1, 1979, the monthly premium is $8.70. All services covered under SMI are also subject to an annual deductible and coinsurance payment.

Medicaid recipients who are eligible for Medicare under the "buy-in" program established by the Social Security Act are exempt from the Medicare cost-sharing requirements. The States "buy in" to Medicare by paying the monthly insurance premiums, coinsurance, and deductibles using Medicaid funds for Medicaid recipients who are also eligible for Medicare. Therefore, Medicare makes the primary payment for services and the States' Medicaid program pays the deductibles and copayments. All but five States and jurisdictions have "buy-in" agreements with the Social Security Administration. 26/

In 1976 out of 3.6 million aged persons who received Medicaid benefits, an estimated 2.3 million had their SMI premiums paid for under the "buy-in" provisions. Approximately $2.1 billion in Medicare benefits were received by this group. 27/ Because of Medicare, Medicaid expenditures for inpatient hospital care and physicians' services are relatively small with a larger percentage going to services not covered or only minimally covered under Medicare. In FY 1975 Medicaid expenditures for the aged were distributed as shown in table 3. 28/

Table 3

Percentage Distribution of Medicaid Expenditures

Inpatient hospital care	8.8
Nursing home services (SNF/ICF)	74.1
Physician services	3.9
Dental Care	0.7
Prescribed drugs	9.0
Other services	3.6
Total	100.1

Medicare was not intended to cover all health care services for the elderly. It does, however, relieve people 65 and older of a large portion of their medical bills associated with hospitalization, surgery, and the accompanying periods of recovery. In FY 1977 Medicare benefits paid 44 percent of the elderly's medical bills; if deductibles and coinsurance amounts are deducted, Medicare's share of the bill is reduced to 41 percent. However, during this year, 74 percent of the elderly's hospital expenses and 56 percent of physician expenses were paid by Medicare. 29/

Payments for other medical services often must be made by the elderly from private funds. While an estimated $1,745 was spent per person on health care costs in FY 1977 for the elderly, $463 (plus the SMI Medicare premium) came from private resources--either an individual's own or family income. 30/ Some of these expenditures were for services which are critically important to the health of the elderly but are not covered by Medicare. These include: drugs and medicines outside of a hospital or skilled nursing facility, vision care including eyeglasses, dental care, hearing aids or periodic physical examinations. In FY 1977 the elderly paid 95.5 percent ($976 million) of all dental expenditures and 84.7 percent of all drug costs ($2.423 billion) out of private resources. 31/

Medicare's long-term care benefits are also limited. Under Part A, after a hospital stay of at least 3 consecutive days, Medicare will pay for up to 100 days of extended

care in a SNF. To be eligible for this care, an individual must need skilled nursing or rehabilitation services on a daily basis for a condition for which the individual received care in the hospital (or for another condition which arose while receiving extended care in a SNF for a condition treated in the hospital). The first 20 days of nursing home care are paid in full; the next 80 require a daily copayment. These benefits were included to encourage use of nursing homes as a substitute for more costly hospital care in the course of treatment. The program does not pay for custodial care in a nursing home. In FY 1977 approximately 3 percent of the elderly's nursing home expenditures were paid for by Medicare. 32/

Medicare coverage of home health care is available if it has been prescribed by a physician because an individual is confined to the home and needs part-time or intermittent skilled nursing services and/or physical or speech therapy. A patient, if eligible for home health care, may also receive other covered services such as occupational therapy, home health aides, medical social work under the supervision of a physician, and medical equipment and supplies. Part A provides for 100 home nursing visits in the 12-month period following a 3-day hospital stay or discharge from a skilled nursing facility. Part B covers up to 100 medically necessary visits a year without a requirement of previous hospitalization.

Because these benefits focus on skilled care they do not include custodial or supportive care (e.g., help with activities of daily living) unless the patient requires skilled nursing care, or physical or speech therapy. Expenditures for home health care in FY 1977 were $458 million out of total Medicare expenditures of $20.770 billion. 33/ Of the 530,000 beneficiaries who received these services, over one-third lived in the Northeast. 34/

Many chronically ill elderly go without needed health services

In spite of Medicaid and Medicare, many low income elderly persons are faced with costly medical bills due to illness. The 1970 Health Insurance Survey identified low income elderly who made large expenditures for medical bills (not including nursing home costs) out of personal resources. Ten percent of the surveyed population with incomes below $5,000 spent 10 percent or more of their income on medical care. 35/

Cost sharing under Medicare also has an effect on elderly utilization of health care services. Eleven percent of the elderly population in Long Beach, California, according to a recent survey, was too poor to pay the Medicare copayments and deductibles but had incomes too high for Medicaid eligibility. 36/ Studies have found that elderly with low to moderate incomes who are not able to participate in either program may go without needed medical and other long-term care services. 37/

Even though Medicare has the same set of benefits available to all covered persons, major differences in participation have been identified. 38/ One study divided the SMI population without hospital stays into groups by income level and compared their use of out-of-hospital medical care to the charges incurred for that care. Medicaid recipients were the heaviest users of Part B (SMI) services due to payment by Medicaid for all of their cost sharing requirements under the "buy-in" program and because they often experience more illness. Enrollees with low to moderate family incomes, not covered by Medicaid, were more affected by the deductible, reported a higher rate of unmet need for physicians' services and appeared to delay seeking medical care for a longer period than did persons with high family incomes or with private insurance to help pay the cost-sharing requirements. 39/

Similar findings were obtained by our office in a survey of individuals 65 and older in Cleveland, Ohio. In this analysis we found that, overall, Medicaid recipients received more medical care and were more likely to be hospitalized than both low income and middle income older persons not on Medicaid. One reason was that Medicaid recipients were generally more impaired. Fifty-nine percent of Medicaid recipients were physically impaired compared to 35 percent of the low income and 25 percent of the middle income elderly not on Medicaid. When older people with similar health status were compared, impaired Medicaid recipients still received more medical care than impaired people not on Medicaid. As shown in table 4, only 10 percent of the impaired Medicaid recipients received less than $100 in medical care during a year's study period. Of the impaired individuals not on Medicaid, 43 percent of the low income and 35 percent of the middle income elderly received less than $100 in medical services.

Table 4

Percentage Distribution of

Medical Expenses for Medicaid and Non-Medicaid Elderly

Medical expenses	Non-Medicaid Middle income	Non-Medicaid Low income	Medicaid
None	19	29	4
$1-99	16	14	6
$100-499	26	18	28
$500-2999	22	17	37
$3000-over	18	23	25
Total	100%	100%	a/100%
Number of impaired in sample	(129)	(199)	(114)
Number in sample	(506)	(566)	(194)

a/Columns may not total to 100 due to rounding.

For some low and moderate income elderly, their failure to obtain medical and health care services may be due to insufficient financial resources to purchase this care. An individual who requires drug prescriptions several times per month may only be able to afford one prescription a month. Lack of funds could also result in postponed visits to the physician and delayed dental and eye care. Inadequate medical treatment could have an effect on an individual's health as well as on his or her ability to function in everyday activities.

Chronically ill and disabled elderly often need homemaker and home health services, physical and speech therapy and personal care services, yet may find them unaffordable. In Austin, Texas, a survey revealed that the income required to privately purchase home health and homemaker services was far higher than the median family income of older persons in that area. 40/ Individuals not covered under Medicaid would be ineligible to obtain assistance in paying for these and

other medical care expenditures from Medicaid unless they incurred large medical expenses and could qualify under the spend-down requirement. For most elderly, this would occur only when an individual has high institutional costs due to hospitalization or nursing home care. 41/

Also, in some States "spending down" to Medicaid eligibility is not an option. In Texas, a large segment of the population is composed of persons whose monthly income is above the ceiling for Supplemental Security Income ($208.20 for a single person and $312.20 for a married couple) yet below the Federal poverty level. Because Texas does not have a medically needy program, individuals who have incomes above the SSI levels are not eligible for Medicaid services and must pay their own medical bills even if these bills "cause disposable income to drop below these levels." 42/*

In summary, elderly individuals with chronic illnesses and disabilities have turned to the health care system for support for their long-term care service needs. Under this system, they may receive limited coverage under Medicare or are dissuaded from participation at all because of the program's cost sharing features. At the same time, they may be ineligible for Medicaid, or if they are eligible, they are unlikely to receive the comprehensive mix of health and social services they need to assist them in maintaining a maximum level of functioning.

MEDICAID SUPPORT TO ELDERLY IN NURSING HOMES IS OPEN-ENDED AND EXTENDS TO MANY WHO ARE NOT ELIGIBLE FOR COVERAGE IN THE COMMUNITY

While Medicaid coverage is limited or nonexistent for services needed by chronically impaired elderly living in the community, its nursing home coverage is extensive, and available to individuals who would not have qualified for Medicaid outside of the institution. Therefore, some individuals are admitted to nursing homes to obtain care even though they had the potential to remain in their own homes if in-home or community-based services had been equally well subsidized.

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*Texas has no spend-down requirement because (in addition to not having a medically needy program) it uses SSI criteria for determining Medicaid eligibility. See page 21.

Medicaid policies support nursing home use in the following ways:

--Many elderly poor are ineligible for Medicaid benefits while living in the community; if they are admitted to a nursing home, different income standards apply and they are now eligible for Medicaid support.

--Many low and moderate income elderly enter nursing homes as private pay patients; if they become impoverished by using up their resources or transfering their assets to relatives, they are now eligible for Medicaid coverage.

Figure 5 illustrates these factors.

Many low and moderate income elderly are only eligible for Medicaid benefits if they enter a nursing home

All States with Medicaid programs are required to provide skilled nursing facility (SNF) services to categorically needy individuals and may also provide intermediate care facility (ICF) services. ICF services are included in all State Medicaid plans. They may include either or both services for the medically needy. Eligibility for these services varies significantly by State. Individuals in States that cover the medically needy or cover the categorically needy only under the 209 (b) option, because of the spend-down provision, will be eligible for Medicaid in a nursing home if their income is less than the Medicaid established rate for nursing home payment.* 43/

States which do not fall under these categories may set higher standards in covering individuals in nursing homes

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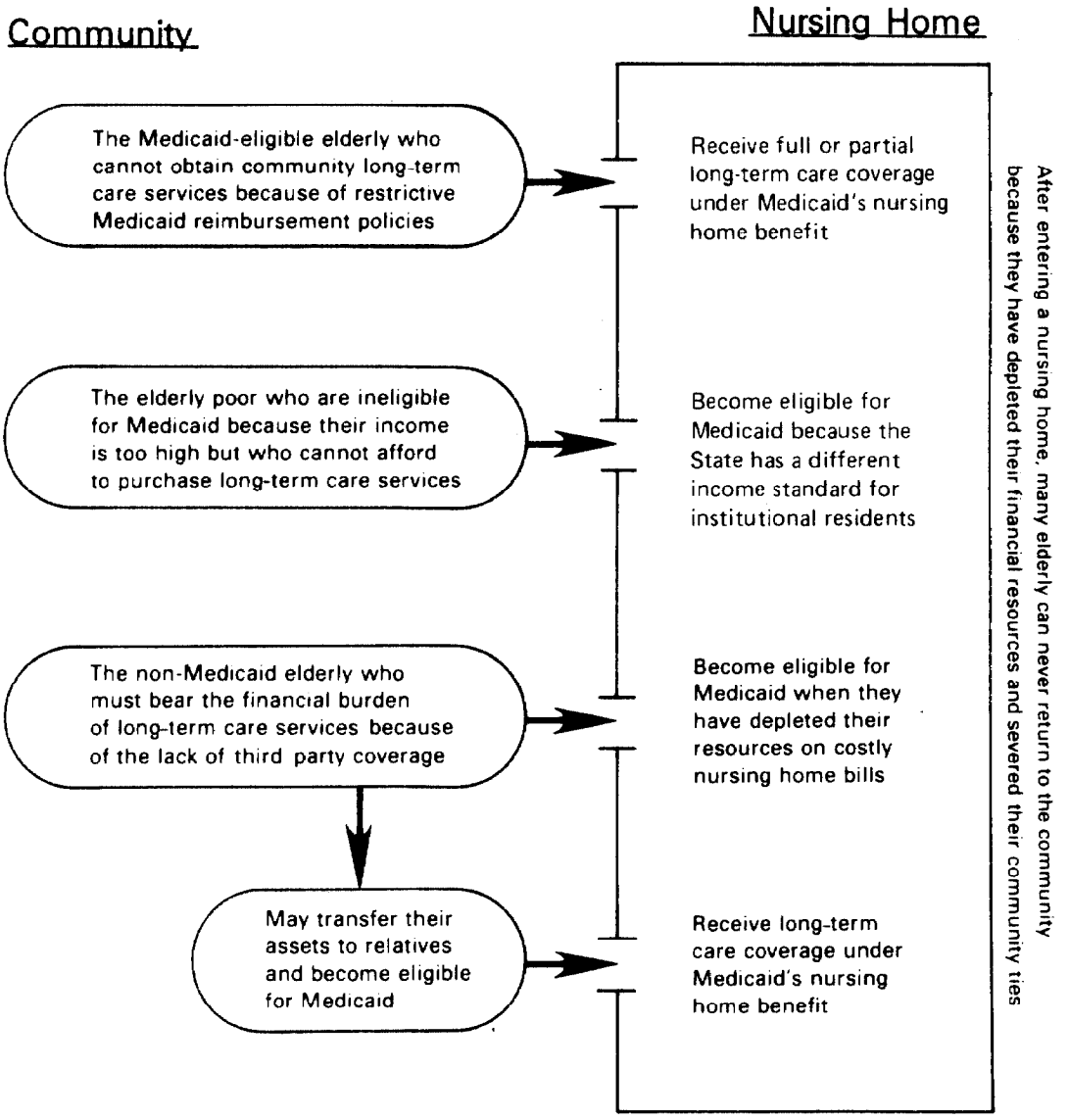
*The significance of the noncash assistance eligibility category is evident in that 70 percent of all Medicaid expenditures for the elderly are for recipients in this group. 44/ While noncash assistance recipients in 1975 represented one-third of all Medicaid recipients 65 and older, 45/ this is reversed in nursing homes where 71 percent of all Medicaid-supported elderly are not receiving cash welfare. 46/ Not all noncash recipients fall into the medically needy category as some in this group meet the income and assets levels for cash support but because they are institutionalized cannot receive it.

Figure 5

Medicaid Subsidizes Nursing Home Care for Individuals Ineligible for Community-Based Coverage



than would apply to noninstitutionalized recipients as long as the standards do not exceed 300 percent of the SSI standard payment amount. As of July 1979, this institutional standard--known as the Medicaid "cap"--was set at $624.60 based on an SSI benefit level of $208.20. As a result, an individual who had an income of $590 a month would qualify for Medicaid coverage if he or she entered a nursing home. Medicaid would then pay the difference between the individual's available income (less a personal needs allowance which is usually $25 a month) and the cost of care in the institution.* Medicaid would also pay for drugs, physician services, eye and dental care, and other covered medical services to the extent they are not paid for by Medicare.

Ironically, the same individual with an income of $590 a month would be ineligible for Medicaid coverage outside of a nursing home because the noninstitutional income level for eligibility is lower ($208.20 unless there is a State supplemental payment). The Medicaid "cap" States are

Alabama	Idaho	Oregon
Alaska	Iowa	South Carolina
Delaware	Nevada	South Dakota
Florida	New Jersey	Texas
Georgia	New Mexico	Wyoming

Because these States do not have a spend-down provision, if an individual's resources increase while in the nursing home, thereby exceeding the set dollar eligibility level, he or she would lose Medicaid coverage.

Individuals in many States, therefore, have incomes which are too high to make them eligible for Medicaid coverage outside of a nursing home. Once in a facility they can qualify for Medicaid even though their income is the same. Other individuals, because of the medically needy eligibility category and the spend-down provision, coupled with the high cost of nursing home care, also qualify for Medicaid coverage.

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*Under Medicaid, which is a vendor payment program, payments are made directly to service providers which must accept this reimbursement as payment in full. In nursing homes, however, all States require individuals to turn over most of their income to help pay for their care. This is based on the concept that since Medicaid is paying for most of the institutionalized person's basic needs (shelter, food, etc.) any income above personal needs should be contributed to defray nursing home costs.

However, outside of these facilities they would have had difficulty qualifying for Medicaid under the spend-down option because it is unusual to incur noninstitutional medical bills as high as required to obtain Medicaid support.

Some elderly enter nursing homes as private pay patients and become eligible for Medicaid after using up their resources

Other individuals enter nursing homes and because of their personal resources (e.g., the proceeds from the sale of a home) initially are ineligible for Medicaid support and must use their own funds or rely on Medicare coverage to pay for care. Medicare, however, provides only limited support; it was the primary source of payment for only 2.9 percent of resident days in nursing homes in 1976. 47/ Private insurance also provides little coverage. Out of total national expenditures for nursing home care of $15.751 billion in 1978, private insurance paid only $108 million. 48/

Because nursing home care is expensive and stays are often lengthy, private resources may be used up quickly, placing the individual in a position of being eligible for Medicaid. In 1977 the average charge for care was estimated to be $689 per month; one-fourth of all residents were charged $800 or more per month. When expenditures for extra services are included, the monthly bill can rise to over $1,000. While these extra services are defined differently from one nursing home to another, they usually include medications, physical therapy, beautician and barber visits, and sometimes such items as laundry, special feeding, and terminal care. Physicians, dentists, and podiatrists usually make their own charges for any visits. The lengthy stays many residents experience in nursing homes were identified in the 1977 National Nursing Home resident survey. Sixty-four percent, or 828,600 individuals, had been in a home 1 or more years; 48.4 percent of this group (400,800) had been in a home for 3 or more years. The median stay for all residents was 597 days. 49/

For many individuals, the longer their stay in a nursing home, the greater chance there is that Medicaid or other public assistance sources will pay for their care. This was identified in the NNH survey of all individuals discharged from nursing homes during calendar year 1976. This survey differed from the 1977 resident survey because it included a large number of short-term users since it covered all discharges during a 1-year period. The resident sample included residents in the nursing home on the night before the survey was initiated and would more likely

show long-term users. The disparity in the length of time in the nursing home between the two surveys may be due to different reasons why the two groups of individuals are using these facilities: "those admitted for relatively long periods of time because there is little chance of their chronic problems improving, and those admitted for relatively short periods of time because recuperative care is needed."50/

The discharge survey revealed that longer stay residents tended to have their care paid for by Medicaid. As shown in table 5, the median duration of stay for Medicaid residents in a skilled nursing facility was 176 days and in an intermediate care facility 220 days. In contrast, the Medicare resident's median stay was 24 days, and private pay 59 days. 51/

Table 5

Type of Support and Length of Stay in Nursing Homes

Primary source of payment	Number of discharges from nursing home (note a)	Percent distribution of discharges	Median duration of stay in days (note b)
Own income or family support	419,500	37.5	59
Medicare	189,600	17.0	24
Medicaid			
Skilled care	201,600	18.0	176
Intermediate care	191,000	17.1	220
All other sources	115,700	10.4	85
All primary sources of payment	1,117,500	100.0	84

a/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 101.

b/NCHS, "A Comparison of Nursing Home Residents and Discharges from the 1977 National Nursing Home Survey: United States," Advance Data from Vital and Health Statistics No. 29, p. 6.

We obtained similar findings in our analysis of the 1976 Survey of Institutionalized Persons (SIP) data on elderly nursing home residents. This survey is based on a representative sample of the entire long-term institutionalized population at a single time. The results of our analysis indicate that the longer a person has been in a nursing home, the more likely it is that he or she is receiving Medicaid support.

We grouped each elderly nursing home resident (aged 65 or older) in the SIP sample according to what percentage of the nursing home bill was paid with personal resources. We considered the following as personal resources: insurance plans or annuities; private retirement plans; family contributions; social security benefits; Supplemental Security Income (SSI) benefits; and Veterans' Administration pensions. Figure 6 shows that the majority of the elderly nursing home population is divided into two distinct groups: those who paid more than 90 percent of their nursing home bill out of personal resources and those who paid 10 percent or less.

Of the 813,500 elderly nursing home residents for whom we have data, 54 percent (443,900) were receiving Medicaid support towards the cost of their care. As shown in figure 7, 87 percent of the Medicaid residents were paying 40 percent or less of their nursing home bill with personal resources. Of the 369,600 residents not receiving Medicaid support, 75 percent were paying more than 90 percent of their nursing home bill out of their own resources. Ten percent of the non-Medicaid group paid 10 percent or less of their bill out of personal resources. The cost of nursing home care for these individuals was predominantly paid by public assistance, other governmental sources, and churches.

To determine whether long stay residents are less likely to be paying for the greatest portion of their nursing home bills with personal resources, we compared length of stay data for:

--Medicaid residents

--Non-Medicaid residents personally responsible for paying 0-90 percent of their bill

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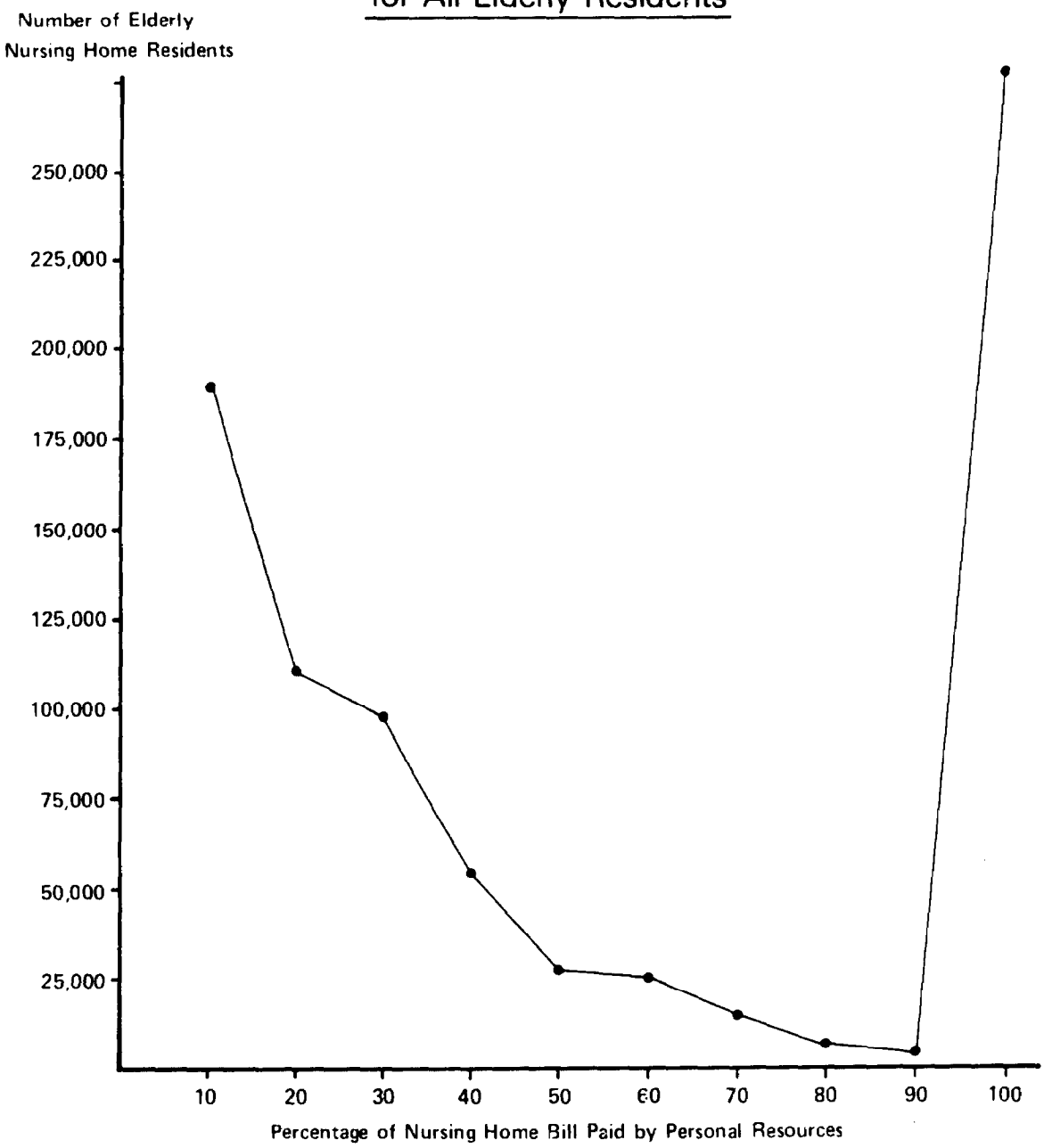
*These funds were classified as personal resources because they would be available to the resident regardless of whether the individual was in an institution or not. This also applies to SSI payments although the amount is reduced when a person is in a nursing home.

Figure 6

Percentage of Nursing Home Bill Paid by Personal Resources for All Elderly Residents



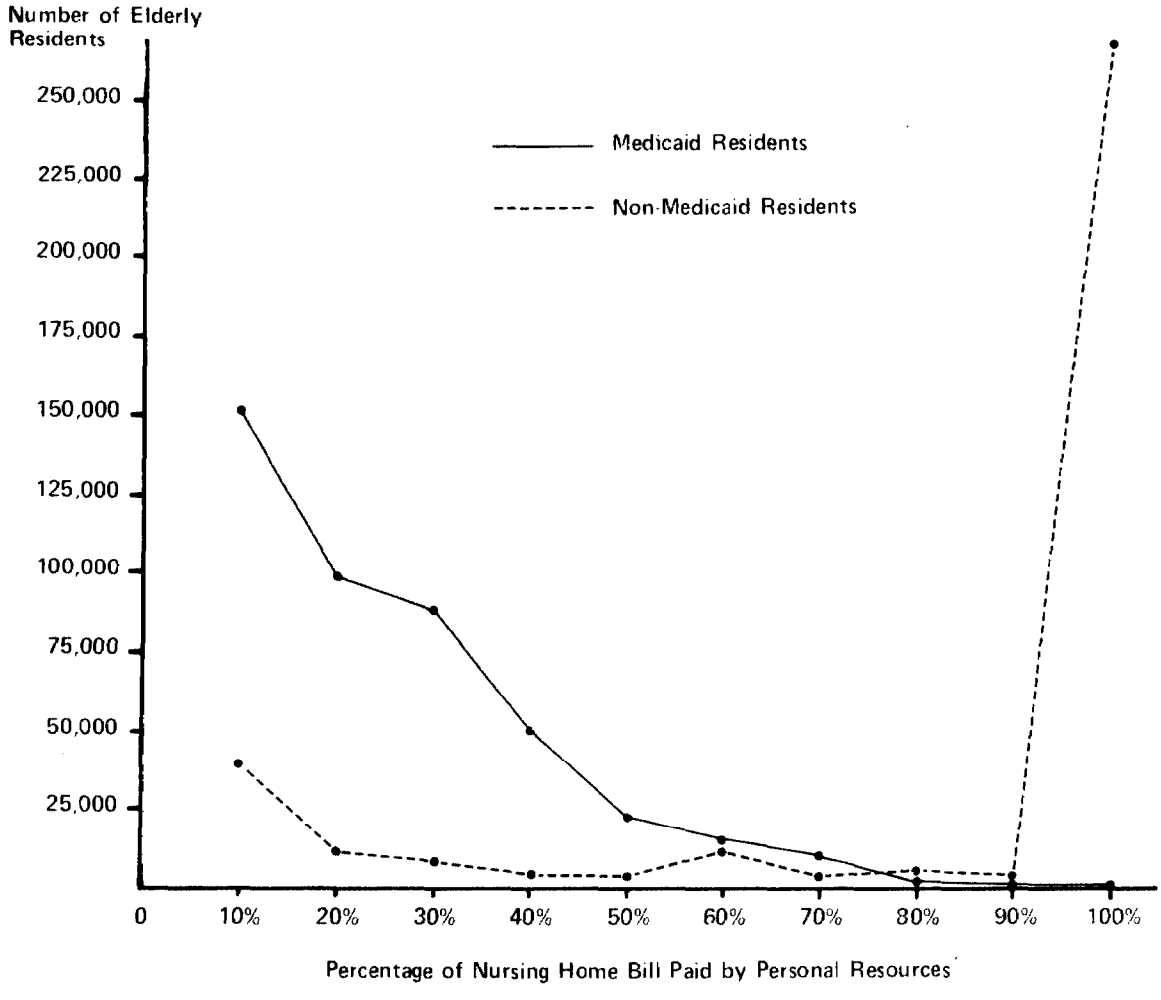
VALID CASES = 813,500

MISSING CASES = 201,700

TOTAL ELDERLY NURSING HOME POPULATION = 1,015,200

Figure 7

Percentage of Nursing Home Bill Paid by Personal Resources for Medicaid and Non-Medicaid Residents



VALID CASES =	813,500	MEDICAID RESIDENTS=	443,900
MISSING CASES =	201,700	NON-MEDICAID RESIDENTS=	369,600
TOTAL ELDERLY = NURSING HOME POPULATION	1,015,200	TOTAL	813,500

--Non-Medicaid residents personally responsible for paying more than 90 percent of their bill.

We divided the non-Medicaid population into two groups because the group paying 90 percent or less included a proportion of residents whose care was subsidized extensively by governmental or church funds. These residents were similar to Medicaid recipients because they contributed little of their own or their family's money toward the cost of their care.

