

# About Long Term Care

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## What Is Long Term Care?

When a person requires someone else to help him with his physical or emotional needs over an extended period of time, this is long-term care. This help may be required for many of the activities or needs that healthy, active people take for granted and may include such things as:

- Walking
- Bathing
- Dressing
- Using the bathroom
- Helping with incontinence
- Managing Pain
- Preventing unsafe behavior
- Preventing wandering
- Providing comfort and assurance
- Providing physical or occupational therapy
- Attending to medical needs
- Counseling
- Feeding
- Answering the phone
- Meeting doctors' appointments
- Providing meals
- Maintaining the household
- Shopping and running errands
- Providing transportation
- Administering medications
- Managing money
- Paying bills
- Doing the laundry
- Attending to personal hygiene
- Helping with personal grooming
- Writing letters or notes
- Making repairs to the home
- Maintaining a yard
- Removing snow

The need for long-term care help might be due to a terminal condition, disability, illness, injury or the infirmity of old age. **Estimates by experts are that at least 60% of all individuals will need extended help in one or more of the areas above during their lifetime.** The need for long-term care may only last for a few weeks or months or it may go on for years. It all depends on the underlying reasons for needing care.

Temporary long term care (need for care for only weeks or months)

- Rehabilitation from a hospital stay
- Recovery from illness
- Recovery from injury
- Recovery from surgery
- Terminal medical condition

Ongoing long term care (need for care for many months or years)

- Chronic medical conditions
- Chronic severe pain
- Permanent disabilities
- Dementia
- Ongoing need for help with activities of daily living
- Need for supervision

Long-term care services may be provided in any of the following settings:

- In the home of the recipient
- In the home of a family member or friend of the recipient
- At an adult day services location
- In an assisted living facility or board-and-care home
- In a hospice facility
- In a nursing home

## Custodial Care versus Skilled Care

Custodial care and skilled care are terms used by the medical community and health care plans such as health insurance plans, Medicare, Medicaid and the Veterans Administration. They are used primarily to differentiate care provided by medical specialists as opposed to care provided by aides, volunteers, family or friends. The use of these terms and their application is important in determining whether a health care plan will pay for services or not. Generally, skilled services are paid for by a health care plan and custodial services, not in conjunction with skilled care, are not covered.

***However, custodial services are almost always a part of a skilled service plan of care and by being included, custodial services are paid by the health care plan as well. Many people have the misconception that only skilled services are covered. This is simply not true.***

**According to the American College of Medical Quality:**

*" Skilled care is the provision of services and supplies that can be given only by or under the supervision of skilled or licensed medical personnel. Skilled care is medically necessary when provided to improve the quality of health care of patients or to maintain or slow the decompensation of a patient's condition, including palliative treatment. Skilled care is prescribed for settings that have the capability to deliver such services safely and effectively.*

*Custodial care is the provision of services and supplies that can be given safely and reasonably by individuals who are neither skilled nor licensed*

*medical personnel. The medical necessity and desired results of skilled care must be clearly documented by a written treatment plan approved by a physician. A patient may have skilled and custodial needs at the same time. In these circumstances, only those services and supplies provided in connection with the skilled care are to be considered as such. The treatment plan must include:*

- *The applied therapies;*
- *The frequency of the treatment which is consistent with the therapeutic goals;*
- *The potential for a patient's restoration within a predictable period of time, if applicable;*
- *The time frame in which the prescribing physician will review the case for the purpose of evaluating a patient's status and before reassessing the medical necessity of ongoing treatment; or*
- *The maintenance, palliative relief, or the slowing of decompensation in a patient's status, if applicable.*

*Determinations of the medical necessity of skilled care must be based on the applicable standard of care."*

Writers and advisers who are not part of the medical community often confuse custodial care and skilled care with specific care activities. For example help with the activities of daily living and many of the items on the list in the previous section are care activities thought to be by definition custodial care. Whereas the monitoring of vital signs, ordering medical tests, diagnosing medical problems, administering of intravenous injections, prescribing and dispensing medicine, drawing blood, giving shots, dressing wounds, providing therapy and counseling are all activities normally associated with skilled care. **But many non-medical advisers and writers don't know that skilled and custodial refer to the people who deliver the care not the actual care given.**

A skilled care provider can also provide services normally thought to be provided by custodial caregivers. Such things as help with activities of daily living and so-called instrumental activities of daily living are often furnished by skilled providers in the course of their treatment. Or a skilled care plan may call for services that can be delivered by a custodial caregiver but it would still be under the skilled plan of care for that individual. On the other hand people who deliver custodial services may from time to time perform those activities supposedly reserved for skilled providers. Such things as taking blood pressure, administering medicines, giving shots or changing wounds might be provided under certain circumstances by a custodial provider.

**Please remember that the terms skilled and custodial do not refer to specific types of long-term care services but rather who delivers those services.** Also the delivery of skilled services must be done under a written plan of care which often includes custodial care services.

#### **Does Medicare Cover Custodial Care?**

Of course it does. Medicare routinely pays for custodial care in every skilled care setting for which it provides payment. Medicare will not pay for custodial care in the absence of a skilled care plan.

#### *Medicare covered nursing home stay*

A patient receiving skilled care in a nursing home from Medicare not only receives care from skilled providers such as nurses, therapists or doctors but also receives care from custodial providers such as aides or CNA's. This care usually consists of help with

bathing, dressing, ambulating , toileting, incontinence, feeding and medicating. Medicare does not exclude the custodial services but pays the entire bill because custodial care is a necessary part of the skilled care plan in a nursing home.

#### *Medicare covered home care*

Custodial care is always a part of a skilled care plan for home care. The patient receives skilled care from a nurse or therapist and custodial care from an aide for help with bathing, dressing, ambulating , toileting, incontinence, medicating and possibly feeding. Medicare pays for both types of services.

