# Overview

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People who require long-term care (LTC) are a subset of a much larger population of individuals with disabilities. The number of individuals with disabling chronic conditions is growing, while the composition of this group is changing. At the same time, the LTC service system is evolving in response to the different service needs of subpopulations, technological advances, and the preferences of those with disabilities and their families.

There are both important similarities and differences in the service delivery and financing issues we face in supporting LTC for various subgroups of the disabled. So as to foster a more integrated approach that can inform both the current policy debate and our future research and demonstrations agenda, we have compiled this issue of the *Review*, entitled "Long-Term Care: Emerging Trends." The articles in this issue highlight information from recent work exploring many of the issues previously mentioned.

An introductory article by Vladeck, Miller, and Clauser describes the LTC population and highlights aspects of service delivery systems that are evolving in response to the changing LTC population. This introduction is followed by a discussion of cross-cutting issues related to the organization of service delivery, quality assurance (QA), and financing. Current and future research and demonstrations emerging from these issues are then described.

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Articles by Dubay and Kenney address questions of access to care, focusing on post-acute care. Post-acute care occupies a position between acute care and LTC; its development is attributed in part to the Medicare prospective payment system (PPS), which created incentives for hospitals to shift care from the hospital setting to other types of post-hospital care, including nursing facilities, inpatient rehabilitation hospitals, and home health agencies. Both articles compare access to post-acute care between urban and rural beneficiaries; Dubay focuses on skilled nursing facility use in 1987, whereas Kenney explores home health use from 1983 to 1987. These two articles highlight concerns about access to post-acute care services and whether access is more limited in rural, relative to urban, settings.

Most LTC is provided informally by family and friends. While there has been a strong institutional bias for formal (paid) LTC, there has been increasing growth in a wide range of home and community-based services and residential options. In light of the economic constraints on public financing of these services, attention has turned to methods to better target services to those at greatest risk of institutionalization, as well as financing and delivery systems that integrate acute care and LTC and provide incentives to constrain health care costs. Jackson, Eichorn, Sokoloff, and VanTassel demonstrate a method to evaluate the predictive validity of pre-admission screens, used to make determinations of both nursing

home admissions and eligibility for community-based care. The utility of screening criteria to identify those most in need of services has focused largely on the elderly; it is important to continue work in this area, given the chronic care needs of the elderly and the extent to which their use dominates public LTC dollars. At the same time, it is important to consider whether pre-admission screening or other techniques are more suited to targeting services to those in greatest need in other subpopulations of the disabled.

Several articles address service system issues for individuals requiring LTC. Medicare home health has experienced tremendous growth in recent years. The Medicare home health benefit has undergone changes in eligibility and coverage policy, while home health as an industry has been strongly impacted by the emergence of post-acute care as a service modality. These changes in both the benefit and the industry make it difficult to attribute the growth to specific factors. Further, some have questioned whether Medicare home health is moving toward serving individuals with chronic care needs in addition to those with acute care needs, hence transforming it, in part, to an LTC service and further affecting growth rates. Branch, Goldberg, Cheh, and Williams provide descriptive information on Medicare home health users in 1986, including demographic characteristics of home health users, their episode lengths, and mix of home health care service use. This article provides an important baseline description against which to compare the current home health user, given these changes in the environment.

Continuing care retirement communities (CCRCs) are a relatively new service entity that typically combine housing and meals with a mix of skilled nursing and maintenance-oriented LTC services. Ruchlin, Morris, and Morris explore how medical service utilization by CCRC residents differs from elderly patterns in more traditional settings, both for a specific year and in the last year of life. Of interest is the ongoing question of whether different service structures can foster downward substitution of skilled to non-skilled services and whether such substitution reduces expenditures. Although such patterns have been studied at length for the elderly disabled, individual and family preferences for home and community-based care continue to compel us to assess whether community-based services can be provided more cost-effectively for the elderly.

Policy interest in managed care settings is pronounced. Of concern is whether managed care programs can meet the entire continuum of acute care and LTC needs of persons with disabling chronic conditions. Traditional health maintenance organizations (HMOs) that participate in public and private programs typically limit coverage of acute care benefits and do not provide the full array of LTC benefits required to support persons with disabling conditions in the community. Moscovice, Lurie, Christianson, Finch, Popkin, and Akhtar examine the impact of HMO-based managed care on access to and use of physical and mental health services and chemical dependency services by Medicaid recipients with chronic mental illness. Unlike previous studies, their analysis of service use in the Minneapolis area HMOs found slight improvements in most measures of access and no significant decreases in service utilization for those with chronic mental illness. Whether these findings

would be sustained during a longer time period (these researchers studied a 9-month period) or would be found in another HMO market (providers in the Twin Cities market have considerable experience in providing services in prepaid settings under competitive market constraints) is of interest as we continue to assess whether managed care settings can appropriately meet the range of medical and social needs of individuals with chronic disabilities.

Efforts to foster integration of acute and LTC services continue in demonstration projects for both the elderly and non-elderly disabled. These include ongoing initiatives such as On Lok Senior Health Services and its replication, the Program of All-inclusive Care for the Elderly (PACE), as well as developing initiatives such as the Pew Charitable Trust and Robert Wood Johnson Foundation-sponsored Medicaid Working Group, and several State-based initiatives, including Minnesota's Long-Term Care Options and Rhode Island's Aging 2000. Attention in these various initiatives to better integrate care has focused primarily on service system and financing issues.

Unexplored areas include the question of QA and the form that a QA program might take in more integrated settings. Kane and Blewett describe the development of a QA approach for the PACE model, which provides comprehensive acute and LTC medical and social services to the frail elderly in a managed care setting. Of particular interest is the extent to which their approach can be applied to other integrated systems for the elderly disabled, as described in the current article, as well as modified for use in integrated settings providing acute and chronic care services for diverse non-elderly disabled populations.

The final set of articles are concerned with payment, eligibility, and financing issues in LTC. Swan, Harrington, Grant, Luehrs, and Preston present data on trends in State Medicaid nursing home reimbursement methods, ratesetting methods, and per diem rates for a 12-year period through 1989, then discuss the potential impact of these trends on concerns such as access to care for patients with greater care needs. In a similar fashion, we need to begin to monitor the impact of payment mechanisms on access to and use of services by the non-elderly disabled.

Cohen, Kumar, and Wallack explore the impact of changing the asset limit under the Medicaid program, so as to allow individuals to retain more of their assets yet meet Medicaid eligibility criteria to receive LTC. Their simulations suggest that asset limits could be increased to offer some protection to the elderly yet not impose what they view as an undue burden on the Medicaid program. It is important to consider how these changes would affect both the effort to encourage development of private LTC insurance and the current concern that the non-poor face incentives to divest their assets so as to meet Medicaid financial eligibility criteria.

As previously discussed, LTC services are currently financed by public dollars (primarily Medicaid) but also are financed heavily by private dollars; only 1 to 2 percent of LTC costs are financed through private insurance. Interest has been expressed in either expanding eligibility for Medicaid-financed services through

mechanisms such as changes in the treatment of assets as described by Cohen, Kumar, and Wallack, or in encouraging the development of private LTC insurance. A third approach would be to alter financing of LTC to a fully publicly financed program, as is currently found in Canada. One fear in moving to a publicly financed program is that of the unknown cost of the program over time. Miller analyzes public LTC financing in two Canadian provinces so as to address how well these programs were able to contain LTC service use and expenditures throughout the 1980s.