As shown in figure 8, the percentage of individuals who are paying more than 90 percent of their nursing home bill out of personal resources declines as the length of stay in the nursing home increases. Forty-five percent of the elderly in nursing homes 6 months or less paid 90 percent or more of their nursing home bill out of their own resources. This decreased to: 32.8 percent of the elderly in nursing homes for 1 to 1-1/2 years, 29.0 percent of the elderly in nursing homes for 2 to 3 years, and 28.9 percent of individuals in nursing homes for 4 years or more.

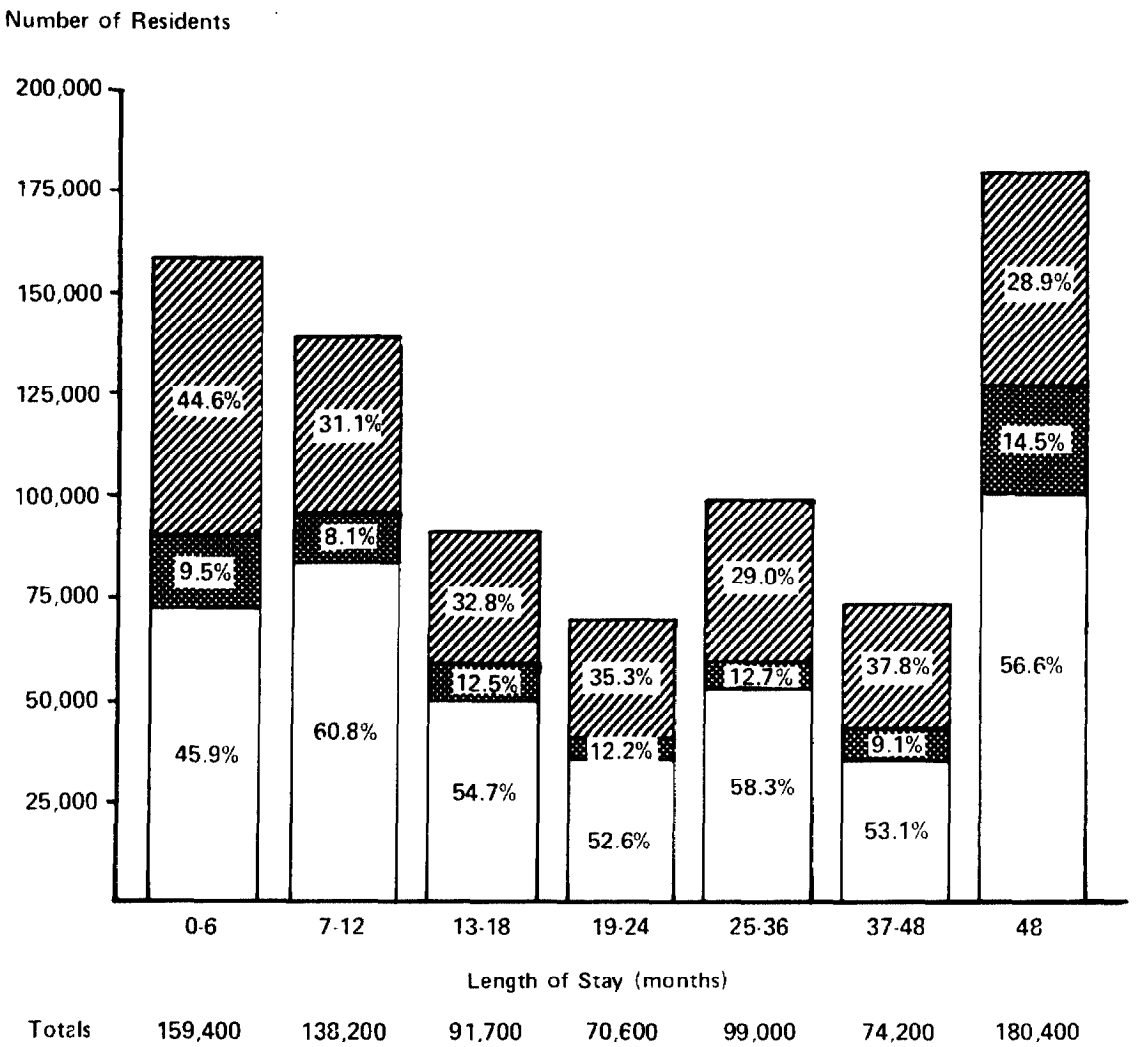
In summary, the analysis shows a decline in the proportion of residents paying most of their care out of their personal resources while the individuals whose care is predominantly paid for by Medicaid or other public and church funds increases as length of stay increases. The difference in payment source for long stay versus short stay residents may be a result of the elderly residents who started off paying most of the cost of care out of their own funds and who turned to Medicaid or other public or church sources when their funds were exhausted.

Private pay conversions often represent a major portion of nursing home residents supported by Medicaid

The transition of nursing home residents from private pay status to Medicaid coverage has been documented in several studies. In a 1976 nursing home survey conducted in South Dakota, 30 percent (1066) of the Medicaid patients in nursing homes at the time of the study had been admitted as private pay patients. Thirty-nine percent (412) of these patients had converted to Medicaid in less than 1 year; 22 percent (239) converted in more than 1 but less than 2

Figure 8

Comparison of Medicaid and Non-Medicaid Residents in Various Length-of-Stay Categories



Totals	159,400	138,200	91,700	70,600	99,000	74,200	180,400

Non-Medicaid residents paying 90.1-100% of their nursing home bill with personal resources

Non-Medicaid residents paying 0-90% of their nursing home bill with personal resources

Medicaid residents

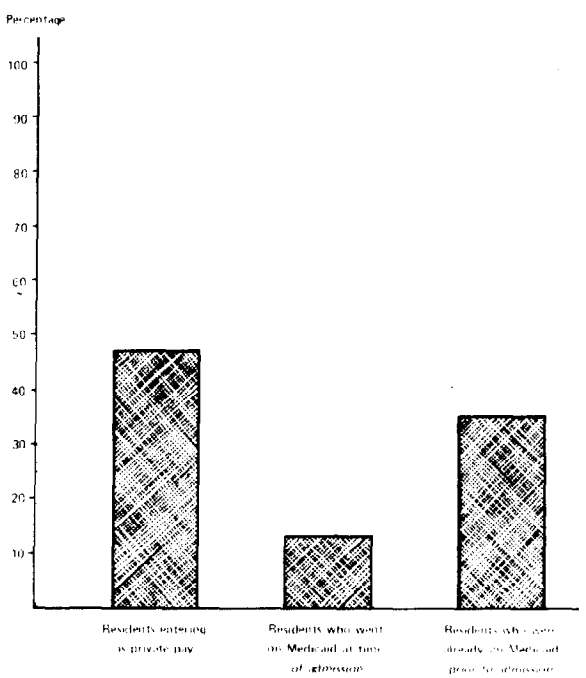
VALID CASES =	813,500
MISSING CASES =	201,700
TOTAL ELDERLY NURSING HOME RESIDENTS =	1,015,200

years, and 39 percent (415) converted in more than 2 years after entry. 52/

A study of the Detroit nursing home population, which was drawn from a sample of 40 nursing homes selected as representative of all nursing homes in the area, collected information regarding the social and financial circumstances surrounding nursing home admissions and the situation after admission. The sample was divided into four categories: 1) patients who entered nursing homes as private patients and afterward applied for and received Medicaid; 2) those who began receiving Medicaid at the time of admission to a nursing home; 3) those who were receiving Medicaid before they applied for nursing home care; and 4) patients who paid privately throughout their nursing home stay. As diagramed in figure 9, the survey found that 48.2 percent of the sample population had entered nursing homes originally as private pay; by the time the survey was conducted, 66 percent of this group had converted to Medicaid. Of the 51.8 percent of the sample who entered nursing homes on Medicaid, 37.4 percent had been on Medicaid prior to admission and 14.4 percent went on Medicaid at the time of admission. 53/

Figure 9

Nursing Home Admissions by Source of Payment



Data on conversions from self pay to Medicaid have also been collected in Monroe County, New York, as part of a long-term care demonstration project. In 1977, 279 patients in SNF's applied for Medicaid coverage. In 1978 applications for conversion increased 66 percent to 462 requests. The number of requests for Medicaid coverage of patients in ICF's increased by 60 percent from 60 requests in 1977 to 96 in 1978. Not all of these conversions were approved; if patients were denied coverage it was generally because they had excess resources which made them ineligible. 54/

While requests for conversion are on the increase, many of the conversions which are approved are occurring within a relatively short time after admission to a nursing home. Of the 395 conversions approved for Medicaid coverage in Monroe County in 1978, 41 percent occurred while the individual had been in the nursing home 6 months or less as a private patient. Almost two-thirds of all individuals who converted to Medicaid had been in a nursing home as a private pay patient a year or less. Table 6 shows the conversion rates for the 395 patients broken down by ICF and SNF status. 55/

Table 6

Conversions of Private Pay Patients to Medicaid After Admission to a Nursing Home

	SNF		ICF		Total	
	Number	Percent	Number	Percent	Number	Percent
Converted within 90 days after admission	69	21	22	32	91	23
Converted between 91-180 days after admission	63	19	9	14	72	18
Converted between 181-365 days after admission	72	22	12	18	84	21
Converted after 365 days after admission	123	38	25	36	148	38
	327	100	68	100	395	100

In a neighboring county, data were collected on the number of conversions from 1976 to 1978. 56/ Table 7 shows the number of residents who entered nursing homes already eligible for Medicaid and the number of residents in a nursing home who converted to Medicaid coverage during the year.

Table 7

Medicaid Admissions and Conversions

	Medicaid-eligible admissions			Medicaid conversions		
	ICF	SNF	Total	ICF	SNF	Total
1976	101	381	482	1	11	12
1977	80	297	377	3	35	38
1978	96	182	278	14	88	102

Nursing home bed census for the county as of:

December 1976 - 983
December 1977 - 982
December 1978 - 967

It is significant that while the number of nursing home patients in the county remained relatively constant over the 3-year period, the number of Medicaid-eligible admissions decreased by 42 percent. On the other hand, the number of conversions increased from 12 in 1976 to 102 in 1978. 57/ In 1976, Medicaid patients who were admitted to nursing homes as private pay patients constituted 2.4 percent of the new Medicaid responsibility; in 1978 this figure increased to 27 percent.

The conversion of private pay nursing home residents to Medicaid coverage can represent a significant proportion of all Medicaid residents in nursing homes. There is also some indication that these conversions are on the increase. In addition to conversions, another group entering nursing homes are newly eligible to Medicaid; the Detroit survey of the nursing home population found that 28 percent of the Medicaid admissions had their eligibility established at the point of entering a nursing home. A major proportion of nursing home residents, therefore, are having their care paid for by Medicaid; yet these same individuals were not,

in many cases, eligible to participate in the program outside of a nursing home.

After conversion to Medicaid, the probability of an individual's return to the community is reduced

When an individual applies for Medicaid coverage, this often means that almost all savings or resources which could have been used for support in the community have now gone to pay for nursing home care. If the patient's condition improves while in the nursing home, or if this level of care was not required initially, it is unlikely that he or she could be returned to the community.

This problem was identified in a study of Medicaid patients in Cincinnati; the income test for Medicaid eligibility was linked to increased nursing home costs to the program because low and middle income residents were forced into near poverty before they could qualify for coverage. The study found that some of these individuals were then unable to leave the institution and return to independent living, thereby increasing Medicaid's nursing home expenditures. 58/

As a result of this research, special legislation was passed in the Ohio legislature in 1977 to enable the Health Resources Coordinating Service in Cincinnati to waive some of the State's Medicaid eligibility requirements to implement an experimental program. Under this new program, individuals in nursing homes not on Medicaid who are identified as having the potential for returning to independent living would be eligible for temporary Medicaid assistance for 3 to 6 months. The program's goal is to allow nursing home residents to preserve adequate resources to enable them to return home. 59/

In response to the same problem, the Department of Social and Health Services in Washington State proposed (in April 1979) a demonstration project to test a "Nursing Home Discharge Allowance." They found that Medicaid recipients no longer needing nursing home care often remain in these facilities because they lack the resources to return to the community. The proposal estimated that approximately 28 nursing home residents per month could be returned to independent living if the obstacles of lack of staff time to plan and work with patients and resources to reestablish them in the community could be overcome. 60/

The impoverishment of individuals by nursing home costs reduces the probability that they can be returned to a more independent living arrangement should this be appropriate. It also increases the probability that Medicaid will be subsidizing their care for the duration of their nursing home stay, whether their admissions were initially medically necessary or not.

MEDICAID POLICIES OFFER MINIMAL SUPPORT TO FAMILIES WHO PROVIDE LONG-TERM CARE SERVICES TO ELDERLY RELATIVES

Medicaid policies, as currently structured, extensively subsidize nursing home care but offer less assistance to elderly who need but cannot afford to purchase health and social services to remain in their own homes or communities. These policies are equally disadvantageous to families who provide care for their chronically impaired elderly. Many of these families, after exhausting their personal, social and financial resources, seek nursing home placement for their relatives as a last resort.

Families often can only obtain public support for the long-term care service needs of their relatives through nursing home placement

Extensive research has documented that when "older people are in advanced old age, are mentally and/or physically impaired, and are functionally disabled, the critical determinants of who is admitted to institutions and who remains in the community, are the social supports available, primarily family." 61/ A New York City survey found, for example, that of the services which were most critical to maintaining an elderly person at home, 77 percent were provided by the daughter, spouse and other family members. 62/ Because of this support, families are one of the key factors in delaying if not preventing the institutionalization of the chronically impaired elderly. 63/

Providing assistance to an elderly person who has chronic health problems can require a great deal of time and money. A University of Michigan study, based on a 1975 national survey of households, documented that for the elderly living in a relative's home, care being provided by two-fifths of the family members was equivalent in hours to a full-time job. 64/ Families providing care to relatives in their own homes are also unlikely to have public support for this care. The Michigan study compared two groups of adults who had

parents over 60 years of age living either with them or in nursing homes. If the parent lived with the adult child his or her source of support was more than twice as likely to be contributions from family members than if the parent was living in a nursing home. Welfare, Medicaid and SSI support were also much less likely to be available to parents living with their children (5.9 percent) compared to parents living in a nursing home (23.1 percent). The sources of support for these two groups, as reported by the adult children, are presented in table 8. 65/

Table 8

Sources of Support and Housing of Elderly Parents

Parent's main sources of support	Housing environment of parent: Living with child	Housing environment of parent: Living in nursing home
	(Percent)	
Family contributions	26.6	11.0
Parent's own income, savings	22.9	23.7
Pensions	4.1	4.0
Social Security, VA, Medicare	40.2	37.0
Welfare, SSI, Medicaid	5.9	23.1
Other	0.4	1.2
Total	100.0	100.0
(Number of mentions)	(271)	(173)

Families who attempt to provide support to their elderly relatives may receive limited or no financial or social service assistance. If however, the elderly relative is institutionalized and covered by Medicaid, the family receives financial relief. The significance of this was highlighted in work by Burton, et al., who estimated the cost of providing home-based services comparable to those received by individuals in a long-term care facility. It was estimated that services costing $19.19 per day in an institution would cost $15.72 per day in a family setting; this includes items

such as food, nursing and personal care. Under the Medicaid program, however, the $15.72 would probably be paid by the family and the individual's resources, while the $19.19 for nursing home care could be paid, at least in part, by the Government. 66/ If caring for an elderly person in the home prevents an adult relative from working, the cost to the family would be greater. Adult children caring for their relatives, according to the Michigan study, were nearly twice as likely as those with parents in a nursing home to report that their financial situation had become more difficult because of caring for a parent. 67/

Families are often aware that any public support for long-term care they receive may hinge upon the institutionalization of a relative. The Michigan survey found that the majority of families knew that if their elderly relative left the nursing home, he or she would lose some public financial support; that is, remaining in the institution was the key to obtaining Government (Medicaid) assistance. 68/

Families are generally not obligated to contribute to nursing home care paid for by Medicaid

If an elderly parent is placed in a nursing home and is eligible for Medicaid, the adult children are relieved of any financial obligation to contribute toward the cost of care. 69/ Medicaid regulations, in general, do allow States to hold spouses and parents of children under age 21 financially responsible for the costs of care. However these regulations are superseded in the 35 States which use SSI criteria for determining Medicaid eligibility. These States must follow SSI relative responsibility policy which requires spouses (and parents of recipients who are minor children) to support a spouse or child only while he or she is at home. After a spouse, for example, has been institutionalized for 1 month in a nursing home (6 months if both members of a couple are SSI eligible) the spouse is no longer responsible for contributing to the costs of that person's care regardless of the relative's personal financial resources. 70/

States and jurisdictions which are affected by this policy are as follows:

Alabama	Maine	South Carolina
Alaska	Maryland	South Dakota
Arkansas	Massachusetts	Tennessee
California	Michigan	Texas
Delaware	Montana	Vermont
District of Columbia	Nevada	Washington
Florida	New Jersey	West Virginia
Georgia	New Mexico	Wisconsin
Idaho	New York	Wyoming
Iowa	North Dakota	
Kansas	Oregon	
Kentucky	Pennsylvania	
Louisiana	Rhode Island	

A recent survey of Medicaid eligibility practices concluded that cost savings could be achieved if spouses and parents were required to help pay what they could to defray the costs of institutional care. Furthermore, the study concluded that this policy created strong incentives for families to institutionalize the disabled while at the same time penalizing families who did not institutionalize seriously ill members. In general, States would like to "impose some form of continuing relative responsibility, but feel that noninstitutionalized individuals and families ought to be able to retain a fairly substantial income, much higher than that used as a standard for cash assistance." 71/

Some older persons' assets are transferred to their relatives prior to acquiring Medicaid coverage

Because of the high cost of institutional care some residents' assets are transferred to their relatives to ensure that their families, rather than the nursing home, receive their life savings. Prior to SSI, many State cash assistance (and Medicaid) programs would find an applicant ineligible if she or he had transferred assets for less than fair market value within some specified period prior to the date of application. However, the SSI legislation considers as available resources only that property which the applicant (or spouse) could reduce to cash and use for personal maintenance and support; it does not permit consideration of asset transfers. 72/

The 35 States which use SSI criteria in determining eligibility for Medicaid are not permitted to restrict asset transfers by applicants. 73/ SSI policy, therefore, makes it possible for many individuals in nursing homes to qualify for Medicaid if they transfer their financial resources to relatives to become eligible for assistance. 74/ The full impact of asset transfer may not yet be realized. A recent survey of State eligibility practices found that "Because of traditional practices and State laws several States which are supposed to be following SSI criteria for Medicaid eligibility nevertheless are disqualifying adult Medicaid applicants who transfer assets in order to become eligible." 75/

SSI's transfer of assets policy may increase program cost to Medicaid. A recent study noted that:

> Medicaid recipients, particularly those in nursing homes, are more likely than welfare recipients to have financial resources because nursing home care is so expensive that even middle and upper income persons are motivated to get the government to pay for it if they can. SSI's transfer of assets policy is a fiscal burden to States because it increases the institutional caseload. It removes the burden of financing institutional care from recipients who could afford to contribute to the cost of care and places that burden entirely on States. 76/

The Majority of Medicaid and non-Medicaid elderly nursing home residents have relatives who live nearby and visit often

While it has been well documented that families are often the key to whether the individual is institutionalized or not, public policies fail to support these efforts even though the cost, time and effort required to care for an impaired person is tremendous. At the same time, if the family institutionalizes a relative who becomes eligible for Medicaid coverage, families receive financial and emotional relief.

Maddox has pointed out that the capabilities of families to cope with impaired and disabled members is very limited and that the real costs to the family caretakers in terms of physical and psychic stress have yet to be determined. 77/ Because of this stress many families appear to be able to care for their elderly relatives up to a point. At some juncture, a crisis is reached where the family can

no longer provide care; a hasty decision at this time may lead to institutionalization rather than consideration of community-based long-term care options. 78/ A 1978 survey in New York City showed that the only significant predictor of the decision to institutionalize the older person is the extent to which the family perceives the elderly person as an inconvenience. In turn, the dependency of the older person was the most significant factor in predicting whether the family perceives the person as an inconvenience. 79/

To learn more about elderly nursing home residents and their family ties we analyzed data from the SIP nursing home survey. This survey found that 91 percent of the elderly persons in nursing homes had relatives. Our analysis revealed that an overwhelming majority of both the Medicaid and the non-Medicaid residents have family members as shown in table 9.

Table 9

Family Ties of Nursing Home Residents

	Medicaid residents		Non-Medicaid residents	
	Number	Percent	Number	Percent
Has relative	403,700	91.0	357,200	90.9
No relative	39,600	9.0	35,800	9.1
Total	443,300	100.0	393,000	100.0
Not reported	178,800			
Valid cases	836,300			
Total elderly residents*	1,015,100			

Almost 56 percent of these relatives, as shown in table 10, were the resident's son or daughter.

*Totals in our SIP analysis vary due to rounding.

Table 10

Relationship of Relatives to Nursing Home Residents

Relationship to resident	Number	Percent
Spouse	68,900	7.3
Parent	1,900	0.2
Brother/Sister	135,900	14.4
Son/Daughter	525,600	55.5
Grandchild	29,800	3.1
Aunt/Uncle	1,800	0.2
Other Relative	182,300	19.3
Total	946,200	100.0

Both the Medicaid and the non-Medicaid elderly residents received frequent visits from their relatives. As shown in table 11, 64 percent of the Medicaid residents and 63 percent of the non-Medicaid residents were visited at least once a week. Eight-four percent of the entire elderly nursing home sample were visited at least once a month.

Table 11

Frequency of Nursing Home Visits

Relative or spouse visits to resident	On Medicaid		Not on Medicaid	
	Number	Percent	Number	Percent
Once a week	287,700	63.5	232,600	63.4
Once a month	94,800	20.9	71,400	19.5
Once every 6 months	39,200	8.7	42,300	11.5
Once every year	4,300	0.9	7,200	2.0
Less than once a year	8,400	1.9	8,500	2.3
Not at all	18,300	4.0	5,000	1.4
Total	452,700	99.9	367,000	100.1
Valid cases	819,700			
Missing cases	126,400			
Total sample	946,100			

The majority of the relatives lived within 25 miles of the nursing home (see table 12). Seventy-three percent of the relatives of Medicaid residents and 70 percent of the non-Medicaid residents' relatives lived less than 25 miles from the facility.

Table 12

Distance of Residents' Relatives from Nursing Home

Distance relatives live from nursing home	On Medicaid		Not on Medicaid	
	Number	Percent	Number	Percent
Less than 25 miles	325,400	72.5	256,500	70.0
25 to 74 miles	79,400	17.7	43,600	11.9
75 plus miles	44,000	9.8	66,500	18.1
Total	448,800	100.0	366,600	100.0
Valid cases	815,400			
Missing cases	130,700			
Total	946,100			

Thirty-five percent of the relatives of elderly nursing home residents who reported their income had yearly family incomes of over $15,000. Thirty-four percent of the relatives of Medicaid residents and 36 percent of the relatives of non-Medicaid residents had family incomes of $15,000 or more as shown in table 13. Forty-three percent of the relatives of elderly residents had family incomes below $10,000.

Table 13

Income of Family During Past Year by Medicaid Status

Total income of family during past year	On Medicaid		Not on Medicaid	
	Number	Percent	Number	Percent
$4,999 or less	64,000	17.9	49,400	19.5
$5,000-9,999	87,300	24.4	59,200	23.4
$10,000-14,999	86,400	24.2	53,200	21.0
$15,000 or more	119,700	33.5	91,500	36.1
Total	357,400	100.0	253,300	100.0
Valid cases	610,700			
Missing cases	335,300			
Total	946,000			

The SIP data suggest that some of the elderly who are placed in nursing homes may not be the individuals often considered at greatest risk of institutionalization. This "at risk" group includes those individuals who have no family or who have no relatives to turn to for help because they do not live nearby or they have a strained relationship. The SIP analysis shows, however, that of the elderly individuals placed in nursing homes (whether they are on Medicaid or not), the majority have a close relative (generally an adult child) who lives within 25 miles of the facility and visits almost monthly.

When these families were asked the primary reasons for their relative's admission to the nursing home, 66 percent (621,700) responded that it was because the resident needed medical or nursing care. Twenty-nine percent said that the patient was admitted because they were unable to provide care. Table 14 summarizes the reasons for admission.

Table 14

Reasons for Admission to Nursing Homes

Reason for admission	Number	Percent
Need for medical care	621,700	66.0
Family unable to care for person	275,300	29.2
Economic-no money or resources to care for person	6,700	0.7
Legal-person was committed or assigned to facility	2,800	0.3
Other	29,100	3.1
Do not know	6,700	0.7
Total	942,300	100.0

One of the reasons why these families could not provide or could not continue to provide care could be the limited public support available for long-term care services outside of a nursing home. Often missing are financial, health and social services to help families who are caring for their relatives in their own homes. For other families, if supervised residential housing had been available, this would have permitted their elderly relatives to remain in the community where the family could have continued to provide support. Currently, however, most Medicaid financing of long-term care is only available after the chronically impaired elderly relative is in a nursing home.

Summary

The elderly who are functionally disabled and have insufficient financial resources to purchase the health and social services they need are at risk of being institutionalized. Support from health systems is limited. Even if Medicare's cost sharing features do not serve as a deterrent, the program's coverage of services for chronic long-term health problems is limited. Medicaid provides minimal home health care services to the elderly and its coverage of the poor varies by State.

The availability of Medicaid's nursing home benefit, however, serves to reinforce its use regardless of whether care in this setting is actually needed. An individual living in the community with a monthly income of $250 may be ineligible for Medicaid yet unable to pay for needed health services. This individual, if admitted to a nursing home, could have an income of $590 a month and still be eligible for Medicaid. After applying any personal income toward the cost of care, Medicaid coverage would then pay not only nursing home costs but also the costs of other services such as physician fees, drugs and physical therapy.

Other chronically impaired elderly may be admitted to nursing homes as private pay patients whether they need this level of care or not; after they have used up their savings from the sale of a home, for example, or transferred their assets to relatives, they may qualify for Medicaid. A major proportion of residents supported by Medicaid in nursing homes initially entered as private pay patients. Once individuals have qualified for Medicaid it is unlikely that they can ever be discharged because they are now generally without sufficient resources to enable them to return to community living.

Families who are the major source of support for the functionally dependent elderly in the community often experience severe financial and social strain in providing this care. They are unlikely to receive any help from Medicaid; however, if the elderly relative is placed in a nursing home and the care is subsidized by Medicaid, the family is relieved of any financial responsibility.

NOTES

1/Judith LaVor, Long-Term Care: A Challenge to Service Systems. Office of Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare, revised, April 1977, p. 20.

2/General Accounting Office, The Well-Being of Older People in Cleveland, Ohio, (HRD-77-70, April 19, 1977) p. 10. Based on the responses in each of the five areas, an individual's status was categorized according to one of these levels. Unimpaired represented "Excellent or good in all five areas of human functioning" and generally impaired represented "Mildly or moderately impaired in four areas." The range below generally impaired was: greatly impaired, very greatly impaired, and extremely impaired.

3/Saad Nagi, "An Epidemiology of Disability Among Adults in the United States," Millbank Memorial Fund Quarterly, Fall, 1976, p. 449.

4/Robert M. Gibson and Charles R. Fisher, "Age Differences in Health Care Spending, Fiscal Year 1977," Social Security Bulletin, Vol. 42, No. 1, January 1979, p. 15.

5/Jacob S. Siegel, "Prospective Trends in the Size and Structure of the Elderly Population, Impact of Mortality Trends and Some Implications," in Two Statements Before Congressional Committees, Current Population Reports, Special Studies, Series P-23, No. 78, U.S. Department of Commerce, Bureau of Census, May 1978, pp. 7-8.

6/Technical Consultant Panel on the Long-Term Health Care Data Set, Long-Term Health Care: Minimum Data Set, U.S. National Committee on Vital and Health Statistics, DHEW, September 8, 1978, p. 6.

7/Ibid.

8/All States except Arizona currently participate in Medicaid. The District of Columbia, Puerto Rico, Guam and the Virgin Islands also provide coverage.

9/States may also provide: clinic services; prescribed drugs; dental services; prosthetic devices; eyeglasses; private duty nursing; physical therapy and related services; other diagnostic, screening, preventive and rehabilitative services; emergency hospital services, skilled nursing facility services for persons under 21; optometrist's services; podiatrist's services, chiropractor's services; care for patients 65 or older in institutions for mental diseases or tuberculosis; care for patients under 21 in psychiatric hospitals; institutional services in intermediate care facilities. Institute for Medicaid Management, Data on the Medicaid Program: Eligibility/Services/Expenditures, Fiscal Years 1966-1978, DHEW, Washington, D.C., 1978, p. 6.

10/Karen Davis and Cathy Schoen, Health and the War on Poverty, a Ten Year Appraisal. The Brookings Institution, Washington, D.C., 1978, p. 55. For a listing of limitations on services by State as well as recent cutbacks see: Institute for Medicaid Management, pp. 15-18 and 7-12.

11/These services are provided under a Medicaid regulation 42 C.F.R. § 440.170(f). In 1976, expenditures for these services were reported as follows: District of Columbia ($976,361), Massachusetts (N/A); Minnesota ($1,500); Montana (N/A); Nebraska ($93,309); Nevada ($83,784); New York ($126,435,823); Oklahoma ($8,686,446); Wisconsin (N/A). DHEW, "From Simple Idea to Complex Execution: Home Health Services Under Titles XVIII, XIX, and XX," Report to the Congress pursuant to P.L. 95-142. Draft, January 1979, Washington, D.C. p. 25, Appendix I A-I..

12/These services are provided under 42 C.F.R. § 440.20 (outpatient hospital services) and 42 C.F.R. § 440.90 (clinic services). For a complete description of adult day health services, see Adult Day Health Care--A Conference Report on the National Conference on Adult Day Care, supported by Grant No. 1 R13 HS 02580-01 from the National Center for Health Services Research, DHEW, May 1979.

13/Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, DHEW Publication No. (HCFA) 78-03154, Research Report P-5 (FY 78) (Preliminary), June 1979, Table 7.

14/DHEW, "From Simple Idea to Complex Execution", p. 9.

15/Ibid. p. 24.

16/Memo to Secretary, HEW, from Inspector General, Service Delivery Assessment Study, February 1, 1978, p. 4.

17/LaVor notes that, "It is not clear why this regulation has not been applied more broadly, but the regulation is brief, and many people apparently do not fine-comb the regulations and it has not been widely publicized. Many States are fearful of the high use and cost potential of this aspect of Medicaid." Oklahoma and New York are two States which have used it extensively. LaVor, Long-Term Care: A Challenge to Service Systems, p. 47.

18/Some States have shifted to Title XX's "homemaker" service. In 1976 over 1 million received in-home services under Title XX; 90 percent were adults who gained access to service as an SSI recipient, AFDC recipient, or by being income eligible. DHEW "From Simple Idea to Complex Execution," p. 12.

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20/Urban Systems Research and Engineering, Inc., Comprehensive Review of Medicaid Eligibility, Cambridge, Massachusetts, HEW Contract No. SRS 500-76-0014, October 31, 1977, pp. 4-39-44.

21/Institute for Medicaid Management, p. 56.

22/Medicaid coverage is variable by State because each State sets its own eligibility standards and is variable within a State because to be eligible an individual must: 1) have a low income, 2) meet the prescribed test for resources and 3) belong to one of the groups designed for welfare eligibility. Institute for Medicaid Management, p. 1.

23/Judith Feder and John Holahan, Financing Health Care for the Elderly, Medicare, Medicaid, and Private Health Insurance, The Urban Institute, Washington, D.C., February 1979, pp. 37-39.

24/Karen Davis, p. 313.

25/Marjorie Smith Carroll, "Private Health Insurance Plans in 1976: An Evaluation," Social Security Bulletin, Vol. 41, No. 9, September 1978, p. 6.

26/Institute for Medicaid Management, pp. 4, 5.

27/Robert M. Gibson and Charles R. Fisher, pp. 13, 14.

28/Institute for Medicaid Management, p. 60.

29/Robert M. Gibson and Charles R. Fisher, p. 12.

30/Ibid., pp. 12, 14.

31/Ibid., p. 14.

32/Ibid., p. 12.

33/Robert M. Gibson and Charles R. Fisher, "National Health Expenditures, Fiscal Year 1977," Social Security Bulletin, Vol. 41, No. 7, July 1978, p. 7; and DHEW, "From Simple Idea to Complex Execution," p. 6.

34/DHEW, "From Simple Idea to Complex Execution," p. 6.

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49/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 29.

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56/The population of this county is approximately 200,000 while Monroe county's is nearly 800,000.

57/Data collected by Macro Systems, Silver Spring, Maryland, April 1979, as part of the Monroe County Long Term Care Program Fourth Year Evaluation, to be published in November 1979.

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59/Ibid.

60/Budget Initiatives, Washington State Department of Social and Health Services, "Nursing Home Discharge Allowance," April 13, 1979.

61/Elaine M. Brody, "The Formal Support Network: Congregate Treatment Setting for Residents with Senescent Brain Dysfunction," Philadelphia Geriatric Center, Philadelphia, Pennsylvania, December 6-8, 1978, p. 15.

62/Community Council of Greater New York, Dependency in the Elderly of New York City: Report of a Research Utilization Workshop held on March 23, 1978, New York, New York, October 1978, pp. 21-22.

63/Stanley J. Brody, Walter Poulshock, Carla Masciocchi, "The Family Caring Unit: A Major Consideration in Long-Term Care Support System," The Gerontologist, Vol. 18, No. 6, 1978, p. 557.

64/Sandra Newman, with James Morgan, Robert Marans, Leon Pastalan, Housing Adjustments of Older People, Institute for Social Research, The University of Michigan, Ann Arbor, Michigan, 1976, p. 33.

65/Ibid., p. 102.

66/Richard Burton, et al., "Nursing Home Cost and Care: An Investigation of Alternatives," Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina, (Revised, September 1975), p. 8.

67/Sandra Newman, pp. 103-104.

68/Ibid. pp. 106-107. Families confronted with the fact that they could get some public help with long-term care needs of their relatives through nursing home placement may also have been influenced in the use of these facilities because of the effort to upgrade them in recent years. Dunlop states that "perhaps through no other mechanism has Medicaid exerted more impact on the nursing home industry than through its influence on standards enforcement." * * * "The medical model which was followed in developing these standards and which has brought enlarged nursing staffs, nurse's stations, medical charts, pharmacies, and, most recently, medical directors to the nursing home scene, has greatly altered the nursing home image and has made nursing homes more acceptable settings in the minds of those involved in placing patients there." Burton David Dunlop, The Growth of Nursing Home Care, Lexington Books, Lexington, Massachusetts, 1979, pp. 79-80.

69/P. L. 89-97, Section 1902(a)(17)(D) removed from adults the responsibility of being billed for medical care of elderly, impoverished parents. The removal of this prohibition, in conjunction with other sections of the Act, has had, according to authors of a recent history of the Medicaid program, an important effect on expanded utilization of nursing homes. Robert Stevens and Rosemary Stevens, Welfare Medicine In America: A Case Study of Medicaid, The Free Press, New York, 1974, p. 68.

70/Problems in Medicaid eligibility have been compounded because of the requirement to follow the basic eligibility practices established for the cash assistance programs (e.g., SSI). This relationship has been noted because: 1) medical payments for the institutionalized elderly exceed SSI cash payments to all aged; and 2) 70.5 percent of Medicaid expenditures for the aged go to persons receiving no cash assistance (in FY 1975). See Urban Systems Research and Engineering, Inc., Comprehensive Review of Medicaid Eligibility, pp. 4-45-46, and Institute for Medicaid Management, p. 68.

71/Ibid., pp. 3-71, 4-50.

72/Ibid., pp. 3-67-68.

73/Legislation has been introduced in this Congress to restrict the transfer of assets for SSI and Medicaid eligibility. Section 24 of S. 505 (Medicare-Medicaid Administrative and Reimbursement Reform) would authorize States at their option to deny eligibility for Medicaid in cases where an otherwise eligible aged, blind, or disabled person disposes of significant assets by giving them away or selling them for substantially less than their fair market value in order to establish Medicaid eligibility. In addition, HR 4321, part of the administration's public assistance legislation, would restrict SSI and Medicaid eligibility for persons who transferred their assets valued at $3,000 or more without compensation. The period of ineligibility would be 6 to 24 months depending on the amount transferred.

74/Urban Systems Research and Engineering, Inc., Comprehensive Review of Medicaid Eligibility, pp. 4-51.

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76/Ibid.

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78/Barbara Silverstone, "An Overview of Research on Informal Supports: Implications for Policy and Practices," Cleveland, Ohio, presented at Gerontological Society Meeting, Texas, November 17, 1978, p. 3.

79/Community Council of Greater New York, p. 5.

CHAPTER 3

AVOIDABLE ADMISSIONS RESULT FROM DIFFICULTIES ENCOUNTERED IN OBTAINING COMMUNITY-BASED LONG-TERM CARE

Financial barriers are only one of the problems contributing to avoidable nursing home utilization. There are several other crucial factors which encourage the use of institutional services even when this level of long-term care is not required or preferred. Many chronically impaired elderly have been placed in nursing homes because of:

--A lack of information about noninstitutional long-term care options;

--The difficulties involved in locating and obtaining the appropriate mix of health and social services from the fragmented and confusing array of public and private service providers;

--The inability to obtain all the essential community services because the individual cannot meet the eligibility criteria for each service and cannot afford to purchase this care;

--The unavailability of the noninstitutional long-term care services and housing options required to permit an individual to remain in the community;

--The inability of their families to continue bearing the emotional, physical, and financial strain of providing care in the absence of any support from public programs; and

--The tendency of the professionals assisting the elderly (physicians, social workers, hospital discharge planners) to recommend nursing home placement because they lack the time or the expertise to plan, arrange, and coordinate the community services needed to enable the elderly individual to remain in the community.

MANY NURSING HOME ADMISSIONS OCCUR WITHOUT CAREFUL CONSIDERATION OF COMMUNITY LONG-TERM CARE OPTIONS

Despite the potentially high human and financial costs of institutionalization, many elderly are admitted to a nursing home without adequate exploration of long-term care service options in the community. According to one observer, the most striking feature of the decisionmaking process leading to institutionalization is the "absence of order and careful consideration." 1/ This view of the nursing home admissions process is supported by the results of the 1976 Survey of Institutionalized Persons. Surveyors asked the relatives of elderly nursing home residents if other care options were investigated at the time of admission. The results show that 53 percent of the families (477,000 out of 908,500) did not. 2/

Research studies have indicated that the elderly and their families may not investigate community long-term care arrangements because they lack the time or knowledge rather than because they prefer institutional care. Frequently, they do not receive any information or assistance from professionals in seeking noninstitutional long-term care options.

A personal or family crisis may precipitate a nursing home admission

For many elderly, admission to a nursing home is precipitated by a crisis situation such as the death of a spouse, an acute illness, or mounting strain on the family. Prior to the crisis, institutionalization may never have been considered by the elderly or their families. For example, clinical findings from a study of applicants to a long-term care facility in Boston indicate that "husbands and wives--even when both are suffering from substantial physical disabilities--can often maintain themselves in the community in a complementary relationship to each other. Should one be removed from the household by death or hospitalization, the other may no longer be able to function independently in the community." 3/

Many chronically impaired elderly are able to manage in the community until they develop an acute illness which results in the need for a greater level of care. Nursing home placements may appear to be the only viable option if there is no one available to provide the more intensive level of care required to permit the individual to safely remain at home. In cases where the aged person has been hospitalized,

the physician may be reluctant to release the patient to the community if there is no one to provide the necessary care and supervision. In 1977, approximately 32.3 percent of all nursing home residents were admitted directly from an acute care hospital. 4/ These nursing home placements are often "precipitated at the eleventh hour" by the physician when acute care is no longer needed. 5/ In many cases, the hospital utilization review committee or Professional Standards Review Organization which is charged with eliminating unnecessary hospital care creates pressure on the hospital to quickly transfer the patient to a lower level of care and frequently the nursing home is the only care available.

Another frequently cited reason for nursing home admission is the strain on the family members caused by a chronically impaired elderly member. Caring for an impaired individual on a long-term basis can place physical, emotional and financial burdens on a family, particularly when assistance with daily activities is required. A family may reach the breaking point if it must provide this care without any outside assistance or temporary relief.

The results from the 1976 Survey of Institutionalized Persons indicate that an elderly person can be a source of strain in some families prior to nursing home admission. 6/ When interviewers asked the 274,800 families who had lived with the elderly nursing home resident just prior to admission whether the elderly person had caused a strain on the family, 37 percent said yes. 7/ Of these, 74.4 percent said they experienced strain prior to their elderly relative's admission to a nursing home; 22.2 percent reported strain both before and after institutionalization; and 3.4 percent said the strain began after the person entered the nursing home.

Professionals fail to inform elderly of community service options in lieu of nursing home placement

When a change in the care or living arrangements of a chronically impaired person is required, either as a result of a crisis or a gradually increasing need for assistance in daily activities, many people lack adequate knowledge of long-term care options. For example, although New York City operates three home care programs for Medicaid-eligible persons, a survey of 85 eligible elderly in need of home care revealed that 45 percent were unaware of their entitlement to these services. 8/ Similarly, an Illinois survey of the

relatives of elderly persons recently admitted to a long-term care facility found that of those who felt that community services could have helped, approximately 80 percent were unaware of available community services. 9/ Many of these families perceived only two alternatives--caring for an elderly person in their home or placement in an institution.

Community-based long-term care options may never be considered because the professionals who assist the elderly and their families in arranging long-term care--social service department case workers, hospital discharge planners, and physicians--are often unaware of, or too busy to explore, alternatives to institutionalization. Assembling the appropriate package of services can take several hours or several days, depending on the complexity of the individual's problems and the types of services available. Consequently, for professionals with heavy caseloads, it is much easier to admit the aged person to a nursing home. In addition to the time constraint, the professional may feel that home-based care would be unsafe for the client because there is no one to assume responsibility for monitoring the patient's care on a continuing basis or because the services required by the patient are not available.

The New York State Moreland Commission investigation of nursing homes reported that "those making placement decisions in the field * * * are usually in a hurry and in many cases do not consider alternatives to institutional care even when these may be more suitable--and more economical than a nursing home or other institutional placement." 10/ An audit of the South Carolina Medicaid program by the State Legislative Audit Council found that 30 percent of nursing home patients could have remained in their own homes given the necessary support services. 11/ The audit revealed that a person applying for Medicaid coverage of nursing home care at the State Department of Social Services would probably not be informed about possible alternatives. According to a study of long-term care services in New York and New Jersey, social service department case workers were often unaware of community-based services. 12/

Elderly persons applying to a nursing home while in the hospital are also unlikely to receive meaningful assistance in seeking other options, despite the existence of hospital discharge planning programs. Technically the discharge planner's mission is to develop the most appropriate long-term care plan for the patient based on a careful assessment of

the patient's medical and social needs. In practice, however, the hospital discharge planners often devote their time to finding an available nursing home bed for a patient because they lack sufficient information or time to explore and obtain community-based long-term care services.

One study of discharge planning revealed that "in concept, such a service is very useful and necessary. In practice, however, discharge planning is a neglected function; in the majority of hospitals, it is underfunded and understaffed." 13/ A 1978 survey of long-term care programs in Texas concluded that one of the barriers to providing community-based care to the chronically disabled is the lack of discharge planners in many hospitals. 14/ Similarly, the New York State Office of Health Systems Management views the serious weakness in hospital discharge planning as a stumbling block to ensuring the appropriate delivery of a full range of long-term care programs to the chronically disabled population. 15/

In some cases, the discharge planner may not be adequately informed about community-based long-term care services. At the HEW Regional Public Hearings on Home Health Care in 1976, witnesses testified that there is a lack of communication between hospital discharge planners and home health agencies, and as a result, discharge planners refer clients to nursing homes because they do not know about home care. 16/ Similar testimony was obtained in public hearings held in Texas in 1978. 17/

Frequently hospital discharge planners are not given enough time to adequately assess the patient's needs and arrange the appropriate long-term care services because:

--they were not consulted until the patient was ready to be discharged,

--they are under pressure from the hospital administration and the utilization review committees to reduce the patient's unnecessary stay in a costly hospital bed.

A 1978 study of the hospital social worker's role in the discharge planning process for elderly patients found that both of these factors contributed to the limited amount of time that was spent in arranging for long-term care. 18/ The study results indicate that the social worker spent an average of 5 hours on each nursing home placement, of which only 1 hour was spent with the elderly patient. Typically,

elderly patients were referred to the social worker after they had spent 10.8 days in the hospital, which was over half of their total stay. 19/ As a result of last minute referrals, heavy caseloads, and the hospital administrator's expectation that patients will be efficiently discharged, the social worker often had little time to do anything other than to locate a nursing home bed and arrange for the patient's transfer.

Physicians generally play the most important role in the decision to institutionalize an elderly person. In some cases, the physician is the first to suggest nursing home placement, while in others, the physician is consulted after the decision has been made to seek institutional care. For Medicaid and Medicare patients, a physician's participation in the decision is mandatory because Federal law requires a medical certification of need for nursing home placement as a means of preventing inappropriate utilization. However, the physician is often more likely to encourage rather than deter institutionalization because of a lack of awareness of alternatives, a narrowly focused medical view of the patient's needs, and an unwillingness or inability to oversee the packaging and coordination of the services required to keep the person in the community.

One of the commonly cited causes of avoidable nursing home admissions is the general lack of knowledge about community-based long-term care services within the medical community. One study of 100 community referrals to a home care program in New York State found that in only 28 cases did a physician have some role, however limited, in recommending home care. 20/ For the 58 persons who were referred to home care without a doctor's recommendation, 51 had seen a doctor within 3 months of the referral and 33 were assessed as needing home care.

A 1978 Texas study of the process leading to nursing home placement concluded that physicians not only exercise the greatest control over the decision to institutionalize a patient, but that they often bypass other professionals in the decisionmaking process. 21/ The study results are based on a survey of 2,077 physicians with a 34 percent response rate and a survey of 122 community service providers with a 74 percent response rate. The results indicate that only 10.8 percent of the responding physicians consult with hospital discharge planners and only 19.1 percent consult with social workers during the admissions process. 22/

According to one regional director of the Texas Community Care Program which provides social services to low-income aged, blind and disabled individuals, 60 percent of all Medicaid nursing home placements are made without consulting the program staff to determine the appropriateness of community care. 23/

Furthermore, the results of the service provider survey reveal "a disturbing lack of physician referrals to community care services." 24/ The results indicate that 31 percent of the home health agencies' clients, 8 percent of the homemaker/chore agencies' clients, and 5 percent of the meals agencies' clients were referred by physicians. However, of the physicians who responded to the question regarding what services would have prevented the institutionalization of some of their patients, 24 percent said medical or nursing care; 35 percent said housekeeping and meal assistance; and 14 percent said grocery shopping and errand assistance. 25/

The authors of a Massachusetts study on home care concluded that "health professionals are probably more ignorant of its purposes, potentials and limitations than almost any other component of the health system." 26/ The fact that most physicians do not receive any formal training in community health or geriatrics while in medical school partially explains their ignorance of and, according to some critics, their disinterest in, community-based long-term care services. A recent Institute of Medicine report on the treatment of geriatrics in medical education concludes that physicians need to be informed about the range of health and social services available because they serve as the "gatekeepers" in allocating services to the elderly. 27/ Consequently, the authors recommend that medical schools include experience in nursing homes, home health programs and other noninstitutional long-term care programs in training physicians.

THE ELDERLY WHO ATTEMPT TO ARRANGE COMMUNITY-BASED LONG-TERM CARE OFTEN ENCOUNTER SERIOUS OBSTACLES

Many chronically impaired elderly and their families do attempt to arrange home-based services before seeking nursing home admission. However, these efforts frequently end in frustration because community-based long-term care can be extremely difficult to plan and obtain due to the complexity

of the chronically impaired elderly's problems and the fragmentation and gaps in the services available in the community. Consequently, for many elderly the determining factor in the decision to enter a nursing home is their inability to obtain a suitable package of services to permit them to remain safely in their homes.

Arranging community-based long-term care can be complex because chronic conditions create multidimensional problems for the elderly

Arranging community-based long-term care can often be a complicated task because of the nature of chronic diseases in the elderly. The presence of just one chronic condition can impair an elderly person's ability to perform basic functions of daily living, such as bathing, eating, and dressing. The elderly who have one chronic disability are likely to have multiple impairments, often a mix of physical and mental problems. A chronically impaired aged person may have flare-ups of acute illnesses which temporarily require increased levels of care. Chronic impairments can in turn interact with a variety of social, psychological, environmental, and economic conditions to create multidimensional problems for the elderly in coping independently with everyday life.

Because the problems created by chronic conditions are complex and interlocking, the impaired elderly often require a mix of medical, social, economic, and mental health services to prevent or delay institutionalization. Frequently, no single long-term care service is sufficient to meet their multidimensional needs. The services required to maintain the elderly in their homes range from skilled medical and nursing care to housekeeping, transportation and home repairs.

The following case study illustrates the multifaceted problems which can threaten a chronically impaired elderly's ability to remain in the community.

> Mrs. A is a 68-year-old widow living in her own, five room cluttered house. She is obese, pale and disheveled and moves in a hesitant, unsteady fashion. Her speech is slow and slurred. Her primary problems revolve around feelings of nausea and dizziness and an unsteady gait resulting in decreased mobility. She is not maintaining a therapeutic diet for diabetes and her diet is

nutritionally deficient. Her limited visual acuity caused her to read with difficulty using a magnifying glass and, therefore, her previously enjoyed activities of reading and sewing were no longer possible. She was aware of her unsafe environment created by outside steps overgrown with vines and by icy, snow-covered ground. The dirty clutter inside her house inhibited her movements and constituted a fire hazard. Pervasive throughout her conversation are expressions of loneliness, isolation, and depression and a worry about money and health. Isolation stems from her inability to socialize with peers due to a lack of transportation. Mrs. A says she is ready to give up the struggle of maintaining herself and feels inadequate in coping with her problems. 28/

Mrs. A was able to stay out of an institution because she was provided with the following services:

--A complete medical examination which revealed the need for discontinuing her tranquilizer.

--An eye examination and new eye glasses.

--Snow shoveling.

--Cab transportation for such tasks as grocery shopping and medical appointments.

--Financial assistance with medications and additional health care services.

--Mental health counseling services to help with feelings of depression.

Because the chronically impaired elderly's conditions often fluctuate, changes may be necessary in the level and type of services provided. The following case study illustrates how a flareup of an acute illness can result in the temporary need for a higher level of services.

Mr. B is a retired university professor who became a double amputee as a result of a car accident. He has been fitted with prostheses and can usually walk with the assistance of a cane. Mr. B encountered multiple problems. The swelling and ulceration of

his stumps made it impossible to use his prostheses. He also complained of severe congestion, stomach pain, and fatigue. His apartment, in a condemned building, was without heat. Mr. B had become extremely depressed and isolated. 29/

The following services were provided to Mr. B to enable him to remain in the community:

--The furnace in his old apartment was repaired and assistance was provided in finding a new apartment.

--Medical treatment.

--Transportation for medical appointments.

--Employment counselor found Mr. B a part-time job.

--Homemaking services.

--Friendly visitors.

--Home-delivered meals.

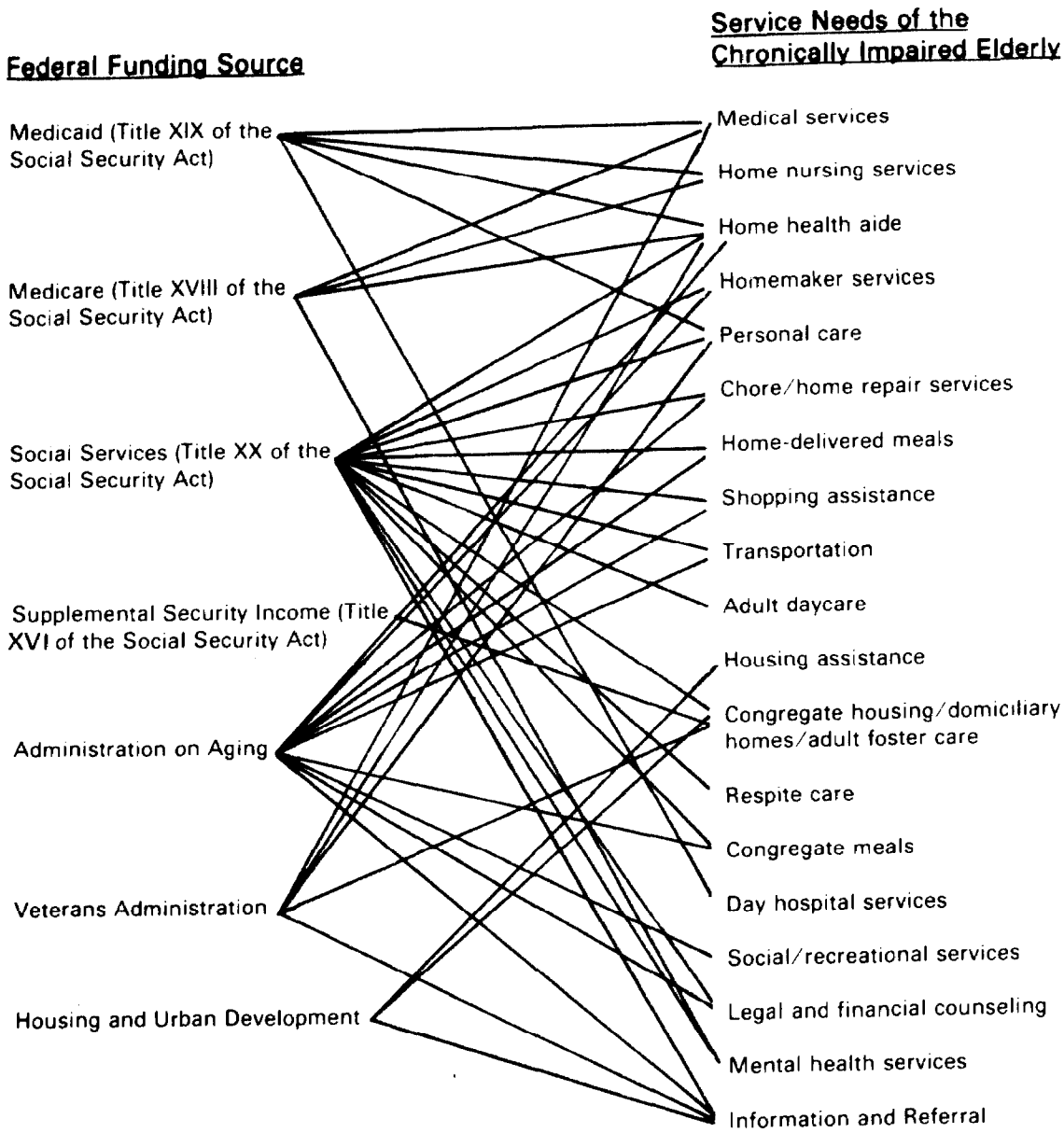
When Mr. B recovered from his acute illness, he no longer required home-delivered meals or transportation services.

The elderly often have trouble locating the appropriate services because of the fragmented and confusing array of service providers

Arranging a package of community-based services to meet the chronically impaired elderly's multifaceted needs can be a highly frustrating if not impossible task because of the fragmentation, lack of coordination, and gaps in the long-term care system. This "system" is really a conglomeration of several Federal, State, and local programs, each of which provides specific types of services, such as medical care, nutrition, or social services. Each program has its own administrative unit, eligibility requirements, and financing mechanisms. Figure 10 displays the complex array of Federal programs which compose the long-term care system. At the local level, this system can become even more confusing because of the addition of State and local programs, as well as voluntary and proprietary service providers.

Figure 10

Major Federal Programs Funding Community Services for the Elderly



The problems caused by the fragmentation of responsibility for long-term care have been well documented in congressional and executive branch hearings, as well as in the long-term care literature. When HEW held a series of public hearings on home health care services in 1976, one of the areas of greatest concern and consensus among witnesses was the inability of individuals and their families to deal with the fragmented, uncoordinated array of home health and support services. 30/ This issue was also raised repeatedly by witnesses in 1978 public hearings on community-based long-term care in Texas. 31/ Because each service focuses on a specific human problem or target group, no single program can meet the chronically impaired elderly's multifaceted needs. Consequently, the elderly who prefer noninstitutional long-term care must contend with a bewildering maze of public and private service providers to locate and obtain the appropriate types of assistance. Because service providers offer different types of services or the same service under different names, the elderly often find it very difficult to identify the providers who can best meet their needs.

For example, agencies providing home care services use several titles for nonprofessional, personal support aides such as home health aides, homemakers, home attendants, and homemaker-home health aides. The distinction drawn between the homemaker and the home health aide is a result of the fragmentation of funding between health programs (Medicare and Medicaid) and social services programs (Title XX of the Social Security Act). Medicaid and Medicare reimburse for the services of a "home health aide" who provides personal care services, such as assisting with bathing, exercises, and medications, and also keeps the bedroom and bathroom area clean and safe. Title XX, a Federal grant program to the States for a variety of social services, reimburses "homemakers" for providing assistance in cleaning, laundry and cooking as well as with some types of personal care. The distinction between the services provided under Medicaid and Title XX is becoming even more blurred since a few States have begun reclassifying social problems as health problems to replace scarce Title XX funds, which have a cap, with open-ended Medicaid funds.

The chronically impaired elderly who attempt to assemble a package of community services often have to make separate trips to several agencies, each with its own application forms and assessment procedures. For example, an aged person may have to apply separately for Medicaid, Title XX homemaker services, meals-on-wheels, transportation services,

and visiting nurse services. Typically, each agency will make an individual assessment of the client's eligibility for its services. Efforts to arrange home-based care may fail because the client is found ineligible for one or more of the services.

In most communities, there is no central organization or professional to whom the chronically impaired elderly and their families can turn for assistance in locating and coordinating the services for which they are eligible or in fact need. Because of the fragmentation in human service programs, many public and private service providers offer information and referral (I&R) services which are designed to assist clients in locating services appropriate to their needs. However, our recent study of I&R providers concluded that these agencies have become part of the maze they were supposed to penetrate because their services are fragmented, uncoordinated, and targeted on specific services or clientele groups. 32/

To coordinate and expand local community services for the elderly, the Older Americans Act established 560 Area Agencies on Aging (AAA) which are administered by HEW's Administration on Aging. The Comprehensive Older Americans Act Amendments of 1978 expanded the role of the AAA's. The Act also authorizes the establishment of model projects and demonstration grants to test methods of developing comprehensive, coordinated systems of delivering community services to the elderly.

Varying eligibility criteria may prevent the elderly from obtaining all the services needed

Eligibility criteria are often based on factors other than client need such as income level, age, or geographic location. Those who cannot afford to pay for services either go without assistance or use only those services for which they can receive reimbursement. "To the extent that in-home health services are dictated by available funding, patients will not be able to obtain services which are appropriate in type, frequency, or duration." 33/

For example, an elderly person may be eligible for Medicare home nursing care but ineligible for Title XX homemaker services because the State has established a very low income requirement. Under Title XX, the States have the authority to set any eligibility requirements, provided they

do not exceed 115 percent of the State median income. Recent studies indicate that States often set low income requirements as a means of limiting the size of the eligible population because only a fraction of the State's social service needs can be met given the ceiling on Title XX funds. A 1977 study of Title XX home services in New York and New Jersey found that in New York State, which permits each county individually to establish the income limits, the maximum eligibility level for homemaker services ranges from 38.75 percent to 62 percent of State median income. 34/ In New Jersey, the maximum income level for homemaker services is approximately 80 percent of the median income. In Texas, according to a 1978 study, the elderly cannot have incomes above 60 percent of the State median income to be eligible for Title XX services. 35/

One of the goals of a recent New York City study was to determine the types of services which chronically impaired clients would use if they were not restricted to services reimbursed by third-party payers or to the limited range of services provided by a traditional home health agency. 36/ The research project, jointly established by the Visiting Nurse Service of New York and the New York City Health Systems Agency, used grant funds to pay for all services and clients normally not covered by the fragmented reimbursement system. The study population comprised 420 chronically impaired adults with varying degrees of functional limitations. Thirty-three percent were totally dependent on others for personal care; 28 percent needed help in one or more activities of daily living; 39 percent required only assistance in housekeeping and shopping. Approximately 50 percent were over 75 years of age, and 80 percent were over 65 years. All but 4 percent had Medicare, Medicaid or private insurance coverage.

The study results indicate that: a) a major barrier to providing the necessary range of home health care services is the lack of third-party reimbursement for a number of essential services; and that b) a wider range of services is required by the chronically impaired than is normally provided by a home health agency such as the Visiting Nurse Service. One-third of the costs of all services utilized was not reimbursed by third-party payers; 43 percent of these costs were for housekeeping and home attendant services. One-half of the total costs was for services obtained from providers other than the home health agency. The authors concluded that

"home health agencies need to consider whether or not they are providing an adequate scope and array of direct home health services." 37/

The range of services provided included physician, nurse, home health aide services, housekeeper and home attendant services, physical and other special therapies, social work, transportation, equipment and supplies, and laboratory services.

ESSENTIAL HOME SERVICES MAY BE UNAVAILABLE IN THE COMMUNITY

One of the major barriers faced by many elderly and their families in attempting to arrange noninstitutional long-term care is the lack of essential types of services--including home-delivered services; support services for family members who care for their disabled kin; and a range of housing options.

In many areas, particularly rural ones, community-based long-term care services are nonexistent or in short supply. Several local research and demonstration projects designed to provide the elderly with a coordinated package of home-based long-term care services as an alternative to nursing homes discover that they must first develop and expand the number and type of services available in the area. For example, Triage, Inc., an HEW funded research and demonstration project providing comprehensive health and social services to the elderly, found that a number of vital home-delivered services were not available in its service area--a seven-town, urban-rural region in Connecticut. 38/ Meals-on-wheels and transportation services were virtually nonexistent. Home services were not available on a 24-hour, 7-day-a-week basis. Physicians' services, drugs, medical supplies, and laboratory tests were inaccessible to the homebound elderly. Since its inception, Triage has been successful in filling these critical service gaps by developing contracts with 196 service providers (as of June 1978) for a wide range of services.

Even when services exist in the community, the supply is often too meager to meet the demand. For example, the study of Title XX services in New York and New Jersey found that although social services are ostensibly available to the elderly under the State Title XX plan, for all intents and purposes they are unavailable. 39/ For example, in 1976, New Jersey provided in-home services to fewer than 5,000 persons. 40/

Support services may be unavailable to families providing long-term care

The critical role families play in preventing the institutionalization of their chronically impaired elderly kin has been well documented. 41/ Most families are strongly committed to keeping their chronically impaired elderly members in the community for as long as possible, often in spite of enormous psychological, physical, and economic burdens. However, because there are no financial or social supports available to relatives providing long-term care, families may reach the point where they are no longer capable of continuing this care and they may be forced to turn to a nursing home.

Several studies indicate that families provide or are willing to provide long-term care to their elderly relatives. An analysis of data from a survey of the aged conducted in 1957, 1962, and 1975 revealed that "the family is the primary basis of security for adults in later life." 42/ The survey results indicate that although the proportion of elderly who live with one of their children has declined, the proportion of elderly living within 10 minutes distance of one of their children has increased. 43/ This trend reflects the preferences of both the elderly and their families to live in separate households while maintaining close ties.

A 1977 study of the willingness of families to care for aged members found that 81 percent of 356 families surveyed would accept an older person into their homes in some circumstances. 44/ Only 19 percent would not accept an aged person in their home under any conditions. A Florida survey of individuals using in-home health services found that the clients, families, and friends were committed to keeping the client at home even when physical problems warranted institutionalization. 45/ Twenty-six percent of the clients interviewed had spent some time in a nursing home, an experience which apparently had reinforced their determination to stay at home, often with great difficulty.

Studies of the problems experienced by families in caring for their chronically impaired members reveal the need for several types of family support services to relieve strain and assist them in continuing to provide care. The support services needed include

--counseling services to help the family arrange services, cope with emotional stress, and handle legal and financial matters;

--an array of home-based health and social services to alleviate the physical and emotional burden of providing constant assistance to the chronically impaired elderly with daily living (eating, bathing, etc.) and basic maintenance activities (housework, laundry, etc.);

--day-care programs providing health and social services to the elderly who are not housebound to enable family members to be employed or obtain relief; and

--respite care services which permit the family members to place the elderly person in another living arrangement (e.g., a nursing home or some other facility) on a temporary basis to permit them to have a break or take a vacation.

A critical gap in long-term care services is the lack of housing options

The lack of an adequate range and supply of housing options between independent living supported by community services and the nursing home is viewed by many as the most critical gap in community-based long-term care services. "Suitable housing and adequate income maintenance are two of the preconditions for effective community care." 46/ Many chronically impaired elderly do not need the level of services provided in a nursing home but require a greater level of supervision and services than can be realistically provided to an individual living alone in a private residence. The types of housing facilities which provide this less intensive level of long-term care, generally referred to as "congregate care," include

a) buildings with separate apartment units which provide some health and social support services, and

b) buildings with common kitchen and dining facilities which provide supervision and personal care services (variously referred to as domiciliary care, shelter care, adult foster care, and board and care facilities).

The need for congregate care facilities is estimated to be greater than that for nursing home care. 47/ Interviews with State officials in 10 sample States and with local service provider and planning agency personnel indicate that the single most critical need in long-term care is for an

expanded supply of congregate care facilities. 48/ In areas where there is a tight supply of congregate facilities and community support services, many individuals may be placed in nursing homes to obtain long-term care. "This results in substantial inappropriate institutionalization in medical facilities and an accompanying drain on Medicaid dollars." 49/

The importance of suitable housing to the chronically impaired elderly emerged during a Worcester, Massachusetts demonstration project designed to test the effectiveness of comprehensive home services as an alternative to institutionalization. The majority of the institutionalized clients in the project's experimental group who were judged to be candidates for community care were unable to return to community living because of the lack of appropriate housing. 50/ The final report on the project concluded that housing is equally, if not more, important than community services in ensuring appropriate care for the elderly. 51/

The lack of adequate reimbursement and financing for congregate care has been frequently cited as a cause for the inadequate supply of these facilities which leads to unnecessary nursing home admissions. 52/ An indirect source of public support for congregate care is the Supplemental Security Income (SSI) program (Title XVI of the Social Security Act) which is a cash assistance program providing a minimum monthly payment to aged, blind and disabled poor. States must supplement the Federal payment if it is less than the public assistance payments provided in the State prior to the Federal establishment of the SSI program in January, 1974. States have the option of making additional supplemental payments, which in many States are used to purchase congregate care. Federal and State SSI payments used to purchase congregate care are only a fraction of Medicaid's expenditures for nursing home care. For example, in FY 1976, SSI payments for congregate care totaled $296 million compared to $5.3 billion in Medicaid nursing home payments.

Summary

Many chronically impaired elderly are admitted to nursing homes without first exploring noninstitutional long-term care options, while others enter as a last resort after fruitless attempts to obtain and finance community-based long-term care services.

The chronically impaired elderly are often placed in nursing homes without consideration of noninstitutional

long-term care services because of a lack of awareness of community-based options or because a crisis, such as an acute illness or a breakdown of family support, makes institutionalization seem essential. Many elderly are transferred directly from the hospital to a nursing home because they require a higher level of care than they usually receive in their homes and there is no one to plan, arrange, and administer this care. Although families are committed to keeping their chronically impaired elderly members in the community, they may be forced to seek nursing home placement when they have exhausted their physical, emotional, or financial resources in providing long-term care themselves because public policies provide them little if any economic or social support.

Even when noninstitutional solutions to their long-term care problems are sought, it is often impossible to assemble or finance the mix of health and social services needed by the chronically impaired elderly to enable them to remain in the community. Essential services are often nonexistent, in short supply, or unavailable on a 24-hour, 7-day-a-week basis in the community. A particularly critical gap in long-term care services is the lack of congregate housing arrangements. Community services are offered by a confusing amalgam of public and private agencies which typically focus on a specific human need, such as nutrition or medical care, or a particular target group. Each service may entail a different needs assessment, application form, and eligibility standard.

Frequently, the chronically impaired elderly and their families are incapable of negotiating the maze of service providers alone, yet they have no one to ask for assistance. In most communities, no central organization has the responsibility to assist the elderly in planning, coordinating, and monitoring noninstitutional long-term care services. Physicians, social workers, and hospital discharge planners, who typically assist the elderly, often lack the time or expertise needed to assume this coordinating function. Unless there is some individual or organization to take responsibility for monitoring the quality and appropriateness of the services provided, community long-term care arrangements could endanger the health and safety of the chronically impaired elderly.

NOTES

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CHAPTER 4

MEDICAID'S ASSESSMENT AND PLACEMENT MECHANISMS DO NOT PREVENT AVOIDABLE INSTITUTIONALIZATION

Identifying the type of long-term care services most suitable for a chronically impaired elderly person requires effective procedures for assessing the individual's needs and preferences. Effective assessment procedures are particularly important in assuring appropriate nursing home placement because the present system of financing and delivering long-term care creates strong incentives to institutionalize the chronically impaired elderly even when they have the potential and desire to remain in the community.

To guard against Medicaid payments for unnecessary institutional services, the Social Security Act establishes several assessment mechanisms to assure that the nursing home care provided to Medicaid recipients is appropriate to their needs. However, these assessment mechanisms have not enabled Medicaid adequately to control avoidable institutionalization because of several problems in their design. In addition, Medicaid has no review authority over the admissions of private pay patients who later may convert to Medicaid. Because they pay higher rates than payments made for Medicaid patients, private pay patients have greater access to nursing home care.

ASSESSMENTS MUST HAVE A COMPREHENSIVE CONTENT TO ENSURE APPROPRIATE PLACEMENT DECISIONS

The purpose of an assessment is to identify the chronically impaired elderly's long-term care needs and to match those needs to the most appropriate type and level of services. Because the chronically impaired elderly often face interlocking physical, mental, social, economic, and housing problems, assessment procedures must be comprehensive to provide an adequate basis for planning long-term care services. A comprehensive assessment generally includes:

--a medical examination;

--an evaluation of the individual's ability to perform activities of daily living (bathing, eating, walking) as well as other essential activities (shopping, cleaning, meal preparation);

--a psychosocial evaluation encompassing the individual's emotional condition, mental functioning, social adjustment, and ability to communicate;

--an evaluation of the individual's and the family's preferences and lifestyles and of the willingness and ability of the family to provide various types of assistance;

--an evaluation of the individual's living conditions to identify any safety or health hazards; and

--an assessment of the individual's financial conditions.

Most chronically disabled elderly are placed in nursing homes without a comprehensive needs assessment. The physician typically is the only professional to examine the elderly and advise them and their families about the need for nursing home placement. However, a medical examination often cannot adequately distinguish the impaired elderly who require nursing home placement from those who have the potential to remain in the community.

Although a thorough physician's examination is required to identify the types of health services needed by an impaired individual, it often does not provide sufficient information to determine whether these and other long-term care services could be more suitably provided in a community or an institutional setting. Since chronic conditions frequently cannot be "cured," the nature of the individual's chronic disease or disability is not as critical a factor in planning long-term care arrangements as the individual's ability to function in activities of daily living. For example, the physician's diagnosis that the patient has a "stroke producing right-sided hemiplegia" is not as useful in determining the patient's long-term care needs as the statement that "he or she cannot use the right arm and leg, and lacking assistance at home or motivation to learn compensatory motions, cannot bathe, feed, move, take medication, or otherwise rely on himself or herself for activities of daily living or even survival." 1/

A comprehensive assessment of an individual's physical, mental, social, and environmental conditions may reveal that, given the appropriate mix of medical care and social support services, institutionalization is avoidable or can be postponed. The following case study illustrates how a comprehensive assessment can reveal critical factors regarding the suitability of nursing home placement.

> Family members bring a disoriented aged patient to the physician and request nursing home placement. The patient is obviously 'senile' and the family has no way to care for the patient at home. The physician

finds that the patient has an acute brain syndrome caused by infection and dehydration. With medical treatment, the syndrome clears. But since the physician has done a thorough appraisal, the problem list also shows a hitherto undetected hearing and vision loss, contributing to a depression that originated when the wife died a few years before. Add the fact that the patient has not been taking medication for angina pectoris and because of pain on climbing stairs has not been leaving a walk-up apartment to shop or meet friends. Meals have been skipped. 2/

If this person had received a standard medical examination, it is likely that the physician would have concurred with the family's decision to place the patient in a nursing home. A comprehensive assessment reveals that the patient may be able to remain at home if provided the appropriate mix of services such as meals-on-wheels, homemaker services, transportation, and friendly visitors.

Comprehensive assessments are more reliable than medical evaluations in determining the need for nursing home care

Several studies have demonstrated that the traditional medical focus on diagnosing the disease rather than on assessing the client's comprehensive needs can lead to both inaccurate diagnoses and avoidable nursing home admissions. One study selected 100 newly admitted nursing home patients in New York and compared the physician's primary and secondary diagnoses made prior to admission with those made by the medical director of the nursing home. 3/ The nursing home director's primary diagnosis was based on that disability which constituted a management problem requiring primary nursing care. The secondary diagnoses were those which did not require a detailed nursing care program. The physician's admission diagnoses were judged to be inaccurate for 64 percent of the primary diagnoses and 80 percent of the secondary diagnoses.

In discussing these findings, the authors emphasized that physicians are trained to concentrate on the structural change in the body (disease) rather than on the functional changes (disorders). 4/ However, for the chronically ill elderly whose diseases may be incurable, the important consideration is the nature of their disorders which affect their ability to function in daily life. While a physician might be a proficient diagnostician for acute care patients,

several factors contribute to a high rate of misdiagnoses in nursing home admissions. One significant factor is the "inability to relinquish traditional orientation toward disease in favor of orientation toward disorders that affect the therapeutic management of the patient's functional capacity and needs on a sustained basis." 5/ Another factor is the lack of appropriate medical school training in treating the chronically ill elderly.

An additional cause of inaccurate diagnoses is that the primary diagnosis made upon hospital admission may be inappropriate upon admission to the nursing home because the acute disease may have subsided. Very often, the elderly will not seek institutional care until they become extremely disabled, either from an acute illness or a worsening of chronic conditions. Without first treating the acute medical problems, it is difficult to accurately assess the patient's long-term care needs.

After a study revealed that over half the patients in long-term care facilities were classified at inappropriate levels of care, an Evaluation and Placement Unit was established in a Rochester, New York hospital to diagnose, evaluate, and place the chronically ill elderly in need of long-term care. 6/ After 30 months of operation, the unit had evaluated 332 elderly patients, most of whom had tentatively decided to enter a nursing home. A comprehensive assessment was made of the patient's medical needs, ability to perform activities of daily living, and social and environmental conditions. After the assessment, 55 percent were found to need further diagnosis and treatment, and 34 percent actually underwent active medical treatment and rehabilitation. No final decisions regarding long-term care arrangements were made until after the necessary treatment had been given.

By providing the required treatment before making a decision regarding long-term care placement, the Evaluation and Placement Unit found that a lower level of care than originally expected was actually needed for most patients. Only a third of the 322 patients were placed in a nursing home. An independent evaluation of the appropriateness of these placements was conducted 6 weeks later. The Evaluation and Placement Unit was judged to have appropriately placed 80-90 percent of the patients, a rate 20-30 percent better than had previously been found in the nursing homes. 7/

The results of another demonstration project indicate that the failure to assess an elderly person's physical, social and environmental problems may result in an inaccurate diagnosis of the patient as mentally ill. 8/ Illinois established a pilot project to test the effectiveness of geriatric preadmission evaluations in reducing the large number of elderly admitted to State mental hospitals. Each patient received an intensive medical, social, and economic evaluation, and treatment was given for any acute condition. Of the 997 patients evaluated, only 46 needed extended psychiatric hospitalization. "All of the other patients were found to be predominantly in need of medical evaluation and treatment, nursing care, social crisis stabilization, and financial assistance." 9/

Undetected physical and social problems were cited in the study as major causes of the mislabeling of elderly persons as "mentally disturbed." Chronic illnesses, such as diabetes and renal disease, can generate symptoms which appear to be caused by mental problems, especially in the elderly. Alleviating the physical ailments may eliminate or improve these symptoms. In many cases, the family situation had deteriorated to the point where support of the elderly person no longer seemed possible. The authors concluded that:

> the aging process creates in the elderly an inability to adapt to new circumstances and they often need special support from those around them * * *. The breakdown in service support often is at the level of the family or the community which does not provide the necessary social-supportive relationships. The provision of these services in many cases would be all that was necessary to prevent further disequilibrium or impairment of the elderly person's functions. 10/

A consensus reached in research and demonstration projects on patient evaluation procedures is that more appropriate decisions regarding long-term care placements can be made by broadening the traditional medical examination into a comprehensive assessment of the elderly's physical, social, mental, and environmental conditions. Medical assessments exclude critical factors, such as the amount of social support available from family, friends, and the community, and the physical and environmental barriers which hinder the patient's mobility, such as long flights of steps or crime in the neighborhood. Since these factors may be as crucial as medical

conditions in influencing the elderly's decision to enter a nursing home they must be analyzed in order to make the appropriate placement decision.

The importance of nonmedical factors in determining a chronically impaired person's long-term care service needs was emphasized in the preliminary report on the proposed Minimum Data Set for Long-Term Health Care sponsored by the U.S. National Committee on Vital and Health Statistics. 11/ The Technical Consultant Panel which developed the report took a "sociomedical" approach in constructing the data items because "in long-term care there is seldom a single medical diagnosis, and people with the same diagnoses respond differently to their impairments," depending on a number of personal, social and economic factors. 12/ The proposed Long-Term Care Minimum Data Set includes information on the client's: physical, social and psychological function; disease classification; family situation; and living arrangements.

Comprehensive preadmission assessments are more effective than postadmission assessments in reducing avoidable nursing home utilization

A comprehensive assessment is a more effective tool in achieving appropriate nursing home utilization if it is used prior to admission rather than after an individual has been placed in a nursing home. The problems involved in attempting to relocate an elderly nursing home resident who has been identified as being inappropriately admitted have been well documented. Some of the difficulties involved in efforts to safely discharge elderly nursing home residents after a long stay are the following: 13/

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

--They may have become less capable of performing activities of daily living because institutionalization can result in feelings of depression, dependency, loss of identity, and loneliness.

Several studies of efforts to relocate incorrectly placed nursing home residents conclude that postadmission assessments are far less useful than preadmission reviews in reducing unnecessary institutionalization. For example, when Minnesota Department of Health personnel assessed the needs of every Medicaid resident in a skilled nursing facility, they judged that 656 residents (8 percent) were receiving too high a level of care. 14/ However, 54 percent of these residents could not be relocated to a more appropriate setting because it would have been harmful to the resident or no lower level of care facility was available near family and friends. The study's findings concluded that there is a need for greater emphasis on appropriate placement before admission to a nursing home.

The ineffectiveness of postadmission reviews in correcting inappropriate placements of long stay residents was also demonstrated by the experiences of 10 recent demonstration projects testing methods of assessing the appropriateness and quality of nursing home care provided to Medicaid and Medicare residents. The demonstration projects were conducted by Professional Standards Review Organizations (PSRO's), nonprofit organizations composed primarily of physicians, established by the Social Security Act Amendments of 1972 to review the medical services provided to Medicaid, Medicare and certain other Federal health program participants. A 1979 Rand Corporation evaluation of these projects found that extremely few nursing home residents were reclassified to a different level of care or discharged after they had been in the facility for 6 months or longer. 15/ According to the authors, the ideal time to make decisions about the appropriateness of nursing home care is prior to admission or, when that is infeasible, immediately after admission. 16/ They suggest that postadmission reviews may be most cost-effective if they are focused on the first 6 months of a patient's stay when he or she is still "dischargeable." 17/

Because of the problems in returning elderly nursing home residents to the community, postadmission assessments of the resident's need for continued institutional care generally have been an ineffective method of achieving appropriate nursing home utilization. Consequently, the time to assess a chronically impaired individual's need for nursing home

care is prior to admission when the individual still has at least some of the financial resources and human supports required to live in the community.

Comprehensive assessments can document the need for community-based long-term care services

How effective comprehensive preadmission assessments are in reducing avoidable admissions is dependent on the availability of long-term care services to maintain the elderly nursing home applicant in the community. If community-based long-term care services are unavailable or unaffordable, denying nursing home admission to an impaired elderly individual could result in grave human consequences. However, comprehensive assessments can still fulfill a critical function by collecting data on:

--the size and the characteristics of the chronically impaired population admitted to nursing homes who had the potential to remain in the community if the required support services had been available, and

--the types of noninstitutional services which need to be developed to reduce avoidable nursing home admissions.

In most areas, this information is not systematically collected and analyzed.

The experiences of several PSRO pilot projects demonstrated that the effectiveness of comprehensive preadmission assessments in achieving appropriate nursing home placements often hinges upon the availability of suitable noninstitutional long-term care services. For example, the Colorado PSRO demonstration project performed comprehensive preadmission assessments of hospital patients awaiting nursing home placement and attempted to find noninstitutional long-term care arrangements for those who were judged as being candidates for community care. Despite a great deal of effort, the staff was unable to prevent nursing home placement for most patients because of the lack of community services. 18/ The Rand Corporation report which evaluated this project raised the question of "whether a PSRO can effectively review levels of care independently of other changes occurring in the community." 19/ The authors concluded that an important function the PSRO's can perform when they undertake long-term care review nationwide is to document the number

of nursing home placements which occur as a result of "social necessity" due to the unavailability of community-based long-term care options. 20/

ASSESSMENT MECHANISMS FOR MEDICAID RECIPIENTS DO NOT ASSURE APPROPRIATE NURSING HOME PLACEMENT

The Social Security Act requires the States to establish several mechanisms for assessing the appropriateness and quality of the nursing home care provided to Medicaid recipients. However, these assessment mechanisms generally have not eliminated avoidable nursing home utilization. This section describes the assessment procedures for Medicaid recipients and compares them to the comprehensive, preadmission assessments which research and clinical experience indicate are essential in identifying the elderly who have the potential to remain in the community.

Medicaid recipients receive several assessments of their need for nursing home care

To qualify for full Federal matching Medicaid funds, Section 1903(g) of the Social Security Act requires a State to make quarterly showings satisfactory to the HEW Secretary that it has an effective utilization control (UC) program which includes the following assessment mechanisms:

1) Physician's Certification of Need--Section 1903(g)(1)(A) requires that a physician certify the necessity for admission to either a skilled nursing facility (SNF) or an intermediate care facility (ICF) at the time of admission or, if the patient has already been admitted, at the time he or she applies for Medicaid. A physician must certify the necessity for continued institutional care every 60 days. Furthermore, each Medicaid nursing home resident must have a written plan of care which is established and periodically reviewed by a physician (Section 1903(g)(1)(B)).

2) Utilization Review (UR)--Section 1903(g)(1)(C) requires that a State must have a utilization review program which assures that the necessity for both the admission and the continued stay of a Medicaid nursing home resident is reviewed in accordance with criteria established by medical personnel not directly responsible for the resident's care.

3) Independent Professional Review (IPR)--Section 1903(g)(1)(D) requires the States to review and evaluate the

care provided to every Medicaid resident in an intermediate care facility by means of an annual independent professional review. According to Section 1902(a)(31), IPR must include a) a medical evaluation of the patient's need for intermediate care and a written plan of care prior to admission or authorization of benefits and b) periodic onsite inspections of each facility by an independent team composed of physicians or registered nurses and other appropriate health and social service personnel. The team must assess the adequacy and appropriateness of the facility's services in meeting each patient's needs, the necessity and desirability of continued ICF care, and the feasibility of meeting the patient's health care needs through alternative institutional or community-based services.

4) Medical Review (MR)--Section 1903(g)(1)(D) requires the States to perform medical reviews of the care provided to every Medicaid resident in a skilled nursing facility. According to Section 1902(a)(26), MR must include a) a medical evaluation of each patient's need for SNF care and a written plan of care prior to admission and b) periodic onsite inspections of each facility by a medical review team composed of physicians and/or registered nurses and other appropriate health and social service personnel. The team must assess the adequacy of the services available in a facility in meeting each patient's needs, the necessity and desirability of continued SNF care, and the feasibility of meeting his or her health care needs through alternative institutional or community-based services.

The most recent development in assessment procedures for institutionalized Medicaid recipients is the entry of Professional Standards Review Organizations (PSRO's) into long-term care review. The objective of PSRO's is to determine whether medical services provided to Medicare and Medicaid patients in hospitals and long-term care facilities are medically necessary, provided in accordance with professional standards, and in the most appropriate setting. The PSRO program was first implemented in acute care hospitals, and by July 1979 there were 190 PSRO's in planning or conditional operation around the country.

In October 1976, HEW designated 15 PSRO's to participate in a 2-year demonstration project to test methods of performing medical reviews of long-term care patients in nursing homes. Since then, a number of PSRO's have expanded into long-term care review. As of October 1979, 51 PSRO's, including 10 of the 15 demonstration projects, were performing

long-term care review. It will be several years before all PSRO's will have assumed full responsibility for long-term care review.

HEW issued a transmittal to State Medicaid Offices in February 1978 (PSRO Transmittal No. 62) regarding PSRO assumption of responsibility for long-term care review. In areas where HEW has approved a PSRO plan for performing long-term care review and the State has signed a Memorandum of Understanding with the PSRO, the State can discontinue its other utilization control functions including the physician's certification of need and plan of care, medical review, independent professional review, and utilization review in skilled nursing facilities. PSRO's will have sole authority for long-term care review of Medicaid patients in skilled nursing facilities only. According to the provisions of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142), Medicaid patients in intermediate care facilities will continue to be reviewed by State Medicaid agencies unless: 1) the State requests the PSRO to assume responsibility; 2) HEW finds that the State agency is not performing effective reviews; or 3) HEW finds that, in nursing homes which have both SNF and ICF patients, it is "inefficient" for the PSRO and the State agency to split the review responsibility.

For the next several years, the States' utilization control programs and the PSRO review systems will be operating simultaneously in many areas. Therefore, we examined both review systems. However, because PSRO long-term care review is still in the early stages of planning and development, no definite conclusions can be drawn about the design or effectiveness of PSRO review of nursing home patients.

Most Medicaid-eligible nursing home applicants do not receive a comprehensive preadmission assessment under current utilization control programs

The current utilization control program has not enabled Medicaid to adequately control avoidable nursing home utilization because it has not established adequate procedures for screening out applicants who are candidates for community care. Although the utilization control program varies by State, in most cases the review procedures are not adequate nursing home screening mechanisms because:

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

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

The only two review mechanisms that afford Medicaid the opportunity to prevent unnecessary nursing home admissions are the physician's certification of need and the MR/IPR requirement that the State perform a preadmission medical evaluation. All the remaining assessment procedures are postadmission. In most States the preadmission reviews focus primarily on the individual's medical condition. Title XIX reinforces this medical focus by assigning physicians the authority to certify the need for nursing home care and requiring States to determine the medical necessity for admission. Despite the fact that many chronically impaired elderly are admitted to nursing homes because they require a mix of social, mental health, economic, and housing services, as well as medical care, nursing home care is largely defined and treated as a medical service because it is reimbursed with Federal health monies.

The purpose of Medicaid's preadmission reviews is to determine whether the individual's conditions fit the Federal and State legal requirements for either SNF or ICF care rather than to match the individual's needs to the most appropriate community or institutional long-term care services. Since physicians are often unaware of or are too busy to arrange community long-term care services, they may certify the need for nursing home care without even considering whether the elderly patient has the potential to remain in the community. In most cases, the State's preadmission reviews are paper reviews of "medical records and abstracts recorded on forms usually completed by nursing staff or physicians." 21/ Consequently, by overlooking the individual's nonmedical needs and conditions, Medicaid's preadmission reviews are not adequate in identifying those applicants who meet the medical criteria for nursing home care but who have the potential to remain in the community.

The assumption of long-term care review by PSRO's may not correct the current weaknesses in Medicaid patient assessment procedures

Although 51 PSRO's were performing long-term care review as of May 1979, it is still too early to evaluate whether

their reviews are significantly more effective than the current Title XIX utilization control program in reducing Medicaid support for avoidable nursing home utilization. However, several factors could limit the ability of PSRO's to alleviate this problem.

First, neither the Social Security Act nor the HEW guidelines on PSRO long-term care review require the PSRO's to perform preadmission assessments of each Medicaid and Medicare recipient's need for institutional care. The HEW guidelines (PSRO Transmittal No. 62, February 28, 1978) state that PSRO's should perform preadmission reviews of Medicaid and Medicare nursing home applicants being admitted from acute care hospitals when they perform their reviews of these patients' need for continued acute hospital care. However, preadmission reviews are optional for nursing home applicants admitted from the community. As of August 1979, 40 PSRO's were performing preadmission reviews in hospitals and 21 were performing these reviews in the community. Patients who do not receive a preadmission assessment must be reviewed upon admission to the nursing home. The PSRO's who do not exercise the option of performing preadmission reviews of community applicants forgo the opportunity to prevent the admissions of those elderly who are likely to be less sick than their hospitalized counterparts and therefore more likely to be candidates for community care.

A second factor which may weaken the impact of PSRO's on avoidable nursing home utilization is the fact that PSRO's are legally charged with determining the medical necessity, appropriateness, and quality of nursing home services. Although the HEW guidelines mention comprehensive assessments as one method of performing preadmission review, the PSRO's are only required to look at whether the nursing home applicant meets the Federal and State eligibility requirements for nursing home care. Therefore, unless the State has established nonmedical eligibility criteria for Medicaid coverage of nursing home care, the PSRO's will continue certifying Medicaid patients as legally qualified for nursing home care even when community care may be more suitable. The Rand Corporation report on the PSRO demonstration projects noted that, "the PSRO, a medical organization, is caught in the uncomfortable position of being expected to make judgments about medical need when social need might be the overwhelming reason for placement." 22/

A third factor which may affect the impact of PSRO's on nursing home utilization is that PSRO's have sole authority

for long-term care review of Medicaid patients in skilled nursing facilities only. Therefore, in areas where the State continues to review Medicaid patients in ICF facilities, the PSRO's will not have any influence on the admissions of this portion of the nursing home population.

The need for more effective utilization control procedures has been recognized at the Federal and State levels

The inadequacy of Medicaid's utilization control program in reducing avoidable nursing home admissions has been a source of concern nationally. The steady increase in Medicaid's nursing home bill has intensified interest in designing better procedures for assessing a client's needs 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 to the Administrator of HEW's Health Care Financing Administration. 23/ The Council urged that greater emphasis be placed on preventing inappropriate institutional placement through 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 SNF or ICF care. 24/ At the same time, the Council recommended abolishment of the physician's certification and recertification of the need for nursing home care because they had not been effective in determining the need for admission or continued stay in a nursing home.

Several States have taken or are considering actions to improve their control over unnecessary nursing home utilization by Medicaid recipients. In May 1977, Virginia established a mandatory preadmission screening program as part of its certification process for Medicaid coverage of nursing home care. To receive Medicaid reimbursement for institutional long-term care, all nursing home applicants in the community who are Medicaid-eligible or who will be eligible within 90 days of admission must be screened by the local health department. The health department screening panel approves or denies Medicaid reimbursement for nursing home care after assessing the applicant's medical, social, and

nursing needs and evaluating whether or not available community services could meet those needs. As of February 1979, 21 percent of the 3,592 nursing home applicants screened were able to remain in the community with the help of available health and social services and, in many cases, family assistance. 25/

New York State also initiated a program designed to divert Medicaid recipients from entering nursing homes when they have the potential to remain in the community. A 1977 New York State law authorized the establishment of Long Term Home Health Care Programs (LTHHCP) at the local level to pay for a comprehensive range of noninstitutional long-term care services to Medicaid recipients who meet the Medicaid requirements for nursing home care but who have the desire and the potential to remain in the community. Once a LTHHCP program has been established in an area, the county social services department must offer it as a long-term care option to all Medicaid recipients if nursing home placement is being considered and they are assessed as medically qualified for nursing home care. Each potential LTHHCP client receives a comprehensive assessment to determine whether community services can safely meet his or her long-term care needs.

Other States are studying proposals for improving their Medicaid procedures for assessing and placing nursing home applicants. For example, in 1977, the Texas legislature established a Joint Committee on Long-Term Care Alternatives to evaluate existing long-term care programs and to recommend actions to improve services to the chronically impaired population. The Committee's final report recommended that all Medicaid-eligible applicants for nursing home care receive a comprehensive medical and social assessment prior to admission in order to prevent the institutionalization of those who could and would prefer to remain in the community with appropriate services. 26/

The State of Washington's Department of Social and Health Services submitted a budget proposal in the spring of 1979 to the State Legislature requesting funding for additional nurses to help assess all Medicaid-eligible nursing home applicants in the community and in hospitals to determine whether community or institutional long-term care services are more suitable to an individual's conditions. This proposal grew out of the experiences of the State's Community-Based Care demonstration project. The project results indicated that by providing all nursing home applicants who had not recently been institutionalized with a

comprehensive assessment and a package of community services, 50 percent could be diverted from entering a nursing home. 27/

MEDICAID'S ASSESSMENT PROCEDURES DO NOT APPLY TO PRIVATE PAY ADMISSIONS

Even if effective preadmission screening procedures were implemented for all Medicaid-eligible nursing home applicants, Medicaid still would not be able to reduce its support for avoidable institutionalization because a substantial number of Medicaid residents initially enter nursing homes as private pay patients and are not subject to Medicaid review. In addition, because nursing homes can charge private pay residents a higher rate than the Medicaid reimbursement rate, they often prefer to admit private pay residents over public pay patients.

This process is illustrated in figure 11.

Private pay patients have greater access to nursing home care than Medicaid patients

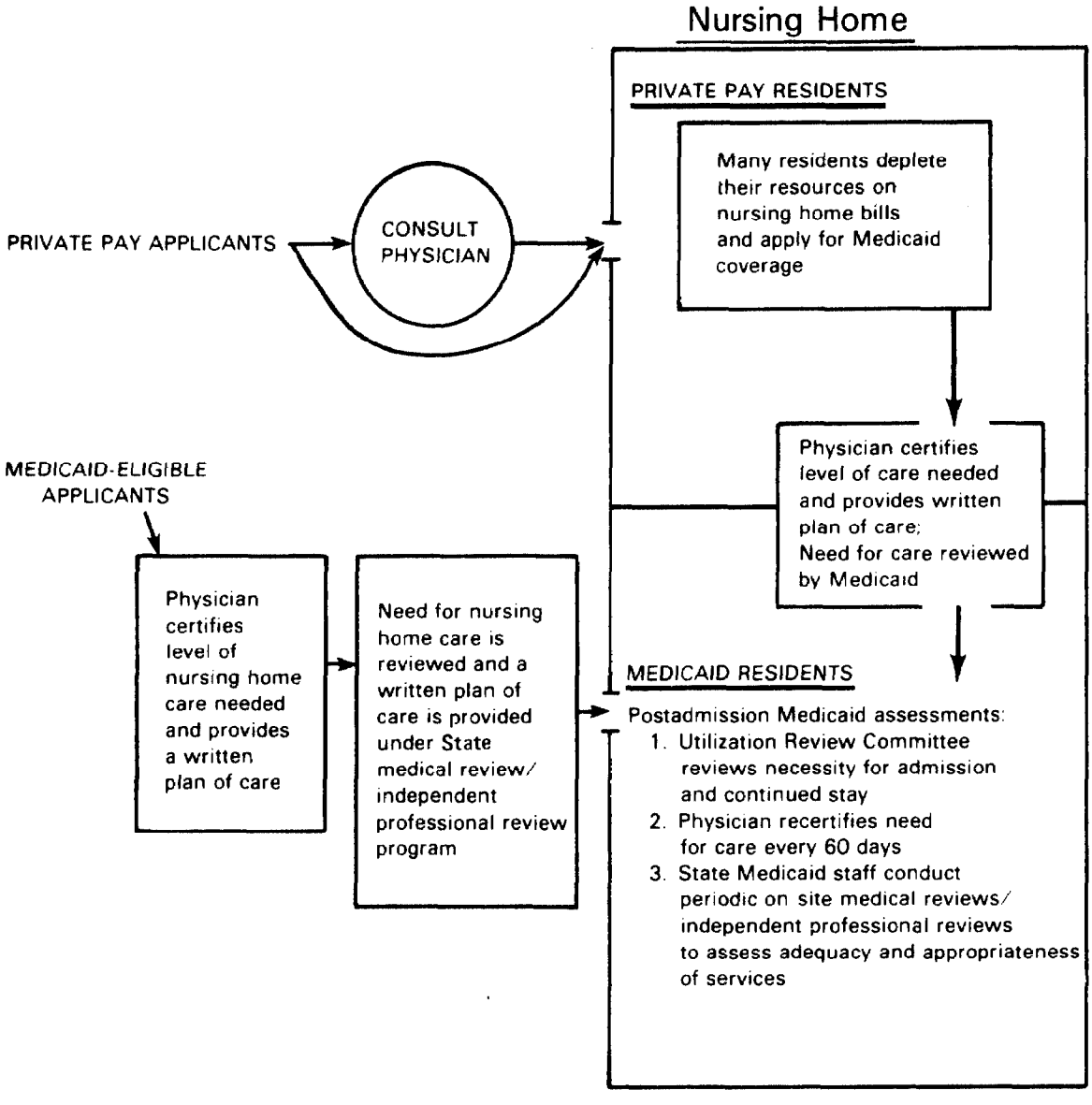
Nursing homes have the authority to determine which public and private pay patients to admit and what rates to charge private pay patients. State payments to nursing homes under Medicaid are often much lower than rates paid by private patients even for the same care in the same nursing homes. Because of an often wide disparity between these rates, nursing homes generally prefer to accept private pay applicants over Medicaid applicants and the less disabled over the highly impaired, difficult to care for patient.

Due to low reimbursement rates, Medicaid applicants experience problems in gaining access to nursing homes. A longitudinal study conducted by Duke University from 1955 to 1976 followed 207 participants who had been carefully chosen to approximate the characteristics of the residents of the area where they lived. Fifty-four members (26 percent) of the group were institutionalized in a nursing home one or more times before death; of these, 45 died in the institution while only 9 had returned home prior to death. In the study group the individuals with the lowest incomes were least likely to be admitted to a nursing home. 28/

The New York State Moreland Act Commission investigation into nursing homes observed that many facilities try hard to accept only the relatively well and the private pay applicants, making it difficult for Medicaid-supported and highly

Figure 11

How Medicaid's Patient Assessment Mechanisms Affect the Admission and Continued Stay of Medicaid and Private Pay Nursing Home Residents



impaired applicants to find a vacant bed. 29/ This situation is exacerbated in areas where there is a tight bed supply. An analysis of facility waiting lists (adjusted for duplication) in six counties in Pennsylvania in 1975 counted 2,066 individuals seeking nursing home care. The authors of this study identified a concerted effort on the part of nursing home administrators not to accept Medicaid patients from these lists. The longest waiting lists were at county facilities which were the major suppliers of nursing home beds for the indigent. Hospital administrators responded during the survey that while many elderly patients in their institutions would have been better served in a nursing home, these individuals could not gain admittance because they were subsidized by Medicaid. 30/

The Ohio Hospital Association, in an effort to document problems in placing posthospital patients, surveyed its members in August 1977. 31/ The hospitals that participated in the survey (56 percent of 218) reported that on the day of the survey they had 223 Medicaid patients awaiting transfer to skilled nursing facilities at an estimated cost of maintaining these patients in hospitals of $38,000 per day. The survey also reported that 944 Medicare patients in 123 hospitals were waiting to be transferred to nursing homes at an estimated cost for maintaining them in hospitals of $161,000 per day. According to the hospital respondents, inadequate Medicaid reimbursement rates also make nursing homes reluctant to accept Medicare patients because of the possibility they would become Medicaid patients after exhausting their maximum Medicare benefit of 100 days and their personal resources. 32/

A 1976 study of inappropriate hospital stays by public patients in two Washington, D.C. hospitals, also identified resistance to accepting Medicare patients when there is a possibility that Medicaid would assume coverage after Medicare benefits terminated. An inappropriate stay was defined as "that period of time, expressed in days, spent in an acute care hospital by a patient who was not acutely ill and who could have been treated at a lower level of care." 33/ Inappropriate stay Medicare patients at Hospital A were found more likely to be placed in nursing homes (49.3 percent) than Medicare patients from Hospital B (5.6 percent). The wait for placement was also longer at Hospital B. Consequently these patients either died in the hospital or were sent home. Hospital A appeared to be more successful in placement because its Medicare patients had a higher socioeconomic status than Hospital B patients and its discharge planning may have been more effective. Private nursing homes were more likely

to accept Hospital A patients who appeared to have the capability of paying for their care after they used up their Medicare benefits; Hospital B patients were dependent on the more limited number of public nursing home beds. 34/

A recent review of inappropriate stay patients in New York noted the disparity in placement between patients on Medicare and Medicaid and all other patients. A 1-day census, conducted on February 28, 1979, reported that Medicare and Medicaid recipients made up 55.6 percent of all patients hospitalized in acute care hospital beds in the State on that day. Almost 11 percent of these patients (3,961) compared to 1.1 percent (348) of the non-Federal patients, were awaiting transfer to other than acute hospital care. The 2,514 Medicare patients and the 1,447 Medicaid patients had been awaiting placement for 143,852 days. Because of the problems in obtaining appropriate placement for public patients who no longer needed acute hospital care, the surveyors estimate that $216,864,750 35/ were being lost every year in New York in unnecessary hospital costs. 36/

A 1978 Washington, D.C. study of 13 acute care hospitals, conducted by the area's PSRO, identified many inappropriate public stay patients who had originally been admitted to the hospital for social reasons. This study broke inappropriate stays into three categories: nonacute stays (certified for payment because of lack of a suitable discharge environment); denied stays (not medically necessary); and non-covered stays (lack of a suitable discharge environment but not covered by Medicare during this period):

13,445 days were spent by Medicare and Medicaid patients waiting for nursing home beds whose stay was covered by Medicare and Medicaid.

3,673 days awaiting placement not covered by Medicare.

23,739 inappropriate days denied as medically unnecessary. 37/

This study was a followup to a survey conducted in 1977 which found that Medicare and Medicaid patients with inappropriate stays accounted for 6.6 percent of all public patient days of stay. While the total estimated hospital bill for Medicaid, Medicare, and other publicly funded patients was approximately $122 million, $7.32 million was spent on inappropriate care. Out of this, $5.32 million was denied as medically unnecessary. 38/

The denials occurred because in many cases patients had been admitted for social needs (e.g., room and board); since "these needs are not met by social programs, the hospital is used essentially as an expensive boarding house." 39/ In 1978, out of 983 patients who were non-covered or denied coverage under Medicaid or Medicare, 337 were denied because the patient had been admitted for social reasons or needed custodial care. Table 15 presents the PSRO's physician adviser reasons for denial of coverage and the patient's final disposition for these 337 cases. 40/

Table 15

Patients Not Covered or Denied Coverage Under Medicaid or Medicare

Physician advisor reasons for denial	No. of cases	Patient's final disposition: Other hospital	Nursing home	Home	Died	Other
Patient admitted for purely social reasons	143	3	12	79	26	23
Patient needs custodial care	87	0	11	58	6	12
Mainly social placement, patient has resolved medical problems	107	0	17	81	1	8
Total	337	3	40	218	33	43

While many inappropriate hospital stay patients have been identified in the surveys discussed above as waiting for transfer to a nursing home, the impetus for this proposed transfer is due in large part to pressure by PSRO's and hospital utilization review committees to move patients to a less costly setting than a hospital. However, for patients who were admitted to the hospital for predominantly social reasons, the preferable placement may instead be residential housing with support services or a return to the individual's own home if the necessary social and health services are provided. The lack of either option often means patients may wait in acute care beds for placement in nursing homes or return home without the supportive care they need. In the latter case, this may result in further deterioration of an individual's health and subsequent rehospitalization.

Private pay patients enter nursing homes without receiving a comprehensive assessment of their need for this care

While Medicaid and sometimes Medicare patients experience difficulty in gaining access to a nursing home, private patients generally have fewer problems finding a nursing home bed. In addition, in the admissions process to these facilities, private patients are not subject to the screening requirements of Medicaid. Although a physician may be consulted (this is often a requirement of the nursing home or the State), in most cases private pay patients will enter nursing homes without first receiving a comprehensive assessment of their need for this care.

Some private pay applicants are admitted even though a comprehensive assessment would have identified that they had the potential to remain in a less intensive care setting. The reasons behind these avoidable admissions, which were discussed in chapters 2 and 3, include the unavailability of long-term care services in the community and the difficulty in assembling the appropriate mix of health and social services to meet an individual's complex needs. Some private patients may have insufficient resources to purchase the community-based long-term care services they need. Frequently, their only long-term care option is to liquidate their assets, often by selling their homes, to finance nursing home care.

In our analysis of the 1976 Survey of Institutionalized Persons we found that non-Medicaid nursing home residents appeared in some cases to need less assistance in activities of daily living (ADL) than Medicaid patients. We derived this by classifying nursing home residents (65 and older) by their need for help with: walking, eating, drinking, bathing, dressing, using a bed pan, and getting in and out of bed. Based on the nursing home staff's ranking of the help each resident needed, an ADL scale was developed by summing the scores for each of these 7 items. 41/ The frequency distribution on this scale is presented in table 16.

Table 16

Scale of Dependence in Activities of Daily Living (ADL)

Scale	Number	Percent
0 - No dependence	116,800	14.1
1 - Slight and irregular dependence	184,400	22.2
2 - Moderate but irregular dependence	123,800	14.9
3 - Moderate and more regular dependence	144,400	17.4
4 - Consistent dependence in most self care activities	131,700	15.9
5 - Extreme dependence in all self care activities	128,600	15.5
Total	829,700	100.0

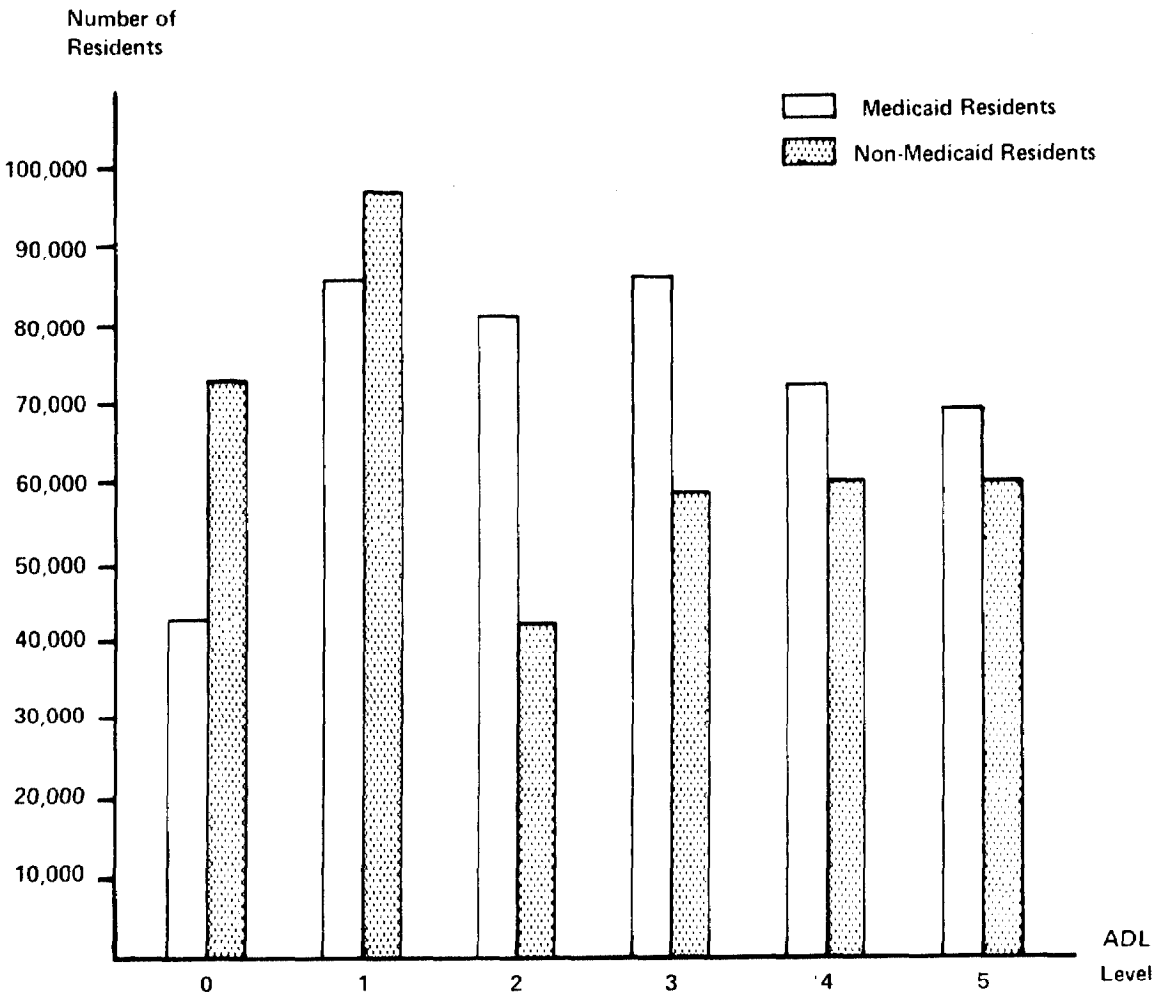
(Missing cases - 185,400)

When compared by whether they were receiving support from Medicaid or not, 55 percent of the non-Medicaid residents and 48 percent of the Medicaid residents needed no assistance or had only slight or irregular dependence on assistance with activities of daily living. Figure 12 shows the comparison of the Medicaid and non-Medicaid elderly nursing home residents by the scale levels of assistance needs. Of the 116,800 residents who had "no dependence on assistance with personal care," 63 percent were not receiving Medicaid support. Some of the private and public pay residents, specifically in this latter category, could potentially have avoided nursing home placement if the community-based health and social services they needed had been available.

Because of a lack of comprehensive assessments for private pay patients, the number of avoidable nursing home admissions is unknown. Yet through conversions, Medicaid ends up paying for the nursing home care of many of these patients. A survey conducted in Monroe County, New York, in 1974-75, examined the source of payment for patients who were assessed by a team of physicians and nurses as not needing the level of care they were receiving. Almost 10 percent of the sample

Figure 12

Medicaid and Non-Medicaid Elderly Residents Requiring Assistance with Activities of Daily Living



Valid Cases=	829,700
Missing Cases=	185,400
Total=	1,015,100 a]

ADL Scale

0 - no dependence
1 - slight and irregular dependence
2 - moderate but irregular dependence
3 - moderate but more regular dependence
4 - consistent dependence in most self care activities
5 - extreme dependence in all self care activities

a] Totals vary in our SIP analysis due to rounding

of 302 patients in skilled nursing home facilities were judged to be placed at too high a level of care. The source of payment for these patients was as follows: private pay (11); Medicaid (16); Medicare (1); Blue Cross (1). Forty-four percent of the inappropriately placed Medicaid patients had originally entered the nursing home as private pay patients. 42/ In the survey of patients in intermediate care facilities, 35 percent of the sample of 157 were judged to be inappropriately placed. Twenty-nine were private pay while 26 were on Medicaid. Half of the Medicaid patients had originally been admitted as private pay patients and subsequently converted. 43/

When private pay patients, after exhausting their assets on nursing home costs, apply to Medicaid, they are subject to review by Medicaid screening procedures. However, since they have already been admitted to a nursing home and are now generally without sufficient resources to return to the community, it is unlikely they would be turned down for Medicaid coverage. This was confirmed in an Urban Institute survey of officials involved with nursing home policy which included onsite interviews in 10 States and a telephone survey in an additional 34 States. According to these interviews, a patient once admitted to a nursing home was rarely later denied Medicaid coverage because his or her condition did not require a further nursing home stay. 44/

Nursing home admissions policies contribute to inefficient use of institutional resources

Because private pay applicants can be admitted without an assessment of their need for this care and are the preferred patients from the perspective of the nursing home operator, those who could have been cared for in a more independent setting end up filling beds which are needed by more critically ill, often public patients. Once in the nursing home, many of these applicants subsequently become Medicaid patients after they have used up their resources; at this point it is difficult for Medicaid to redress any problems with the nursing home placement even if the admission could have been avoided.

The preference for private pay applicants is due in large part to Medicaid reimbursement rates which are generally lower than the rates charged to private pay residents. These reimbursement rates may rise as more States comply with Section 249 of Public Law 92-603. Enacted in 1972, this legislation requires States to reimburse for skilled nursing and

intermediate care facility services on a reasonable cost-related basis. What effect this will have on increasing the availability of nursing home beds for Medicaid patients is unknown. Private patients, however, will continue to be the preferred patients by nursing homes because private rates will generally remain higher than Medicaid rates.

While nursing homes can admit more private patients than Medicaid patients, they often still end up with a large Medicaid population because private pay patients may convert to Medicaid. The extensive use residents make of Medicaid coverage shows up nationally; in 1976 approximately 60 percent of all patient days in nursing homes were financed either totally or in part by Medicaid. Low Medicaid reimbursement rates subsequently have a major effect on the entire nursing home industry.

Predicting future nursing home bed needs is difficult based on current data

The excess demand for nursing home care, as expressed in long facility waiting lists and patients' remaining in acute care hospitals awaiting placement, may in some areas reflect a genuine shortage of beds. In others, however, it is the result of a lack of in-home and community-based care (and the financing to pay for it).

The Delmarva Foundation for Medical Care, a PSRO which covers the Eastern Shore area of Maryland, reviewed statistics for hospital placements from October to December 1978. They found that on an average day about 15 patients were in hospitals waiting for a comprehensive care or skilled nursing home bed placement. However, as of December 31, 1978, about 200 (or 25 percent) of the Medicaid patients in nursing homes in the area could be cared for in less than a comprehensive care bed if it were available and could be paid for. Based on these data, the PSRO staff concluded that there was no nursing home bed shortage on the Eastern Shore; instead, there was a shortage of domiciliary homes, intermediate "b" beds, or other alternatives to nursing homes. 45/

Most planners see the need in long-term care to increase community-based health and social services while at the same time assuring that there is an adequate supply of high quality institutional beds. Yet planning for these services is difficult, as illustrated in the Delmarva data, because current use is not predictive of real need. The lack of comprehensive patient assessments has also meant that there is limited

information on the extent of misplacement and unmet need within the current system of resource utilization.

Weaknesses in the data base for long-term care planning have presented difficulties for Health Systems Agencies (HSA's). These agencies, established by the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), were charged with the responsibility to "review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed" in their area. A recent study, which analyzed 42 plans prepared by the HSA's (and submitted to HEW as of August 1978) found: 1) only one-quarter had planned a comprehensive system of long-term care supports; 2) that the focus of their planning was on institutional services; and 3) over one-half of the plans projected increased nursing home bed need. 46/ In addition, the study identified problems in the methods used for estimating the need for nursing home services. These forecasting methods were largely based on current resource utilization rates projected against future population trends. Many plans noted the inadequacies with this forecasting approach; however, only a few attempted to develop methods which would more accurately reflect the needs of the elderly and disabled population in their area. 47/

Projecting skilled and intermediate care facility demand based on current utilization rates, which include avoidable use yet fail to identify unmet need, may perpetuate current inefficiencies in resource utilization. The study's authors predict that this approach to planning could mean that "the allocation of health care resources within a long-term support system may be unwisely restricted to institutional bed capacity, mirroring the problems now faced in acute care." Overbuilding of hospital beds, combined with the backup of patients awaiting nursing home placement, has led in recent years to the push to convert some of these unused beds to long-term care use. Yet, expanding the supply of skilled and intermediate care beds beyond the level which actually might be needed could mean that "planning programs will be consumed within the decade in attempting to limit and reduce the very institutional resources that are now being created." 48/

Summary

In summary, although Medicaid has a substantial stake in ensuring appropriate nursing home utilization, its assessment and placement procedures have not been adequate. First, private pay patients enter nursing homes, whether they need this care level or not, generally without a formal assessment of needs. After depleting their resources, they may convert to Medicaid. Because nursing homes are free to set their own admissions policies, they give preference to the more profitable private pay patients, making it difficult for Medicaid patients to find a bed in many areas.

A second major problem is that most of Medicaid's assessment procedures occur after the patient has already been admitted when it is too late to correct an avoidable placement because the patient has severed all ties with the community, is now without adequate financial resources, or could not withstand the trauma of another relocation. Medicaid's two reviews which are preadmission focus primarily on medical conditions and therefore do not provide information on other factors which are essential in determining whether an institutional or community setting is the most suitable long-term care placement. The current assessment and screening procedures, therefore, result in the admissions of many individuals, both private pay and Medicaid supported, who with supportive services could have remained in a less intensive care setting. Patients who are unnecessarily admitted take up nursing home beds, thereby preventing more critically ill individuals from gaining access.

Because of the high occupancy rates in nursing homes, there is excess demand for care; public pay patients in particular have trouble getting beds, and many wait for long periods in more costly hospital beds for admission. This has resulted in a push to alleviate the waiting lists by providing more beds. However, under the current system of admission policies, the demand for beds may be more directly a result of inadequate or unavailable in-home and community-based care. The lack of comprehensive patient assessments has also meant there is limited information on the level of misplacement in nursing homes or the extent of unmet need. Because of inefficiencies in the current utilization of nursing homes, coupled with the lack of an adequate data base, there is insufficient information to accurately identify the number of nursing home beds needed.

NOTES

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35/The calculations were derived as follows:

3,961 patients x	$200 (average Statewide) per diem in acute hospital)	= $792,200
3,961 patients x	$50 (average per diem in skilled or intermediate care facility)	= -198,050
	Expended unnecessarily each day	= $594,150

$594,150 x 365 (days per year) = $216,864,750

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41/The scale levels represent the item scores of: 0 = 0; 1 = 1 to 4; 2 = 5 to 9; 3 = 10 to 14; 4 = 15 to 18; 5 = 19 to 21. This methodology for constructing an ADL index as a measure of "functional health" was developed under the direction of Beth Soldo and William A. Tisdale, at the Center for Population Research, Georgetown University, under a grant from the Administration on Aging. "Measurement of Functional Health Status of the Institutionalized Elderly: Rationale and Development of an Index," by Jana Mossey and William Tisdale, Working Paper No. 4, March 1979. This question was also addressed in the National Nursing Home Survey. Data were collected by asking the nurse to report if the resident currently required personal or mechanical assistance in performing six activities of daily living (ADL): dressing, going to the toilet, mobility, continence, bathing and eating. Comparison of 1977 and 1973-74 survey data show:*

	1977	1973-74
Total residents in nursing homes	1,303,100	1,075,800
Independent in all 6 ADL's	10 percent	24 percent
Dependent in all 6 ADL's	23 percent	14 percent

*Based on unpublished data from the 1977 National Nursing Home Survey (NNHS), Long-Term Care Statistics Branch, Division of Health Resources Utilization Statistics, Public Health Service, Department of Health, Education and Welfare, Hyattsville, Maryland.

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CHAPTER 5

STATE AND LOCAL COMMUNITIES ARE DEMONSTRATING WAYS TO REDUCE AVOIDABLE NURSING HOME PLACEMENTS

The social and financial consequences of avoidable nursing home admissions have been acknowledged at all levels of government. Consequently, over the past decade a number of long-term care projects have been established to test and demonstrate the effectiveness of community services in preventing premature or unnecessary institutionalization. Although these projects have encountered serious problems, much has been learned about the changes required in the long-term care system to achieve these objectives. This chapter describes:

--weaknesses in the long-term care research which have often led to inconclusive findings,

--the elements in the long-term care projects which appear to be essential in preventing avoidable admissions to nursing homes,

--recent State and local projects which are demonstrating ways to implement these key elements,

--problems encountered by State and local communities in implementing these projects under the present Federal long-term care system, and

--difficulties with Medicaid, as currently structured, in providing long-term support and leadership to these efforts.

LONG-TERM CARE RESEARCH FINDINGS HAVE OFTEN BEEN INCONCLUSIVE

Many research and demonstration projects have been established to determine whether a certain service or group of services can prevent unnecessary institutionalization or improve the quality of life of the chronically impaired elderly population. Some of these projects have been initiated and supported at the State or local level, while others have been authorized and financed by the Federal Government. For example, Section 222 of the Social Security Amendments of

1972 authorized experiments to determine the effectiveness of homemaker and day-care services in preventing avoidable institutionalization of Medicare beneficiaries and in reducing Medicare costs. In addition to these projects, others have tested a variety of "alternatives" to institutional care, including home health care, personal care services, homemaker/chore services, transportation, foster care, day hospitals, and congregate housing.

Unfortunately, most of these long-term care research and demonstration projects have failed to produce conclusive evidence regarding the effectiveness of these services in reducing avoidable institutionalization because of critical weaknesses in the design and implementation of the research. 1/ A major problem with the projects designed to prevent nursing home admissions has been their failure to demonstrate that the population receiving the services was actually at risk of institutionalization. A fundamental assumption which underlies most long-term care projects is that some, if not all, of its clients would have been in a nursing home if it were not for the alternative services provided. However, the projects often have not objectively measured the characteristics of the service population. Frequently, the determination as to whether the client was prevented from institutionalization was based on the subjective opinion of the project staff. This raises the question of whether the client really would have entered a nursing home without the services. If not, then the services provided can be viewed as "add-ons" rather than replacements for nursing home care.

Another critical problem with the projects is that they often lack a carefully designed evaluation component. "All too often, either by policy or circumstance, the evaluation effort is grafted onto a demonstration project already underway." 2/ Many projects were established by concerned local organizations whose primary goal was service delivery and, therefore, any data collection and analysis were done on an ad hoc basis to disseminate information about the project to others in the field.

A third deficiency in past research and demonstration projects is that they generally have focused on only a few aspects of the long-term care issue. For example, many projects were set up to test the effectiveness of only one service in reducing institutionalization, such as the Section 222 day care or homemaker projects. Although it is unclear what services are the most effective in preventing avoidable institutionalization, there is widespread agreement

that no single service can meet the long-term care needs of the heterogeneous chronically impaired elderly population. Many other issues which affect the decision to institutionalize the elderly have not been adequately researched such as (1) the effect of changes in eligibility policies for publicly financed health and social services, and (2) the willingness and ability of different types of families to provide various kinds of services to their chronically impaired kin.

Other weaknesses in the research and demonstration projects include: very small service populations (25-90 persons); short study periods (approximately a 1-year period); and inadequate cost and utilization data. 3/

SEVERAL LESSONS CAN BE EXTRACTED FROM THE LONG-TERM CARE PROJECTS

The fact that most long-term care research and demonstration projects have not clearly linked their services with a reduction in institutionalization should not lead to the conclusion that nothing has been learned about preventing the nursing home admissions of the elderly who have the potential to remain in the community. The successes and problems experienced by these projects in organizing, delivering, and financing long-term care services indicate that several project elements seem to be required to correct those features of the existing long-term care system which contribute to preventable nursing home utilization and spiralling Medicaid costs. The key project elements include:

--a nursing home gatekeeping mechanism,

--a comprehensive needs assessment,

--a mechanism for planning, coordinating and monitoring community-based services,

--a single, comprehensive source of funding, and

--controls over costs and utilization.

A brief description of these project elements is presented below.

A gatekeeping mechanism

A nursing home gatekeeping mechanism is a single entity established at the local level. It provides an assessment

for nursing home applicants in order to (1) identify those who have the potential to remain in the community, and (2) assure the appropriate placement of those who require institutional long-term care. The gatekeeping mechanism has the authority to approve or deny applications for nursing home admission by persons eligible for Medicaid or other publicly funded programs. Optimally, the gatekeeping mechanism also has the authority to provide voluntary needs assessments to all private pay applicants because these individuals and their families often have no one to assist them in determining whether nursing home care is the most suitable long-term care arrangement. In many cases, private pay applicants are placed in a nursing home even when it is not the preferred arrangement and later convert to Medicaid.

Multidimensional needs assessment

The gatekeeping mechanism ensures that each nursing home applicant receives a comprehensive needs assessment and any necessary medical treatment. The needs assessment collects information on all the client's conditions which affect his or her ability to live independently, including:

--physical and mental conditions and morale;

--degree of independence in performing activities of daily living, such as bathing, eating, and dressing;

--ability to perform other essential activities, such as shopping, housework, and meal preparation;

--living arrangements and structural barriers such as long flights of steps;

--level and type of social supports provided by family, friends, and community organizations;

--the individual's and the family's preferences;

--personal finances.

A coordinating mechanism

One local organization has the responsibility for planning, obtaining, and monitoring a package of services tailored to meet the individual's needs. The coordinating agency provides a single access point for all the services needed by

the client. If a service is nonexistent or in short supply in the community, the coordinating agency takes responsibility for developing service providers. Long-term care planning includes the family and friends to help ensure that publicly financed services supplement rather than replace privately provided assistance.

The coordinating agency is given the flexibility to arrange for any services required to maintain the client in the community, including medical care and social services as well as unskilled, routine support services such as home repair and snow shoveling. These services optimally are available to private pay clients on a sliding fee scale based on income. The coordinating agency also monitors the suitability and quality of the services delivered and alters the care plan as the client's needs change.

A single funding source

A single funding source is established which has the flexibility to reimburse for all the services required to meet the client's needs which are not covered by third party payers and cannot be paid for out of the client's personal resources. For the professionals assisting the elderly in obtaining community services, a single funding source eliminates the need to devote substantial time and resources to developing and coordinating new and existing funding streams to fill in the reimbursement gaps.

Controls over utilization and costs

Some form of control over the utilization of community-based long-term care services is considered essential because so little is known about the mix, amount or costs of the services needed to prevent institutionalization. Controls are needed to safeguard against either the overutilization or underutilization of services and to ensure that the cost of the package of services does not greatly exceed that of nursing home care. Types of controls include: careful planning and monitoring of the services delivered to ensure their appropriateness; ceilings on the amount of services which can be reimbursed; and guidelines on the maximum amount of services which reasonably can be provided in the community.

STATE AND LOCAL COMMUNITIES HAVE TAKEN THE INITIATIVE IN LONG-TERM CARE

Although there is substantial agreement that these elements appear to be necessary to achieve a reduction in avoidable institutionalization, there are no universally accepted methods of incorporating them into a long-term care service delivery and financing system. Nonetheless, States and local communities, convinced that avoidable nursing home placement is a significant problem, are experimenting with ways to divert the chronically impaired elderly from entering institutions when they do not need or prefer this level of care.

We selected several current long-term care projects to illustrate some of the approaches to implementing the program elements of: gatekeeping, needs assessment, a coordinating mechanism, a single funding source and utilization controls. Because these projects have been recently launched or in operation for only a short time, none has been fully evaluated. The projects are: the Georgia Alternative Health Services (AHS) project; the Monroe County ACCESS project; the New York State Long Term Home Health Care Program (LTHHCP); the Virginia Nursing Home Preadmission Screening Program; and the Wisconsin Community Care Organization (CCO) Project. A brief description of each project follows.

Georgia Alternative Health Services Project

The Georgia Alternative Health Services (AHS) project has received an HEW demonstration grant under Section 1115 of the Social Security Act to test the cost-effectiveness and health impact of three alternatives to nursing home care for persons who would have otherwise been placed in institutions because no other options were available in the community.* The three services being tested are as follows:

--home-delivered services--including skilled health care as well as social support services, such as homemaker, chore, and transportation services;

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*Under Section 1115 of the Social Security Act, HEW has the authority to grant "waivers" of certain Medicaid provisions on the types and amounts of services which can be provided under State Medicaid plans for certain purposes such as testing the effectiveness of an expanded, coordinated range of home services in reducing institutionalization and costs.

--alternative living services--sheltered housing provided by a foster home, boarding home, or congregate facility which includes room, board, and personal care assistance; and

--adult day rehabilitation--a central day facility provides health and social rehabilitation services to restore or maintain the clients' optimal level of functioning.

The project serves clients in a 17-county demonstration area who are Medicaid-eligible, over 50 years of age, and either reside in a nursing home or meet the State Medicaid eligibility requirements for nursing home care. The Georgia Department of Medical Assistance initiated the project in June 1976 and began serving clients about a year later. The project's services are scheduled to terminate in June 1980.

Monroe County ACCESS project

The Monroe County Long Term Care Program, Inc., is an HEW Section 1115 demonstration project designed to test the cost-effectiveness of a new long-term care model, ACCESS, in the Rochester, New York, area. ACCESS is a centralized unit responsible for all aspects of long-term care for the elderly in Monroe County, including developing and coordinating community services, administering long-term care funds, approving all Medicaid payments for institutional and community long-term care services, and collecting data. ACCESS staff provides each client with a comprehensive needs assessment, assistance in planning and obtaining either community or institutional services, and ongoing monitoring of the appropriateness of the services. All Medicaid-eligible clients are required to go to the ACCESS unit to receive any long-term care service. Private pay patients may voluntarily use ACCESS services. After 30 months of planning, ACCESS began serving clients in December 1977, and is scheduled to terminate operations in July 1980. The staff will request an extension in project funding from HEW.

New York State Long Term Home Health Care Program (LTHHCP)

A 1977 New York State law, which became effective April 1, 1978, authorizes the establishment of Long Term Home Health Care Programs (LTHHCP) at the local level. In early 1979, the LTHHCP received a Section 1115 waiver from HEW.

As of April 1979, one LTHHCP was in operation and eight others were in various stages of planning and development.

Providers of a LTHHCP may be certified home health agencies; public or private, nonprofit nursing homes; or hospitals. Prospective providers submit detailed applications to the New York State Commissioner of Health who approves or denies their participation in the program after thoroughly assessing the adequacy of their personnel, facilities, services, policies, and financial resources and practices. All LTHHCP providers must offer the following services: nursing; home health aide; personal care and homemaker services; therapy; audiology; medical social work; nutritional services; and medical supplies and equipment. The local social service department works with the LTHHCP agency to provide each client with a needs assessment and an individually tailored package of services to prevent institutionalization.

Medicaid reimburses for all services needed by a client up to a maximum monthly cost of 75 percent of the monthly Medicaid reimbursement rate for an equivalent level of institutional care. The Section 1115 waiver enables the LTHHCP project to obtain Medicaid reimbursement for 10 additional services not normally covered under the New York State Medicaid plan: home maintenance tasks, nutrition counseling/ educational services, respiratory therapy, respite care services, social day care services, transportation, congregate meal services, moving assistance services, housing improvement services, and medical-social services.

Wisconsin Community Care Organization Project

The Wisconsin Community Care Organization (CCO) project has received an HEW Section 1115 Medicaid waiver to test the effectiveness of a communitywide system for providing functionally disabled adults an integrated package of health and social services to enable them to remain in the community. Three CCO sites have been established: LaCrosse CCO is an urban/rural site; Barron County CCO is a rural site; and Milwaukee CCO is an urban site. The CCO is an administrative and management unit which develops contracts with local service providers and coordinates and funds all services for its clients. The CCO staff assesses each client's long-term care needs and plans, obtains, and monitors the services needed to maintain the individual in the community. After approximately a year of planning, the CCO's began serving clients in April 1976 at LaCrosse; in July 1977 at Barron County; and in December 1977 at Milwaukee.

Virginia Nursing Home Preadmission Screening Program

In 1976, the Virginia Department of Health initiated a pilot project to test the effectiveness of a preadmission screening program in reducing the flow of the elderly and disabled into nursing homes and in promoting more appropriate utilization of both institutional and community long-term care services. After a successful 9-month pilot project in both urban and rural areas, Virginia implemented the gatekeeping program statewide in May 1977. Any nursing home applicant who is eligible for Medicaid, or who will be eligible within 90 days of nursing home admission, must be screened by the local health department before he or she can enter a nursing home. If the screening committee decides that available, community-based long-term care services can meet the individual's needs, Medicaid cannot reimburse for the care should the individual decide to enter an institution.

PROJECTS DEMONSTRATE VARIOUS APPROACHES TO IMPLEMENTING NECESSARY CHANGES IN THE LONG-TERM CARE SYSTEM

Each project is experimenting with different methods of implementing the program elements needed to reduce avoidable nursing home admissions. As table 17 shows, only the Monroe County ACCESS project and the New York State LTHHCP incorporate all five of the key elements. A brief description of how the projects implemented these program elements follows.

Table 17

Program Elements in Long-Term Care Projects

	Gatekeeping mechanism	Needs assessment	Coordinating mechanism	Single financing source	Cost controls
Georgia AHS		x	x	x	x
Monroe County ACCESS	x	x	x	x	x
New York LTHHCP	x	x	x	x	x
Virginia Preadmission Screening	x	x	x		
Wisconsin CCO		x	x	x	x

Gatekeeping Mechanism

To target services to the elderly population in imminent danger of institutionalization, three projects have established a mechanism for intervening in the nursing home admissions process to ensure that those elderly who do not need or prefer institutional care are offered community-based long-term care options. 4/ These projects are the Virginia Nursing Home Preadmission Screening Program; the Monroe County Long Term Care Program, Inc.; and the New York Long Term Home Health Care Program. Furthermore, the difficulties experienced by the Wisconsin CCO project in its efforts to gain access to the elderly most at risk of institutionalization support the need for a direct intervention mechanism in the nursing home admissions process.

--Virginia Preadmission Screening Program

A key feature of the Preadmission Screening Program is the health department screening committee's authority to ap-

prove or deny Medicaid payments for nursing home care for applicants in the community who are Medicaid eligible or who would be eligible within 90 days of admission. No Medicaid payment can be made for nursing home care for these applicants without the screening committee's authorization. Nursing homes participating in the Medicaid program are required to refer all such applicants to the local department of health's screening committee. As of April 1979, consideration was still being given to plans for expanding the screening program to include nursing home applicants in acute care hospitals who are either Medicaid-eligible or who would be eligible within 90 days of admission.

The screening committee, consisting of a physician, nurse and social worker, assesses the applicant's medical and social support needs to determine whether the individual requires nursing home care or whether he or she could be maintained in the community with the assistance of available services. If community care is judged more appropriate, the committee refers the nursing home applicant to the agency responsible for the required health, social service, or housing programs.

From May 15, 1977 through February 28, 1979, 3,592 nursing home applicants were screened. Of those, 765 (21 percent) were maintained in the community. 5/

--Monroe County ACCESS project

A unique feature of the ACCESS program is that it includes both public and private pay patients. The ACCESS unit provides its preadmission assessment, service plan development, and case management services free of charge to all Medicaid long-term care clients on a mandatory basis and to all private pay patients on a voluntary basis. However, private pay clients must pay for their long-term care services. ACCESS services were extended to private pay patients to achieve the greatest impact on nursing home utilization. Even though the ACCESS preadmission assessment is only voluntary for the non-Medicaid population, 64 percent of all clients assessed during the first 20 months of project operations were private pay. 6/

To assume responsibility for all long-term care services provided to Medicaid recipients, the Monroe County Long Term Care Program, Inc. entered into agreements with the Monroe County Department of Social Services (MCDSS)

transferring several Medicaid functions to the ACCESS unit. The agreements granted ACCESS the authority to

--certify the medical necessity and approve payment for skilled and intermediate level nursing home care for all Medicaid recipients;

--certify the medical necessity for nursing home care for all private pay residents who apply for Medicaid coverage after nursing home admission;

--certify all changes in levels of care, including discharges to the community, for all Medicaid recipients residing in nursing homes or proprietary adult homes; and

--certify the medical necessity and approve payments for community-based long-term care services to Medicaid clients.

Clients are referred to the ACCESS program from community sources--local agencies, health professionals, nursing homes, and individuals--and from acute care hospitals. Only Medicaid clients are required to be referred to ACCESS. Through a public relations campaign and direct contact with local physicians, ACCESS is seeking to stimulate an increased awareness of its services so that private pay patients will also be referred to them before they apply to nursing homes. The eight local hospitals were phased into the program during the implementation period.

ACCESS began serving clients in December 1977. During the first 20 months of operations, 5,338 individuals were referred to ACCESS, 2,746 from hospitals and 2,592 from community sources. 7/ Of the 5,338 individuals referred: 8/

--3,750 (70.2 percent) were assessed and either provided a package of community services or placed in a long term care facility,

--222 (4.1 percent) were in the assessment and care planning stage,

--322 (6.0 percent) died,

--241 (4.5 percent) withdrew or were transferred to another local agency because they no longer needed long-term care, and

--803 (15.0 percent) were admitted to a hospital or were residents of nursing homes.*

Each of the 3,750 clients who received an assessment was classified as needing one of the following levels of care: 1) skilled nursing facility (SNF) level care, 2) health related facility (HRF)** level care, or 3) domiciliary level care.*** The initial project results demonstrate that individuals at all levels of need can be maintained in the community. As table 18 shows, 63 percent of all ACCESS clients and 54 percent of all clients assessed as needing SNF level care were maintained in the community. 9/

Table 18

Percentage of Clients Assessed at the Same Level of Care Remaining at Home or Entering a Long-Term Care Facility

Assessed level of care	All clients	Clients remaining in community		Clients admitted to long-term care facility	
		Number	Percent	Number	Percent
SNF	2,242	1,216	(54)	1,026	(46)
ICF	694	512	(74)	182	(26)
Domiciliary care	814	617	(76)	197	(24)
Total	3,750	2,345		1,405	
Percentage	(100)	(63)		(37)	

*The majority of these clients are nursing home residents who are admitted to a hospital and then returned to the nursing home. They are counted in ACCESS statistics because they receive an assessment before hospital discharge.

**Health Related Facility (HRF) care is New York's equivalent of Intermediate Care Facility (ICF) services.

***Domiciliary care is the generic term for Proprietary Homes for Adults and Homes for the Aged in New York State.

An examination of the ACCESS clients' sources of payment reveals that Medicaid recipients are more likely to remain in the community than private pay clients. Forty-three percent (1,623) of the 3,750 ACCESS clients are Medicaid recipients. 10/ As shown in table 19, 69 percent of the Medicaid clients remain in the community versus 58 percent of the private pay clients. 11/ For clients assessed as needing skilled nursing facility level care, there is an even greater discrepancy between the percentage of Medicaid and private pay clients who remain in the community. Sixty-six percent of skilled-level Medicaid clients remain in the community versus 44 percent of skilled-level private pay clients. 12/

Table 19

Number and Percentage of Medicaid and Private Pay Clients Who Remain in the Community or Enter a Facility

Assessed level of care	Remaining in the community		Admitted to long-term care facility		Total
	Number	Percent	Number	Percent	
MEDICAID CLIENTS:					
SNF	673	(66)	346	(34)	1,019
ICF	222	(73)	84	(27)	306
Domiciliary care	219	(74)	79	(26)	298
Total	1,114		509		1,623
Percentage	(69)		(31)		(100)
PRIVATE PAY CLIENTS:					
SNF	543	(44)	680	(56)	1,223
ICF	290	(75)	98	(25)	388
Domiciliary care	398	(77)	118	(23)	516
Total	1,231		896		2,127
Percentage	(58)		(42)		(100)

Whether or not a client remains in the community also varies by the source of referral. As table 20 shows, a much greater percentage of clients referred from community sources remain in the community than clients referred from hospitals. 13/

Table 20

Referrals of ACCESS Clients

COMMUNITY REFERRALS:

Assessed level of need	Total	Percent remaining in community	Percent admitted to facilities
SNF	964	86	14
ICF	481	86	14

HOSPITAL REFERRALS:

Assessed level of need	Total	Percent remaining in community	Percent admitted to facilities
SNF	1,278	31	69
ICF	213	45	55

In both the community referral and the hospital referral groups, a smaller proportion of Medicaid clients than private pay clients needing skilled-level care entered a skilled nursing facility. Of the skilled clients referred from hospitals, 55 percent of the Medicaid clients entered a skilled nursing facility versus 81 percent of the private pay clients. 14/ In the community referral group, only 9 percent of the skilled-level Medicaid clients entered a skilled nursing facility versus 19 percent of the skilled-level private pay clients. 15/ For ACCESS clients assessed as needing ICF level care there was little difference in the placement of Medicaid and private pay clients.

In summary, during the first 20 months of ACCESS activities, a greater percentage of Medicaid clients than private pay clients remained in the community. The greatest difference in long-term care placement between the Medicaid and private pay groups occurred at the skilled nursing facility

level of care. A larger proportion of skilled-level Medicaid clients remain in the community than their private pay counterparts in both the hospital and the community referral groups.

Until the independent evaluation of the ACCESS project is completed, it is not possible to draw any conclusions about the effectiveness of the assessment and care planning mechanism in diverting Medicaid and private pay clients from entering nursing homes. However, the ACCESS staff point to two possible reasons why skilled-level Medicaid clients remain in the community more often than skilled-level private pay clients. 16/ One reason is that nursing home administrators often prefer to admit private pay rather than Medicaid applicants because they believe Medicaid's reimbursement levels are inadequate. Consequently, Medicaid clients wait longer for a nursing home bed both in the community and in hospitals.

A second reason is that Medicaid reimburses for a comprehensive array of noninstitutional long-term care services for its Medicaid clients participating in the ACCESS demonstration project while private pay clients must pay out-of-pocket for most of these services. Therefore, private pay clients may view nursing home care as their only long-term care option.

To gain greater leverage over the flow of non-Medicaid clients into nursing homes, the ACCESS staff has submitted a proposal to HEW requesting a grant under Section 222 of the Social Security Amendments of 1972 (P.L. 92-603) to expand the demonstration project to include the Medicare program. Under Section 222, HEW has the authority to grant waivers of certain Medicare regulations to permit research and demonstration projects to use Medicare funds to reimburse for an expanded range of services. The Section 222 waivers would permit ACCESS to offer a comprehensive package of home services as an alternative to institutionalization to Medicare-eligible clients in addition to the Medicaid population it now serves.

--New York Long Term Home Health Care Program

When a Long Term Home Health Care Program (LTHHCP) has been established, the county social services department is required to offer it as a long-term care option to all Medicaid-eligible clients who

--are considering entering a nursing home,

--have been medically assessed as needing SNF or ICF nursing home care, and

--would prefer to remain in the community.

A multidisciplinary assessment team conducts a comprehensive evaluation of the client's long-term care needs and home environment. If home-based care is judged to be a viable alternative to institutionalization, the client is offered an individually tailored package of long-term care services which will be coordinated by the LTHHCP provider, monitored by the county social services department, and financed by Medicaid.

--Wisconsin CCO Experience

In an attempt to ensure that the clients receiving services are truly at risk of institutionalization, the Wisconsin CCO project has successively narrowed its definition of the target population at each of its three project sites. At the LaCrosse site, which was the first one established, the target population includes all elderly, adult blind and adult disabled persons judged to be at some risk of needing institutionalization. Only non-Medicaid eligible clients have to pay for their services. When an independent review panel examination of a sample of LaCrosse clients revealed that 73 percent of the Medicaid and 77 percent of the private pay clients were not considered in imminent danger of institutionalization, the CCO project instituted a functional assessment instrument (the Geriatric Functional Rating Scale) to predict the likelihood of institutionalization. 17/

The Geriatric Functional Rating Scale (G.F.R.S.) is now used as a screening device to determine client eligibility in the CCO projects established in all three sites. The LaCrosse CCO accepts applications with G.F.R.S. scores below 50. The Barron CCO originally accepted applicants with G.F.R.S. scores below 40 which indicate a high probability of institutionalization within 18 months. 18/ Recently, that score has been lowered to 20. At the third CCO site in Milwaukee, the target population was limited by establishing a requirement that 70 percent of the clients must have G.F.R.S. scores below 20 which indicate a high risk of institutionalization. 19/

Despite these refinements in the definition of the client population, there is still a question as to whether the CCO projects are gaining access to the population at imminent risk of institutionalization. In the May 1978 progress report, the evaluators drew the tentative conclusion that

> It has become increasingly evident that if a home care program is to gain access to clients who are headed for nursing homes, there must be some way to intercede with the pathway to the nursing home. Prior assessment is one proposed way to accomplishing this task. It may constitute the most important spin-off of CCO. 20/

Comprehensive Needs Assessment

To correct the deficiencies in the Medicaid assessment and placement procedures for long-term care clients, each project has established a formal process for comprehensively assessing the individual's medical, social, and environmental needs before any arrangements are made for the client's long-term care. The comprehensive needs assessment serves two critical functions. First, it provides the information required to match the client's needs with the appropriate level and type of long-term care services whether institutional or community-based. Second, the assessment yields a wealth of data on the client population which will be essential in finding the answers to a number of as yet unanswered questions, including:

--Who really needs to be in a nursing home?

--What types and quantities of services are needed to safely maintain the elderly with different levels of functional ability in the community?

--What is the impact of long-term care services on the client's health, functional abilities, longevity, morale, and risk of institutionalization?

--What are the costs associated with providing home services to the elderly at various levels of impairment?

In each project, the assessment process draws upon the expertise of a multidisciplinary team, generally consisting

of a nurse, a social worker, and a physician. Every project uses some type of formal assessment tool which was either designed specifically for the project or developed by a researcher in the field of gerontology. The use of a formal assessment instrument is intended to achieve greater objectivity and specificity in identifying the client's long-term care needs. In some projects, a less highly trained or paraprofessional staff member administers the assessment instrument and the professional team reviews the results and formulates a long-term care plan. In other projects, one or more members of the professional team perform the assessments.

Central coordinating mechanisms

Each project has taken a different approach to establishing a central coordinating mechanism, depending on the resources of a particular community. The projects differ in the types of organizations which serve as the coordinating mechanism and in the functions performed by these mechanisms.

The types of coordinating mechanisms include existing agencies, new governmental units, and new private, nonprofit organizations. Three projects have utilized existing public agencies to serve in this capacity. The Virginia Nursing Home Preadmission Screening Program is utilizing local health departments to determine what community services could be mobilized to divert the Medicaid-eligible elderly from entering a nursing home. The New York Long Term Home Health Care Program and the Georgia Alternative Health Services (AHS) Project both rely on the local social services departments as well as on service providers to plan and coordinate services.

The Wisconsin CCO project established a private, nonprofit corporation to serve as the coordinating mechansim at two of its sites. The CCO established in LaCrosse has a corporate membership consisting of 85 community groups and health and social service agencies. The Milwaukee CCO does not have a corporate membership. Instead, the Governor appointed 15 representatives of interested public and private agencies to serve as the Board of Directors of the nonprofit corporation.

The Monroe County Long Term Care Program, Inc. is also a new organization, but it differs from the others because

its goal is to supersede all the public payers, local government units, fiduciaries and current approaches and authority insofar as long-term care is concerned. 21/ The project has a Board of Directors composed of an equal number of public officials, health and social service providers, and consumers.

Each coordinating agency either performs or oversees most or all of the following functions:

--providing a single intake point for all long-term care services required by its clients;

--assisting in the assessment of the client's long-term care needs;

--identifying the types of assistance provided to the client by relatives and friends;

--planning the package of services, in conjunction with the client and family members, which would permit the client to safely remain in the community;

--locating and arranging for the delivery of the services;

--monitoring the continued quality and appropriateness of the services delivered; and

--revising the service plan as the client's needs change.

All the projects except the Virginia Preadmission Screening Program are performing each of these functions. The Virginia preadmission screening panels provide central intake, assessment, service planning, and referral to the appropriate community service agency (usually the local health or welfare department) but do not formally coordinate and monitor the services delivered on an ongoing basis.

The other projects are testing various methods of performing the coordinating mechanism functions. For example, in the ACCESS project, one of the case managers on the staff assumes responsibility for all phases of the client's long-term care, from intake through the monitoring of the services delivered. In the Georgia AHS project, the assessment team determines the client's needs, develops a care plan, and

monitors the services provided, while the major service provider coordinates all the services delivered and submits status reports on each client every 60 days to the assessment team.

By creating a single access point for all long-term care services, these projects have been successful in identifying and filling many of the gaps in the community services required to permit the impaired elderly to remain in their homes. In some cases, the projects developed new services which were not offered by any local service providers. For example, the Georgia AHS project found that adult day rehabilitiation centers did not exist in most of the demonstration areas. The AHS project initiated and developed 10 adult day rehabilitation centers which offer health and social rehabilitation services on a daily basis to the chronically disabled elderly who do not require 24-hour care.

In many communities, the projects' staff discovered that essential support services, while available, were inaccessible to a large number of the elderly because of an insufficient supply or a lack of home delivery. By establishing contracts with existing and new service providers, the projects have been successful in expanding the quantity and the flexibility of community resources. For example, to participate in the New York Long Term Home Health Care Program, a service provider must offer nursing, home health aide, personal care, and homemaker services, as well as a 24-hour crisis contact telephone service.

Single funding mechanisms

All of the projects except Virginia's Preadmission Screening Program have established a single financing mechanism by obtaining special Medicaid waivers from HEW which permit the use of these funds to reimburse for a comprehensive array of services. Section 1115 of the Social Security Act gives HEW the authority to grant "waivers" of certain Medicaid restrictions on the types and amounts of services which can be provided under State Medicaid plans to test the impact of an expanded, coordinated range of home services on institutionalization and costs. After gaining experience in operating under the Section 1115 waivers, each project concluded that this funding mechanism enabled the staff more effectively and efficiently to serve their clients' needs by removing the traditional reimbursement barriers and allowing them to expand their range of services. For example, the Medicaid waivers

permit the Monroe County ACCESS project to reimburse for the preadmission needs assessment for all clients regardless of income as well as for seven new community services for Medicaid clients--transportation for nonmedical purposes, friendly visitors, housing improvements, housing assistance services, respite care, home maintenance tasks, and moving assistance services.

These services can be delivered in a much more efficient manner because far less staff time is spent on integrating services with different financing mechanisms. For example, prior to the initiation of the Georgia AHS project services,

> * * * a client at home in need of both health and social services required several agencies with access to multiple funding sources and persistence to coordinate the service delivery. Those involved in delivering services were required to overcome limitations of categorical funding, to resolve the conflicting eligibility requirements and to overcome the barriers of legislative and regulatory restrictions. AHS Home Delivered Services, in contrast, have substantially improved the organization and coordination of health and social services. 22/

The only project operating with no new funding sources is the Virginia Nursing Home Preadmission Screening Program. The results from this program also support the need for supplementing or replacing the existing categorical Federal funding streams with a single, flexible financing mechanism for all long-term care services required by the elderly at risk of institutionalization. The Virginia program depends on existing community services available under Titles XVIII, XIX, and XX of the Social Security Act and Titles III and VII of the Older Americans Act to provide alternatives to Medicaid-eligible nursing home applicants. No new Federal or State financing sources have been developed.

The screening program's results reveal that the services required to maintain the nursing home applicant in the community are frequently unavailable. Table 21 displays the number and percentage of clients who did not receive a community service recommended by the screening panel because it was unavailable to them. 23/

Table 21

Availability of Community Services

Community service	Clients for whom service was recommended but unavailable: Number	Percent
Companion service	1,036	29
Chore service	793	22
Meals	768	21
Homemaker	726	20
Day care	604	17
Home health	122	3

According to the Virginia Department of Health, the required services may be "unavailable" to a client for one of three reasons. First, there is an insufficient supply of home-based services in many areas of the State. In Virginia, as in many States, the demand for social services far exceeds the amount which can be provided with the State's Title XX funds. A 1978 HEW-financed study of State initiatives in developing alternatives to institutionalization concluded that

> * * * the home health and home based care services offered by the (Virginia) Department of Health and the Department of Welfare, respectively, seem more of a pro forma answer to the requirements of the Title XX legislation than an effort to provide alternative services to prevent institutionalization. 24/

Second, many applicants do not meet the income eligibility requirements for the services provided under a particular program. According to the Virginia Department of Health, this problem arises most frequently with the elderly whose income exceeds the allowable amount for Supplemental Security Income eligibility and who are therefore ineligible for critical types of assistance, such as chore and companion services under Title XX. 25/ A third reason that services are

"unavailable" is that the essential services may not be offered for the number of hours required to meet the client's need.

Cost controls

In view of the spiraling costs of nursing home care, a major goal of each project is to test and demonstrate the feasibility of delivering long-term care services in a more cost-effective manner than institutional care. Therefore, four projects have established ceilings on the costs which can be paid for an individual's home-based service package.

The Georgia AHS project established a Maximum Units of Service (MUS) guideline to assist the assessment teams in determining whether a client requires more intensive care than can reasonably be provided by AHS services. The MUS guideline quantifies the costs of providing each AHS service and recommends a maximum amount of service to be provided to a client. The guideline is used in conjunction with the client assessment instrument, the physicians' medical report, and the caseworker's evaluation to allow the assessment team to consider both the appropriateness and the costs of maintaining the client in the community with AHS services. The assessment team does not use the guideline to unilaterally screen out clients from the AHS project. For example, if a client's service needs exceed the MUS guideline but are expected to decline in the future, the assessment team may decide to include the client in the AHS project.

The Wisconsin CCO project has experimented with providing services both with and without cost ceilings. At the first two CCO sites (LaCrosse and Barron County), no cost caps were imposed. The April 1978 progress report states that preliminary analysis of the cost data collected at LaCrosse CCO

> * * * suggests that if the client population currently being served in community settings by CCO-LaCrosse were in a Wisconsin nursing home, the over-all public cost would probably be comparable * * *. However, it should be noted that while over-all public costs would be comparable, some clients cost substantially less, and others cost substantially more. 26/

As a result of the experiences of the first two CCOs, Milwaukee CCO set a cost limit of $475 per month on the

amount of services that can be delivered to one client. Current data show the cost of the CCO Milwaukee to be $7.84 per client per day. One of the evaluation goals of the Wisconsin CCO is to determine which client characteristics result in higher service costs.

New York State has established the same type of cost caps in the Monroe County Long Term Care Program, Inc. and the Long Term Home Health Care Program. In both projects, the cost of community-based service options offered to Medicaid clients cannot exceed 75 percent of the Medicaid reimbursement rate for the equivalent level of nursing home care. For example, if the Medicaid reimbursement rate is $1,500 per month for a skilled nursing home, a Medicaid client assessed as needing skilled nursing care could receive an alternative package of services costing up to $1,125 per month. If the client must incur a large, one-time expense, for example, an architectural adjustment, the cost can be prorated over 3 months. The Monroe County ACCESS program uses the following formula in determining the maximum allowable cost of the noninstitutional long-term care package:

> Monthly recurring care and service costs
> PLUS
> Average monthly cost of initial (nonrecurring) capital expense (average to be computed by totaling initial capital expenditures and dividing by 3 months).
> IS EQUAL TO OR LESS THAN
> Seventy-five percent of the allowable Medicaid rate for institutionalizing that client at the appropriate level of care (as determined from the preadmission assessment). This is true only for SNF and HRF levels of care.

Preliminary cost analyses of project data are favorable

To date, the data collected and analyzed by the projects suggest that, in terms of public dollars, the cost of home-based long-term care is less than or comparable to the cost of the equivalent level of nursing home care. Since the Federal demonstration projects have only been in operation a short while, this finding is based on preliminary cost analyses of the data collected on a small sample of clients. No cost data are available from the Virginia Nursing Home Preadmission Screening Program or from the Long Term Home Health Care Program, which is in the earliest stages of implementation.

--Wisconsin CCO Project

Preliminary data from the Wisconsin LaCrosse CCO indicate that the overall public costs of community-based and institutional long-term care services are roughly comparable. The independent evaluation staff includes all governmental programs in "public costs," including social security income, food stamps, and subsidized housing.

For the entire CCO LaCrosse client population, the average per diem cost for an individual is $2.22 higher than nursing home care. 27/ However, the evaluation staff has not yet determined whether the higher average per diem cost for CCO clients is due to the cost of services or basic maintenance costs such as food and housing. When the cost data are analyzed by level of care, it is found that the average cost of CCO services is 1) lower than the cost of nursing home care for clients assessed as needing skilled nursing care and 2) higher than the cost of nursing home care for clients assessed as needing lower levels of institutional care. According to the CCO project staff, the preliminary cost findings suggest that the average higher cost of CCO clients could be attributed to basic maintenance rather than service costs. 28/ At lower levels of care, basic maintenance costs would constitute a higher proportion of total public costs.

--Georgia AHS Project

The Georgia Alternative Health Services Project has conducted preliminary cost analyses of services provided to 394 clients during the first months of operation. 29/ The cost data were collected from claims filed by service providers through July 31, 1978, and represent only the costs incurred by Medicaid for AHS services. No other Federal program costs, or private expenditures, were included. The preliminary analyses indicate that the average monthly cost of the AHS services is $162 compared to the estimated average monthly cost to Medicaid of $500 for nursing home care. 30/

--Monroe County ACCESS Project

The Monroe County ACCESS project has estimated the costs of the noninstitutional long-term care packages provided to the Medicaid clients who have been maintained in the community during the first 20 months of operations. As shown in table 22, the Medicaid costs for direct, noninstitutional services for the 673 clients needing skilled-

level care in the community was estimated to be $22.80 per day versus $45 per day for Medicaid's reimbursement rate for skilled nursing facility care. 31/ For clients receiving a health related level of community services, the Medicaid costs were 41 percent of the Medicaid reimbursement rate for health related facility care. 32/

Table 22

Daily Medicaid Costs for Home Care Services

Assessed level of care	Number of cases	Total estimated cost	Percentage of Medicaid institutional reimbursement rate for equivalent level of care
Skilled nursing level	673	$22.80	51% of $45
Health related level	222	$11.15	41% of $27

STATE AND LOCAL LONG-TERM CARE PROJECTS ENCOUNTER SERIOUS DIFFICULTIES

Although several States and local communities have established demonstration projects and small-scale permanent programs designed to reduce avoidable institutionalization, it is extremely difficult to develop these projects and to demonstrate their effectiveness within the existing system of financing and delivering long-term care.

Obtaining adequate funding for noninstitutional long-term care services is a major obstacle

State and local experiences indicate that the viability and effectiveness of projects designed to prevent avoidable nursing home admissions hinge upon the establishment of adequate funding for a comprehensive array of community long-term care services. However, the fragmentation and gaps in current Federal sources of funding for long-term care seriously impede efforts to initiate and maintain these

projects. Financing and authority for long-term care are splintered among the Health Care Financing Administration, which houses Medicare and Medicaid; the Office of Human Development Services, which encompasses the Title XX program and the Administration on Aging; the Social Security Administration, which administers the Supplemental Security Income program; and the Public Health Service, which administers the National Center for Health Services Research. National Health Insurance, if enacted, is unlikely to resolve this fragmentation since most proposals exclude long-term care services from their benefit packages because of their long-term nature and the fact that they are considered social or health-related rather than medical.

Because each Federal office channels its own funds to the State and local levels, the patchwork long-term care system is preserved at each level of government. Staff who attempt to develop comprehensive long-term care projects, whether as demonstrations or permanent programs, must spend an enormous amount of time piecing together and coordinating several Federal funding sources with varying and often conflicting program requirements. For example, the Georgia AHS project encountered a number of difficulties in coordinating the Medicaid, Title XX, Social Security, SSI, Food Stamp, and Older Americans Act programs. These difficulties arose as a result of divergent Federal laws and regulations regarding a) client eligibility b) Federal-State cost-sharing arrangements, c) allowable program costs, and d) reimbursement methods and reporting requirements for service providers. 33/

Projects that rely solely on existing Federal financing sources are constrained by restrictive eligibility policies and benefit structures from serving the entire population at risk of institutionalization or from providing the comprehensive range of services needed to prevent avoidable nursing home admissions. Because most projects use Medicaid and Title XX funds to provide home services, they are limited to serving a predominantly welfare population. By excluding the nonwelfare, Medicare population, these projects miss the opportunity to prevent avoidable admissions of private pay and Medicare patients who can later convert to Medicaid.

Services required to maintain a chronically impaired individual in the community are often inadequately funded or not covered by any third party payer. Medicaid and Medicare restrict the amount and type of noninstitutional services

included in their benefits packages because they are primarily designed to serve acute rather than chronic health care needs. Funding for many support services, such as housing improvements, moving assistance, and transportation, may be inadequate or nonexistent under the social services programs within a State.

To help fill the major gaps in third party reimbursement for health, social, and housing services, many projects seek demonstration grants and waivers of Medicaid or Medicare regulations on the amount and type of services which can be reimbursed. Four of the five projects discussed in this chapter have obtained waivers of Medicaid regulations under Section 1115 of the Social Security Act. However, even if a project obtains a demonstration waiver which permits greater flexibility in reimbursing for community long-term care services, financing issues still absorb an enormous amount of staff time.

Applying for demonstration grants can be a highly frustrating experience, particularly for project staff unfamiliar with the Federal bureaucracy and relevant laws, policies, and regulations. Because demonstration grants and waivers are time-limited, the staff must continually reapply for assistance as the grants expire. For example, the Minneapolis Age and Opportunity Center, Inc., a nonprofit service agency which provides a wide array of health and social support services to the elderly and disabled, has had to devote substantial staff resources to the exercise of applying for and obtaining 19 Federal grants from several different agencies over the period 1969 to 1978. 34/

Even after the grant or waiver has been obtained, the project staff must spend a great deal of time coordinating with Federal, State, and local agency officials and service providers. For example, Triage, Inc., a comprehensive long-term care project operating with Medicare waivers granted under Section 222 of the Social Security Amendments of 1972, took over 2-1/2 years to implement. The Triage project involved:

> * * * nearly every aspect of DHEW health and social service policy, grant and contract management, and such complex issues as privacy, confidentiality, and the protection of research subjects. 35/

At the Federal level, Triage staff worked with the Administration on Aging, the Social and Rehabilitation Service,

Bureau of Health Insurance, the Social Security Administration, the Health Resources Administration, and the Offices of the Assistant Secretary for Health and the Secretary of HEW. At the local level the staff coordinated with the State Department of Human Services, the State Department of Social Services, the State Department of Aging, the Secretary of State, and the Governor, as well as with 191 service providers. 36/

In addition to the problems of locating and coordinating Federal funds, demonstration projects often experience a number of other serious difficulties which undermine their ability to achieve their goals within the relatively short time limits under which they operate. Because of these difficulties, it can take several years to establish a long-term care project.

Most projects must devote an enormous amount of time to the development and expansion of the range of community-based long-term care services which are needed to prevent institutionalization. One of the most critical long-term care options--residential housing--can take years to develop. Without a stable, comprehensive funding source for community long-term care services, demonstration projects often have a difficult time developing and maintaining an adequate supply of service providers. For example, the Georgia Alternative Health Services project encountered resistance among provider agencies to expanding their services because of past experiences in which they had responded to funding initiatives by offering new services only to be forced to discontinue them due to the termination of the funds. 37/ Although the AHS staff was able to overcome the reluctance of the provider agencies, it appears that some providers are already concerned about the implications for their clients of the scheduled project termination date.

Even when demonstration projects become fully operational, they generally lack control over several other factors which have a significant impact on their results. For example, a project's ability to reduce avoidable nursing home utilization by Medicaid recipients is critically affected by at least two factors outside its control--Medicaid nursing home reimbursement rates and private pay nursing home admissions. Because many nursing home operators perceive Medicaid reimbursement rates as inadequate, they prefer to admit private pay patients. Many of these private pay nursing home residents deplete their resources and convert to Medicaid. Unless a project has the authority to screen and offer noninstitutional long-term care options to all nursing home

applicants, Medicaid will continue to subsidize nursing home care for residents who had the potential to remain in the community.

Because it can take up to 3 years to establish a comprehensive long-term care project, the staff often has very little time left in which to provide services and collect meaningful cost and utilization data before the demonstration grant expires. After a lengthy startup period, both the Georgia AHS and the Monroe County ACCESS projects have had approximately a year of actual operating time. Consequently, both projects have requested extensions of their Section 1115 waivers from HEW to permit enough time to collect meaningful data on utilization and costs.

Other extremely time-consuming tasks which are crucial to the success of a demonstration project are

--recruiting and training the project staff;

--conducting an outreach campaign to inform the public as well as the local physicians, social workers, hospital discharge planners and service providers about the project;

--gaining the confidence of the physicians, service providers and other professionals which is required before they will entrust their patients to a new and unknown project; and

--designing and implementing a data collection system.

Permanent funding is unavailable to most demonstration projects under current Federal and State programs

After struggling to become operational, most demonstration projects 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. Critical changes in either Federal or State long-term care policies would be required to enable any public program to permanently finance the range of services required to prevent both public and private pay nursing home applicants with the potential to remain in the community from entering a nursing home where they often become totally dependent on Medicaid support. Although Medicaid is the major

program would have to be changed substantially in order for it to assume this role.

Medicaid's goal is to provide medical assistance to certain low income groups. Consequently, it is not designed to finance the program elements considered essential to reduce avoidable nursing home admissions:

--comprehensive assessments for all public and private pay nursing home applicants to screen out those who are candidates for community care,

--a full range of noninstitutional long-term care services to permit the chronically disabled to remain in the community, and

--planning, coordination, and monitoring of community-based services to ensure that clients receive appropriate care.

Without essential changes in Federal or State financing for long-term care, whether through Medicaid or some other program, projects will be seriously hampered in their efforts to reduce avoidable nursing home admissions.

SUMMARY

The results of long-term care research and demonstration projects suggest that to have an impact on the flow of the elderly into nursing homes, it is necessary to:

--intervene in the nursing home admissions process to screen both public and private pay applicants on the basis of a comprehensive needs assessment.

--package and finance the community services required to permit those who do not need or desire institutional care to remain in the community.

Furthermore, to effectively serve the clients' needs and reduce costly bureaucratic impediments, a single, comprehensive financing mechanism is needed. Some form of control over cost and utilization of community-based long-term care services should also be instituted until more information is available about the mix, amount, and costs of services which prevent institutionalization.

States and local communities have taken the initiative in the long-term care area, and several recent projects have incorporated the key elements required to divert the elderly from entering nursing homes. These projects, which are often on a small scale or demonstration basis, are hampered in their efforts to reduce avoidable nursing home placements by: difficulties in getting a permanent source of financing; the length of time it takes to develop an adequate supply of community-based long-term care services; and the inability to serve the entire population at risk of institutionalization (the private pay patients). Because of the nature of available funding (program grants or waivers) many of these projects will be short-lived.

Implementing these projects on a more comprehensive and permanent basis would require significant changes in the eligibility policies and benefit packages of an existing program or the establishment of a new program. These changes, whether made within Medicaid or some other program, are essential if Medicaid is to have any success in reducing its support for avoidable nursing home use.

NOTES

1/For a detailed discussion of the weaknesses in long-term care research see Sonia Conly, Critical Review of Research on Long Term Care Alternatives, Project Share, A National Clearinghouse for Improving Management of Human Services, SHR-0002153; Applied Management Sciences, "Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long Term Disabled," Executive Summary (Revised), May 1, 1976, contract No. HEW-OS-74-294; and Robert L. Kane and Rosalie A. Kane, Alternatives to Institutional Care of the Elderly: Beyond the Dichotomy, The Rand Corporation, Santa Monica, California, January 1979.

2/Kane and Kane, p. 16.

3/Applied Management Sciences, pp. 9, 12.

4/The Georgia AHS project director has submitted a grant proposal to HEW which requests authority to establish a mandatory preadmission screening program in the AHS project area.

5/Unpublished data obtained from the Virginia Department of Health.

6/Unpublished data prepared by the Monroe County Long Term Care Program, Inc., ACCESS Staff, Rochester, New York, September 1979.

7/Ibid.

8/Ibid.

9/Ibid.

10/Ibid.

11/Ibid.

12/Ibid.

13/Ibid.

14/Ibid.

15/Ibid.

16/Ibid.

17/Frederick W. Seidl, Carol D. Austin, D. Richard Greene, Kevin Mahoney, The Wisconsin Community Care Organization: Interim Evaluation Report II, May 1, 1978, pp. 23-24.

18/Ibid., p. 36.

19/Ibid., p. 46.

20/Ibid., p. 54.

21/The New York State Department of Social Services, Fourth Year Continuation Application for the "Monroe County Demonstration of a Community-Wide Alternative to Long-Term Care Models," April 24, 1978, SRS Grant No. 11-P-90130/2-04, p. 7.

22/Georgia Department of Medical Assistance, Alternative Health Services Annual Report 1977-1978, Grant No. 11-P-90-334/4-01, p. 59.

23/Unpublished data obtained from the Virginia Department of Health.

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27/Ibid., p. 9.

28/Letter from Wisconsin Community Care Organization Project Director, April 23, 1979.

29/Unpublished data obtained from Georgia Alternative Health Services Project.

30/Ibid.

31/Unpublished data prepared by the Monroe County Long Term Care Program, Inc., ACCESS Staff, Rochester, N.Y., September 1979.

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CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Medicaid has become the major payer of long-term care for the chronically impaired elderly in nursing homes. Many of these residents, however, are using this intensive and costly medical service as a substitute for the types of health, social, and income assistance which they would have required to live independently in the community. The following conclusions summarize the factors which contribute to the avoidable utilization of nursing homes by Medicaid recipients.

CONCLUSIONS

1. As long as Medicaid's nursing home coverage is the only readily available source of financial assistance for long-term care, many chronically impaired elderly will be placed in nursing homes even though this is a more intensive care level than is needed.

Although in-home and community-based long-term care services can often postpone or prevent institutionalization, there is little or no financial assistance available for these services from Medicaid, Medicare, or other public programs. Consequently, low and moderate income elderly often experience difficulties in purchasing the medical and other long-term care services they need. In contrast, Medicaid's nursing home benefit covers not only those who are Medicaid-eligible in the community but also many individuals who, although ineligible outside a nursing home, become eligible after they have been admitted. Many elderly are placed in nursing homes not because they need this level of service, but because it is often the only place where they can get any long-term care and it is extensively subsidized by Medicaid. Families, who are often the major source of support to chronically impaired elderly, also receive little if any publicly provided economic or social assistance. After exhausting their financial, physical and emotional resources in providing care, many seek nursing home placement for their relatives to obtain relief.

2. Financial barriers to obtaining community-based long-term care are only one of the factors contributing to avoidable nursing home utilization.

In addition to inadequate financial resources, other factors discourage or prevent the arranging of community-based long-term care services. Many chronically impaired elderly require a package of health and social services which can be extraordinarily complex, if not impossible, to assemble because the services are fragmented, inaccessible, or unavailable. These services are provided by a maze of public and private providers, each with its own eligibility criteria, assessment procedures, and application forms.

Generally the elderly and their families have no one to turn to for assistance in planning and obtaining the services needed. Noninstitutional long-term care may never be considered due to a lack of information about available options. Furthermore, there is a tendency among some professionals (physicians, social workers, hospital discharge planners) to recommend nursing home placement because they lack the time or expertise to plan, arrange, and coordinate the community services necessary to maintain the individual in the community.

In contrast to the overwhelming problems of arranging and financing community-based services, nursing home placement offers a packaged solution to the chronically impaired elderly's long-term care problems. And, unlike many community and home-based services, nursing home care often can be financed totally or partially by Medicaid.

3. Medicaid cannot adequately control avoidable nursing home utilization because of inadequate assessment mechanisms and lack of authority to screen all applicants for admission.

Federal efforts to reduce avoidable nursing home utilization by Medicaid patients have been unsuccessful because they:

--often occur after the patient has been admitted when it is difficult to correct an avoidable placement,

--overlook essential characteristics and conditions which affect the individual's ability to remain in the community.

One of the issues which makes long-term care complex is the fact that "need" for nursing home care often cannot be correctly diagnosed by a medical examination alone. Many chronically impaired elderly living in the community and in nursing homes can be closely matched in terms of their medical needs. The key to why some impaired elderly remain in the community while others are institutionalized is often a difference in the personal, family and community resources available to them rather than a difference in medical needs or level of impairment. Therefore, medical reviews cannot identify those applicants who have the potential to remain in their own homes or in a residential setting with supportive services. A comprehensive assessment which includes social, environmental, health, financial, and medical components is considered essential if an individual's long-term care needs are to be adequately identified. These assessments should be conducted prior to admission to a nursing home because it is easier to develop a service plan before an individual has given up a home and made what was thought to be a "permanent" move to an institution.

Even if Medicaid implemented an effective preadmission assessment mechanism for screening its recipients, support for avoidable utilization would not be eliminated because a substantial number of Medicaid nursing home residents are initially admitted as private pay patients not subject to Medicaid review. Private pay patients, whether they need this level of care or not, generally enter without receiving a formal or thorough needs assessment. After admission, when resources have been depleted, they may apply to Medicaid for coverage. At this point Medicaid's review procedures are less effective because many residents will no longer have the physical or financial resources to return to the community. Consequently, Medicaid ends up supporting some private pay patients whose admission was initially avoidable. And, since the nursing home industry has an economic incentive to fill as many beds as possible with the more profitable private pay patients, these patients are more likely to be admitted to nursing homes than public patients.

4. Reliable projections of the need for nursing home beds cannot be made using current nursing home utilization data.

In many areas, there is pressure to expand the nursing home bed supply because of long waiting lists and the backup of Medicaid (and Medicare) patients in costly acute care

hospital beds awaiting nursing home placement. However, until the factors which encourage avoidable utilization have been corrected and the data required to accurately estimate the optimal number of nursing home beds obtained, it will be unclear how many additional beds are actually needed. The little data currently available, such as occupancy rates and the length of admissions waiting lists, may be misleading because they conceal the number of elderly residents and applicants who have turned to institutional care due to a lack of viable community options.

Because both public and private pay patients enter nursing homes without an adequate needs assessment, no one knows who really "needs" nursing home care and why. Furthermore, little information is available on the number of chronically impaired elderly at risk of institutionalization or on the types, mix, and costs of services needed to enable them to remain in the community. Until better data have been developed on the chronically impaired population's need for both institutional and community services, there will be no way to determine whether there are currently too many or too few nursing home beds.

5. State and local efforts to reduce Medicaid support for avoidable institutionalization are impeded by the fragmentation and gaps in Federal long-term care funding and the current structure of the Medicaid program.

Findings from long-term care research and demonstration projects indicate that to have an effect on avoidable utilization it is essential to intervene in the nursing home admissions process to offer individuals a viable community-based long-term care option. Components necessary to accomplish this include: a nursing home gatekeeping mechanism, a comprehensive needs assessment, a mechanism for coordinating and monitoring community services, a financing source, and controls over cost and utilization.

Although States and local communities have taken the initiative in testing these components, their efforts have been seriously hampered by problems in: coordinating the maze of public programs--Medicaid, Medicare, Title XX, Supplemental Security Income, Older Americans Act programs, and other Federal, State, and local programs--each with its own eligibility requirements and benefit structures; the length of time and the amount of resources it takes to develop an adequate supply of community-based long-term care services; and the inability to serve the entire population at risk of

institutionalization (the private pay patients). Projects developed to reduce avoidable admissions are often on a small scale or funded on a time-limited demonstration basis. Most experience difficulties in acquiring a permanent source of funding and have found their efforts hamstrung by the inflexible and categorical nature of Federal financing sources. Because of funding problems, many projects operate under perpetual uncertainty about their continued survival. While Medicaid provided the initial support for the demonstration phase of many of these projects, it was not designed to serve as the vehicle for permanent funding.

Reducing avoidable nursing home admissions requires an adequate supply of community or in-home services and financial support to ensure all low and moderate income elderly a viable community-based long-term care option. To achieve this would necessitate an expansion in the services covered and in the individuals eligible to participate, an expansion which goes beyond the current scope and purpose of the Medicaid program. Unless these changes are instituted, either within Medicaid or some other program, the effectiveness of State and community programs in reducing avoidable nursing home admissions will be limited.

RECOMMENDATIONS TO THE CONGRESS

Specific changes are needed to assure that Medicaid funds are spent effectively to meet the long-term care needs of the chronically impaired elderly and to reduce program expenditures for avoidable institutional care. There are significant problems, however, in proposing solutions to the causes of avoidable nursing home placement.

First, many individuals are admitted to nursing homes because of gaps or inadequacies in the health, social service, income support, housing or medical insurance systems. Attempting to remedy these deficiencies would require changes in numerous legislative and administrative rules cutting across a wide spectrum of programs--changes which would go beyond the scope of a particular facet of the long-term care system. Second, despite the potential human and financial advantages of developing and increasing community and in-home health and social service options for the elderly, there is little information or even agreement on how best to organize the comprehensive changes needed. There is however, a general consensus that the elements presented in chapter 5 should be part of any revised system.

Finally, there is no reliable information on the number of individuals who need or would use community services for different levels of functioning ability in lieu of nursing home care. In large part this is due to the current unavailability of such services. This makes it difficult to estimate the costs and the systemwide effects of any recommended policy changes. At the same time, until there is a move toward a more comprehensive and integrated system for delivering care for older persons, most of these current questions will remain unanswered.

In spite of these constraints, certain steps can be taken toward increasing the choices older people have when they need long-term care and for assuring that Medicaid expenditures for avoidable nursing home use are minimized. In view of the strong Congressional interest expressed in recent years for legislative recommendations with respect to all aspects of the delivery of home health and other in-home services, we are proposing, in general terms, an approach aimed at providing the elderly with a viable option to institutional care. This approach includes the following components:

1. Establish a Preadmission Screening Program to serve nursing home applicants

Reducing avoidable institutionalization requires an effective method of intervening in the admissions process. This could be achieved by establishing a Preadmission Screening Program with the following features:

A. Mandatory comprehensive needs assessments for all individuals applying to nursing homes whose care would be reimbursed by Medicaid or Medicare. Assessments should also be available on a voluntary basis to all other applicants to institutions participating in Medicare and Medicaid. 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) similar to the existing Medicare home health benefit.

B. Based on these assessments, and in consultation with the elderly and their families, plans of care would be developed for all those individuals who have the desire and potential to remain in their homes or a

community setting. These plans would identify the services needed to support in-home or community-based care.

C. The required services would be assembled, coordinated and monitored to assure that clients receive care which is both appropriate to their needs and of high quality.

D. The actual in-home or community-based services provided under the Preadmission Screening Program could be financed out of general revenues based on a Federal-State cost sharing arrangement comparable to the Medicaid program. The Program could pay for those services (other than the comprehensive needs assessment which would be reimbursed as a benefit under Medicare) which (a) are not available under an existing program (either because they are not covered or they are inadequately funded) or (b) are available under a program for which an individual is not eligible.

E. Control over costs and utilization of services provided to individuals to remain in a community setting could be achieved by limiting reimbursement to some percentage of the cost (e.g., 75 percent, 100 percent, 110 percent) of the appropriate level of institutional care as determined by the comprehensive needs assessment.

2. Assign responsibility for administering the Preadmission Screening Program to one agency

To reduce avoidable nursing home admissions the Preadmission Screening Program should provide both Medicaid and private pay applicants with the option of an affordable package of noninstitutional health and social support services. Locating this program in an agency which serves the entire community (rather than the welfare population alone) and encompasses health-related and social services (as well as medical services) would achieve this objective. One approach would be to locate the Preadmission Screening Program in HEW with responsibility for its administration assigned to public health departments at the State and local level. If this option is selected it should feature the following principles:

A. In administering the Preadmission Screening Program the public health departments should be given flexibility in determining the most appropriate organization in their particular community for carrying out

the Program. This organization could be, for example, a new agency, an area agency on aging, a local hospital, a nursing home, a home health agency, a community health center, or a combination of organizations. The health departments should retain overall responsibility for ensuring that nursing home applicants receive assessments and that noninstitutional services are planned, assembled, monitored and evaluated for those individuals who have the potential to remain in the community.

B. The public health departments 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 Agencies.

Initially, many older people assessed as having the potential to remain in the community would still be placed in nursing homes because the necessary supportive services would be unavailable. Assessments should be used to provide data for long-range planning, for identifying those services which are most critically needed in a community, and for monitoring the level of avoidable placements and costs incurred because these services were not available.

Date from assessments should also be used to assess the impact of different services and costs on clients by different levels of function, for evaluating the effectiveness of alternative long-term care programs, and for developing a more reliable basis for projecting nursing home bed needs.

The above approach has been developed to focus on those individuals who would be directly admitted to a nursing home if they did not receive supportive in-home and community-based services. Controls on costs for each individual served could also be maintained at the comparable level of 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 communitywide long-term demonstration project in several areas to obtain more information on costs, people who could be served, service utilization and total system effects.

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AGENCY COMMENTS AND OUR EVALUATION

We provided Department of Health, Education and Welfare officials with a draft copy of this report for their comments. Their response is printed in Appendix II.

HEW generally agreed with the study's findings and its conclusions and responded that "no issue is of greater interest and concern to HEW's Health Care Financing Administration (HCFA) at this time." HEW believed it would be premature to implement broadly our recommended strategy but concurred that it should be tested in community-wide long-term care demonstrations. HEW also believed that preadmission screening appears to be a promising approach for containing costs and for providing more appropriate services.

HEW raised several issues for consideration under different components of the recommendations. These issues are addressed below.

1. Assessment - HEW, while supporting preadmission assessment, raised some cautionary notes. They believe that assessment itself is expensive and may not be cost-effective. They also note that assessment tools now available are far from comprehensive and need further development and testing. They suggest that the capabilities of health and social service professionals nationwide to carry out a comprehensive needs assessment must be determined and skills developed before this could be implemented.

We believe first that assessment does not have to be expensive--that many tools have been developed which can be administered inexpensively and yet still provide the information needed to develop a plan of care. Projects described in chapter 5 have each developed instruments which they have found to be effective. Second, the merit of the assessment should not be determined only if services prescribed for an individual are outside of a nursing home and less expensive. Instead, the assessment is a service made available to individuals to help them find the right types of care--in many cases this care would appropriately be provided only in a nursing home. If this is the case the assessment should not be considered a failure.

If the intent is to mandate a uniform assessment instrument for use nationally, then we agree that further development and training of staff are necessary. However, for the past two decades health and social service

organizations across the country have been working with different assessment tools and reporting success in improving the appropriateness of long-term care placements. Several assessment instruments, although still in need of refining, have been shown to be useful guides in planning long-term care.

Because nursing home admissions represent for many elderly an irreversible placement, every effort should be taken to help individuals identify (through an assessment mechanism) whether this is the place to receive the care they need. We believe, therefore, that assessments could be instituted based on the years of experience which have already been devoted to this effort. The tools, however, should be subject to revision as experience is gained and the effectiveness of the instruments can be ascertained.

2. Service Fragmentation - We proposed in general terms an approach which would offer the nursing home applicant a viable option to institutional care. This approach, described as a Preadmission Screening Program, includes:

--comprehensive needs assessments covered under Medicare and available to all applicants (mandatory for Medicare and Medicaid applicants);

--the development of plans of care based on these assessments;

--the assembling of the services (if available) for individuals who have the potential and desire to remain in their own homes or another community setting;

--payment (on a cost-sharing basis) for those services which are needed but not covered or available under a current program or are covered but the individual is not eligible for support.

HEW, while stating that these components would be considered in a demonstration project, believes that prior to their implementation nationally they should be tested further. They also question whether our approach would result in adding a new program to an area that is already overloaded with programs thereby causing further service fragmentation.

We disagree. The Preadmission Screening Program was proposed as a method of ensuring that nursing home applicants have the option of remaining in the community by coordinating existing resources and filling gaps in services and financing. Rather than adding to the confusion in long-term care delivery, the proposed approach should provide administering agencies greater flexibility in planning long-term care services. The availability of funding for noninstitutional services under the Program would give the administering community organization an opportunity to offer financial and service incentives to the elderly and their families to help them remain in the community.

3. Control Over Cost and Utilization - We proposed that controls over costs and utilization should be built into the Preadmission Screening Program. One way to accomplish this would be to put a cap on reimbursement for community-based services vis-a-vis the reimbursement level for nursing home care. Another control would be to restrict the program to individuals who otherwise would be eligible for nursing home care. HEW concurred that incentives should be incorporated to control cost and utilization. They suggest problems with the option we proposed; for example, tying community care costs to rising nursing home costs could serve as a disincentive to States to fund community care. In response, a designated cap could be artificially placed on a nursing home rate to control for the actual increase in nursing home costs if more impaired individuals are cared for (e.g., care would be funded at 90 percent of the 1979 reimbursement rate). Another option would be to increase the Federal match for community-based care to provide States with an incentive to support these types of services. Other methods designed to control for cost and utilization would have to be carefully considered before any specific mechanism was selected. We believe that these are policy issues which should be addressed in designing the program if the proposed plan is adopted.

4. Health Departments - The Preadmission Screening Program could be set up as a separate entity or it could be incorporated as part of an already established program. We suggested as one option that it be located in HEW with responsibility for its administration assigned to the State and community public health departments. HEW agreed that this would be considered in a demonstration. At the same time they noted that by adding another program this could further fragment the administration of the long-term health/social service delivery and financing programs. HEW

also suggested problems with locating the program in health departments.

We proposed health departments as one option for several reasons. The Preadmission Screening Program would serve all individuals (not just Medicaid eligibles) and could serve individuals younger than the age of 60 (not just persons eligible for services under the Administration on Aging programs). The public health department offers an already established agency which has a long tradition of serving the total population in the community. Public education is also a major responsibility of these agencies--a function which would be critical to the effectiveness of the Preadmission Screening Program. The health departments' established linkages with other public agencies (welfare agencies, social service programs) would facilitate the types of inter-agency coordination required in administering the program.

We also proposed that if public health departments were assigned the Preadmission Screening Program that they should have the option to contract with community organizations to implement any of the program's components. This would enable these agencies to take advantage of the experience already gained by community organizations in delivering long-term care.

5. Demonstrations - In our recommendations to Congress we proposed a general approach (the Preadmission Screening Program) which, while not addressing comprehensive long-term care reform, would be a beginning method to serve some individuals who otherwise would be in nursing homes. It would also provide a means to collect information and gain experience in long-term care delivery on a broader basis than can be accomplished in demonstration projects. At the same time there are considerable uncertainties--even if controls are instituted--over costs, utilization, and duration of service use. Because of these unknowns we suggested that Congress may want to consider implementing this program as part of a demonstration project.

HEW either concurred in our recommendations or proposed to consider them as it plans several long-term care demonstration projects. HEW currently has established a task force with representatives from the Administration on Aging, the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation to develop guidelines for establishing and evaluating methods for delivering long-term care. Beginning in FY 1980

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approximately $20 million will be committed to testing the effectiveness of assessment, case coordination, and monitoring agencies at the local level.

However, HEW has been supporting demonstration projects in long-term care for several years. Some of these were discussed in chapter 5. One example is Triage, a model project in Connecticut, which was initiated in February 1974. It was instituted to test the concept of a single-entry system for the provision of health and social services for the elderly. Triage was also designed to test the effectiveness and measure the costs of this system of delivering care to the elderly.

Although demonstration projects are intended to focus on critical questions regarding the cost-effectiveness of long-term care services, it may be that these questions cannot be answered within the confines of time-limited, small-scale experiments. As discussed in chapter 5, demonstration projects experience a number of serious difficulties which may prevent them from achieving any conclusive results regarding the effectiveness and costs of providing the chronically impaired population comprehensive assessments and a package of community long-term care services. Consequently it is possible that the only way to learn about the mix, amount and costs of the services needed by the chronically impaired population is through systemwide changes. Our recommendations offer an approach to making modest changes in the long-term care system which are designed to provide the information needed to develop a broad national long-term care policy.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

OCT 25 1976

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Nursing Home Utilization: Costly Implications for Medicaid and the Elderly." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard B. Lowe III
Acting Inspector General

Enclosure

APPENDIX II

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED, "NURSING HOME UTILIZATION: COSTLY IMPLICATIONS FOR MEDICAID AND THE ELDERLY"

Overview

Preadmission screening of nursing home applicants appears to be a promising approach for containing costs and for providing more appropriate services; however, there are a number of possible dangers in this approach. Assessment itself is expensive and may not be cost effective. Alternative services themselves may prove to be more costly for most patients than institutional services. Moreover, alternative services may not be affordable by the Medicaid population or available to them.

As a result HEW believes that it would be premature to implement broadly the recommended strategy in the report, but concurs in the suggestion that it should be tested on a demonstration basis. House and Senate conferees have agreed that $20 million will be available in the FY 1980 budget to demonstrate and study the effectiveness of assessment, case coordination and monitoring agencies at the local community level similar to those supported by GAO. Instead of giving public health departments lead responsibility for assessments, the HEW program will experiment with a variety of local agencies performing the case coordination function, e.g. local health departments, area agencies on aging, welfare departments, newly created independent community agencies, social security district offices, etc. Other factors such as the methods of financing or whether or not the coordinating agency could effectively control service dollars would be systematically tested.

HEW supports the GAO recommendation to engage in community-wide long term care demonstration projects and is proceeding to implement this recommendation.

As the report establishes, dependence on nursing home care is a social and economic problem that far transcends health concerns alone. Therefore, within HEW we are pooling resources across major functional lines, and where appropriate will reach outside HEW to address this problem. No issue is of greater interest and concern to HEW's Health Care Financing Administration (HCFA) at this time. We will be developing specific short-term (1-2 years) and long-term (3-5 years) strategies for responding to this problem. As an immediate step, we will be reviewing existing program mechanisms and provisions for encouraging appropriate service utilization. For example, we believe effective hospital discharge planning would contribute significantly to lessening the dependence on nursing home care.

The report focuses primarily on the elderly. It should recognize that younger disabled beneficiaries currently covered by Medicare or Medicaid are also a major concern. When they go into nursing homes they are there much longer than an elderly person.

(See GAO note 1.)

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The portion of the report dealing with the problems resulting from current Medicaid eligibility is substantially correct; HCFA is attempting to minimize these problems within the limits of the current law.

PSRO Review in ICFs

GAO identifies several factors which lead to the institutionalization of the elderly who have the potential and the desire to remain in the community, including:

--Medicaid eligibility and benefits policies which create financial incentives to use the institutional rather than community services;

--Barriers encountered by the elderly and their families who attempt to obtain noninstitutional long term services;

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

The report clearly presents the existing funding mechanisms and array of services; however, it does not reflect the extent of PSRO/ICF review activity. As of August 1979, 51 PSRO's have been funded to conduct LTC review, and most of these are or will be doing ICF review and preadmission certification (scope of components varies considerably between PSROs). (See GAO note 2.)
The report also does not indicate awareness of the current role of Medicaid in adult day health services. Six States (Massachusetts, California, New Jersey, New York, Georgia, and Washington) currently provide reimbursement through Medicaid for adult day health services in 90 programs; Massachusetts leads the way with 40 programs. In each State, standards for this service have been developed, with monitoring carried out by the State Medicaid agency. A recently released report presenting recommendations from a National Conference on Adult Day Care should also be referenced in the GAO report. (See GAO note 3.)

Report Methodology and Selection of Evidence

No mention was made of the growing literature on the cost effectiveness of adult day care, home health, and homemaker services for persons otherwise requiring nursing home care. A recent study of the National Center for Health Services Research, for example, casts doubt on the ability of adult day care and home health services to provide a cost effective substitute for a large segment of the nursing home chronically ill. Only the mildly functionally impaired seem to be assisted in a cost effective manner by noninstitutional services. While this study is not definitive, the issues they raise concerning service substitution should have been considered by GAO.
(See GAO note 4.)

APPENDIX II

Recommendation to the Congress

1. Establish a Preadmission Screening Program to Service Nursing Home Applicants

Department Comment

We believe that it is premature to legislate and implement this type of program until its effectiveness can be determined. Within HEW the Health Care Financing Administration (HCFA) currently has several demonstrations in progress which are designed to determine the costs and benefits of several approaches to needs assessment and care planning for long term care. Together with the Administration on Aging, HEW will implement a major initiative in FY 1980 aimed at evaluating the usefulness of this planning and service delivery approach. We would recommend the postponement of a judgment on a national "Preadmission Screening Program" until our demonstration results are available.

Recommendation to the Congress

1.A. Comprehensive needs assessments would be required for all individuals applying to nursing homes whose care would be reimbursed by Medicaid or Medicare. Assessments should also be available on a voluntary basis to all other applicants to institutions participating in Medicare and Medicaid. 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) similar to the existing Medicare home health benefit.

Department Comment

These items will be considered in the demonstration:

Although such a program may be attractive in principle, there is an implied assumption that valid assessment techniques are generally available or could be quickly generated, and would be cost effective. Before such a program could be implemented issues of developing adequately trained personnel to perform assessments and the improvement of methods and instructions need to be analyzed and adequately addressed. Most important, the basic usefulness of the method needs to be fully evaluated.

Outside the few demonstration projects by HCFA, the Administration on Aging (AoA), and the Public Health Service (PHS), there are few places with assessment teams prepared to carry out "comprehensive assessments of health and social needs." The quality and comprehensiveness of the assessments done by some of the demonstration projects as they began working in teams left something to be desired. This and discussions with leaders in the field have indicated that the vast majority of health and social service professionals have not been prepared to do this type of assessment, or to work closely as an interdisciplinary team.

In addition, assessment tools available now are far from comprehensive and need further development in the areas of social needs and resources. This will require a minimum of 2 years development and field testing before they are ready for general use.

The demonstration and research planned by HCFA should increase knowledge in this area in the next 2 years. Even if the demonstrations prove successful, the capabilities of health and social service professionals nationwide to carry out a "comprehensive needs assessment" must be determined and skills developed before such a program can be implemented.

Recommendation to the Congress

1.B. Based on these assessments, and in consultation with the elderly and their families, plans of care would be developed for all those individuals who have the desire and potential to remain in the home or community setting. These plans would identify the services needed to support in-home or community based care.

Department Comment

As indicated above, the utility of this approach should be fully assessed on a demonstration basis.

Before it can be carried out in a community, the area must develop at least a basic group of services with enough capacity to handle the increased caseload. Our demonstrations have indicated that considerable effort must be given to develop this service capacity.

Recommendation to the Congress

1.C. These essential services would be assembled, coordinated and monitored to assure continued need as part of the plans of care.

Department Comment

We concur (on a demonstration basis).

If there are teams to do needs assessment and care planning, if a broad array of services are available in the community, and if these services would be purchased by or for beneficiaries.

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Recommendation to the Congress

1.D. The actual in-home or community based services provided under the Preadmission Screening Program could be financed out of general revenues based on a Federal-State cost sharing arrangement comparable to the Medicaid program. The Program could pay for those services (other than the comprehensive needs assessment which would be reimbursed as a benefit under Medicare) which are not covered under existing programs (e.g. Medicare, Medicaid, Title XX, Older Americans Act, private insurance etc.). Cost sharing could be based on the recipient's ability to pay.

Department Comment

Since we are not yet sure whether the increased availability of community care will effectively substitute for or supplement expensive institutional care, how much inappropriate institutionalization Medicaid pays for, or the effect of expanding entitlement programs on the substitution of formal care for family-provided informal care, recommendation of a specific grant mechanism adopted on a nationwide basis should await the results of further demonstration efforts. Medicaid 1115 Waivers would be appropriate in the demonstration phase to cover capacity development for new service packages.

Recommendation to the Congress

1.E. Control over costs and utilization of services provided to individuals to remain in a community setting could be achieved by limiting reimbursement to some percent of the cost (e.g. 75%, 100%, 110%) of the appropriate level of institutional care as determined by the comprehensive needs assessment.

Department Comment

We would support building into the program incentives to control cost and utilization of services. Whether this particular method could be an effective one is questionable. Concentrating institutional care on the most needy and seriously disabled could increase the per diem cost of institutional care. Thus in the short run nursing home costs might increase as beds remain filled with sicker patients. Tieing community-based costs to rising nursing home costs might reduce the incentive for States to pick up community-based services in addition to escalating nursing home expenditures. Using this cost control mechanism with an open-ended funding mechanism might, therefore, be self-defeating in the long run.

Recommendation to the Congress

2. Assign responsibility for administering the preadmission screening program to the State and community public health departments.

To reduce avoidable nursing home admissions, the Preadmission Screening Program should provide both Medicaid and private pay applicants with the option of an affordable package of noninstitutional health and social support services. Establishing this program in an agency which is intended to serve the entire community (rather than the welfare population alone) and encompass health-related services (as well as medical services) would achieve this objective. One option would be to locate it in HEW with responsibility for its administration assigned to public health departments at the State and local level.

Department Comment

These items will be considered in the demonstration:

This recommendation might further fragment the administration of the long term health/social delivery and financing programs. Medicaid and title XX programs are primarily administered by State departments of social services (although responsibility for each program is usually delegated to different divisions within the Department), the Medicare program is administered at the Federal level, and programs mandated under the Older Americans Act are administered by the area and State agencies on aging. Adding another agency might create further administrative complexity and confusion of the public. In this context the proposed solution may contribute to the very problem it seeks to resolve. As the GAO initial recommendation for assessment programs suggests, what may be needed is consolidation of services at the point of delivery, not more governmental agencies and override.

Recommendation to the Congress

2.A. In administering the Preadmission Screening Program the public health departments should be given the option of determining the most appropriate organization in their particular community for carrying out the Program. These organizations could range from a local hospital, a nursing home, home health agency, area agency on aging, a community health center or a combination of organizations. The health departments would retain overall responsibility for ensuring that nursing home applicants receive assessments, and for those individuals who have the potential to receive long-term care services in the community, that services are planned, assembled, monitored, and evaluated.

APPENDIX II

Department Comment

These items will be considered in the demonstration:

We have the following reservations against designating prime responsibility to health departments:

1. This is much more than a health problem. The medical model for the assessment process has been correctly deemed inappropriate in the subject GAO report for purposes of successful patient placement. Traditionally, health departments have followed the medical model approach.

2. Health departments are primarily staffed by health care professionals, and the report did not indicate this was the most appropriate group to use for comprehensive patient assessment.

3. Generally speaking, health departments have relatively little involvement in coordination of community-based social or support services.

4. Health departments have had little involvement in cost containment initiatives.

GAO's reliance on evidence from small demonstration projects ignores the macro issues of the uneven development of single State agencies in different environments. Where the substitution of in-home and community-based services for institutional nursing home services may be high (service-rich urban-suburban areas), growth of such agencies may be significant. However, in rural areas where potential economies of substituting modalities may be low, comprehensive administrative structures will be slow to develop.

Recommendation to the Congress

2.B. The public health departments 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.

Assessments should be used to provide data for long range planning, specifically for identifying those services which are most critically needed in a community, as well as monitoring the level of avoidable placement and costs incurred because these services were not available.

Data from assessments should also be used to assess the impact of different services and costs on clients by different levels of function, for evaluating the effectiveness of alternative long term care programs, and for developing a more reliable basis for projecting nursing home bed needs.

Department Comment

We concur in part.

While, as previously stated, we do not agree with the role proposed for public health departments, we certainly agree that information generated by any assessment program should be provided to the Health Systems Agency.

Recommendation to the Congress

> Congress may want to consider implementing this approach as a community-wide long term demonstration project in several cities to obtain more concrete information on costs, people who could be served, services utilization, and total system effects.

Department Comments

We concur.

The report acknowledges the lack of available data on potential need for and cost of alternative care sources and points to comprehensive assessment as a tool to obtain the necessary information. This underscores the need for using the demonstration approach to test the validity of assessments as a permanent operational alternative. Subsequent evaluation of the cost effectiveness of these demonstrations would serve as a guide in the development of specific legislative initiatives.

We would also suggest removing the emphasis on cities since the availability and appropriateness of alternate services in rural areas should also be tested.

(See GAO note 5.)

APPENDIX II

GAO NOTES

1. The report focuses on the elderly because the subject of the report--nursing home admissions and utilization--predominantly affects the elderly. Eighty-six percent of all nursing home residents on a given day are 65 or older. This extensive use and accompanying risk of institutionalization for the elderly are discussed in chapter 1, pp. 5-7. The use of nursing home services by younger disabled beneficiaries is also of concern. For many of these individuals our findings and recommendations (e.g., preadmission assessment and screening) would also be appropriate. However, many younger individuals--who are physically disabled, mentally ill or retarded--also have very special requirements which are different from individuals 65 or older. They often need for example, vocational rehabilitation, employment and educational services. The reasons for admitting younger individuals to nursing homes and the problems in supporting them in community living may also be different. These issues were beyond the scope of the report and could more appropriately be addressed in a separate analysis.

2. The expansion in PSRO/ICF review activity has been noted. See pp. 99-100.

3. Information on Medicaid adult day health services has been incorporated. See pp. 19, 20 and 56.

4. We specifically addressed the question of whether long-term care "alternatives"--adult day care, home health, homemaker and other services--are used as substitutes for nursing home care or as add-on services in chapter 5 (see pp. 121-123). We extensively reviewed the literature on long-term care research and demonstration projects to determine whether these projects served individuals at risk of institutionalization, what types of services were provided, how much these services cost, and how these costs compared to nursing home care. This review included the National Center for Health Services Research study of adult day care and home health services (funded under Section 222 of P. L. 92-603). To summarize our chapter 5 discussion, we found that the research has produced equivocal results to date because of several serious weaknesses including: poor research design, the failure to target services on those individuals at high risk of institutionalization, and the failure to provide a comprehensive range of services.

Long-term care experience and research to date do not provide an adequate basis for determining the cost-effectiveness and substitutability of various services. Some research, such as the evaluation of the 222 projects, suggests that only the mildly functionally impaired are assisted in a cost-effective manner in community-based care arrangements. On the other hand, other research indicates that noninstitutional long-term care services can be delivered cost-effectively. For example, an SRI International study funded by HEW compared eight alternative long-term care projects to traditional nursing homes and concluded that the most cost-effective settings are the ones that are noninstitutionally based. (Feasibility and Cost-Effectiveness of Alternative Long-Term Care Settings, SRI Project URU-3567, May 1978, Menlo Park, California.)

The cost-effectiveness of various long-term care services is extremely difficult to assess because:

--Evaluators may end up comparing costly and high quality community services provided by the demonstration project to low quality care in a nursing home. In some cases, the community care costs include expensive health care services while there is no assurance that nursing home residents receive this care. Furthermore, the cost of nursing home care is kept artificially low in some areas by State Medicaid reimbursement rates.

--The mix and amount of long-term care services needed by individuals with different levels of impairment and varying family supports are currently unknown. Consequently, there may be a tendency to over-serve individuals in long-term care demonstration projects.

--The cost issue varies for public and private pay patients. For example, is it less costly to supplement the personal resources of private pay patients in the community or provide extensive Medicaid support in the nursing home after they have depleted their resources? The question of how to measure and compare public and private costs has not been resolved.

--Some benefits of long-term care services, such as a reduction in deaths or improvements in quality of life, are difficult or impossible to measure in comparing alternative care settings.

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--Intermittent community care may be more costly over short periods than nursing home care but less costly in the long run.

Because of the uncertainty surrounding the issue of whether community-based long-term care services can provide a cost-effective alternative to nursing home care, we carefully tailored our recommendations to control costs while experience is gained in providing the chronically impaired elderly a number of long-term care options. Specifically, we recommended that:

--services be targeted to the population most at risk of institutionalization by intervening in the nursing home admissions process to offer community options when appropriate,

--services be provided to an individual based on a comprehensive assessment of needs rather than on income criteria and reimbursement policies alone,

--some type of cap be placed on the costs of the alternative services which can be provided to a potential nursing home candidate, and

--data be collected to assess the impact of various services on clients with different functioning levels and the costs of these services.

5. "Cities" was inadvertently substituted for areas (which would include both rural and urban communities); see p. 164.

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*U.S. GOVERNMENT PRINTING OFFICE: 1979 620-386/367 1-3

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