#### *Medicare hospice care*

The hospice team consists of a doctor, a nurse, a social worker, a therapist when needed, a counselor and an aide to provide custodial care. Help with activities of daily living is provided at home or in a Medicare approved hospice facility. Custodial care is always a part of a hospice plan of care and Medicare routinely pays for these services.

Please note that there is no such thing as a custodial nursing home. All nursing homes are by definition skilled care facilities because they have nurses who are skilled care providers. Also be aware that not all states license intermediate care facilities which might provide less than 24 hour registered nursing care. "Skilled care patients" in nursing homes are referred to as such because they are receiving payment from Medicare or sometimes payment from private health insurance plans. Practically all nursing home residents have medical needs but Medicare and other insurance plans will only pay for patients that have certain acute medical needs where recovery is anticipated. Patients with chronic medical problems are typically not covered by Medicare but would be covered by Medicaid.

The confusion with understanding the term "skilled nursing care" probably comes from Medicare itself. To be a certified Medicare nursing home and receive payments from Medicare a nursing home must meet the Medicare definition of a "skilled nursing facility". This means there must be registered nurses on duty 24 hours a day, there must be a doctor on call at all times and there must be ambulance service to a local hospital. Medicare may also require additional staffing and facility arrangements to receive certification. It is unfortunate that the word "skilled" is used in this definition. All nursing homes whether they meet the definition of a "skilled nursing facility" or not provide services from a nurse, doctor or therapist and this meets the medical definition of skilled care. Many states have adopted the same federal criteria for licensing their nursing homes. In some states the "skilled" definition is the only option for a nursing home. But in some states facilities with lesser services can receive different licensing classes. These might be called intermediate care facilities or "small nursing homes".

## **Formal Care versus Informal Care**

### **Formal Caregivers**

Formal caregivers are volunteers or paid care providers associated with a service system. Service systems might include for-profit or nonprofit nursing homes, intermediate care facilities, assisted living, home care agencies, community services, hospice, church or charity service groups, adult day care, senior centers, association services, state aging services and so on. More detail on the services, availability and costs of nursing homes, assisted living facilities and home care agencies are provided in other sections of this article.

During 1998, in the U.S. , 9.5 million patients were served by home health agencies and 576,000 by hospice care. This care was provided by approximately 13,000 agencies, nationwide. The percent distribution of disorders requiring home care were: diseases of circulatory system–25.2%, injuries and poisoning–9.9%, muscle and skeletal disease–8.8%, respiratory–8.4%, cancer–7.3%, endocrine, nutrition, metabolic, immune–5.4%, nervous system– 4.3%, others–balance of distribution. Of the patients served by hospice, about 76% had cancer or heart disease.

In 1997, there were about 17,000 skilled and intermediate term nursing homes in the US serving 1,609,000 residents. About 1,465,000, or 91% of residents, were age 65 and older. Out of those 1.5 million elderly patients in nursing homes in 1997, as a percent of the total, help was provided with 1 or more activities in the following categories: bathing or showering–96.2%, dressing–87.2%, using toilet room–56.2%, eating--45%, transferring to chair or bed–25.4%.

As of the year 2000, an estimate by NatWest Securities places the total number of assisted living beds nationwide at 1,387,836 beds with total revenue of \$33.1 billion.

Some ALFs have found a niche in providing care to Alzheimer's patients and many ALFs are exclusively dedicated only to Alzheimer's residents. This disorder requires constant supervision but not necessarily from the more costly skilled medical staff found in nursing homes. And since at least 5% of those over 65 and 46% of those over 85 suffer from mental impairment, this provides a potentially large market for ALF Alzheimer's facilities

Not all residents of ALFs need care or assistance. Many are there because they want a simpler lifestyle without the worry of maintaining a home and they seek the companionship of other people their own age. They have chosen assisted living because they may need some minor help with IADLs but they anticipate a time when they may need the more intensive care available with an ALF.

As of 1996, ALF residents who were independent with ADLs (needing no assistance) were as follows: eating--88%, transferring--84%, toileting--78%, dressing--58%, bathing--49%. A recent survey of assisted living administrators estimated that 24% of their residents received assistance with 3 or more activities of daily living, such as bathing dressing and mobility. They estimated that about one-third of residents had moderate to severe cognitive impairment.

### **Informal Caregivers**

Informal caregivers are family, friends, neighbors or church members who provide unpaid care out of love, respect, obligation or friendship to a disabled person. These people far outnumber formal caregivers and without them, this country would have a difficult time providing funding for the caregiving needs of a growing number of disabled recipients.

Depending on the definition of caregiving, estimates of the number of informal caregivers range from 20 million to 50 million people. This could represent about 20% of the total population providing part-time or full-time care for loved ones.

The typical caregiver is a daughter, age 46, with a full-time job, providing an average of 18 hours per week to one or more of her parents.

Among adults aged 20 to 75, providing informal care to a family or friend of any age, 38% care for aging parents and 11% care for their spouse. About two-thirds of those

caregivers for people over age 50 are employed full-time or part-time and two-thirds of those—about 45% of working caregivers—report having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities.

A recent study estimates these people lose about \$660,000 in wage wealth over their lifetime because of work sacrifices. And estimates of productivity losses to businesses because of time off for caregiving range from \$11 billion to \$29 billion yearly. The average amount of time informal caregivers provide assistance is 4.5 years but 20% will provide care for 5 years or longer.

## Understanding Who Is Receiving Care and For What Reason

The following was taken from a presentation for the congressional hearing below:

*Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on long term care. **The hearing will take place on Tuesday, April 19, 2005, in the main Committee hearing room, 1100 Longworth House Office Building , beginning at 4:30 p.m.***

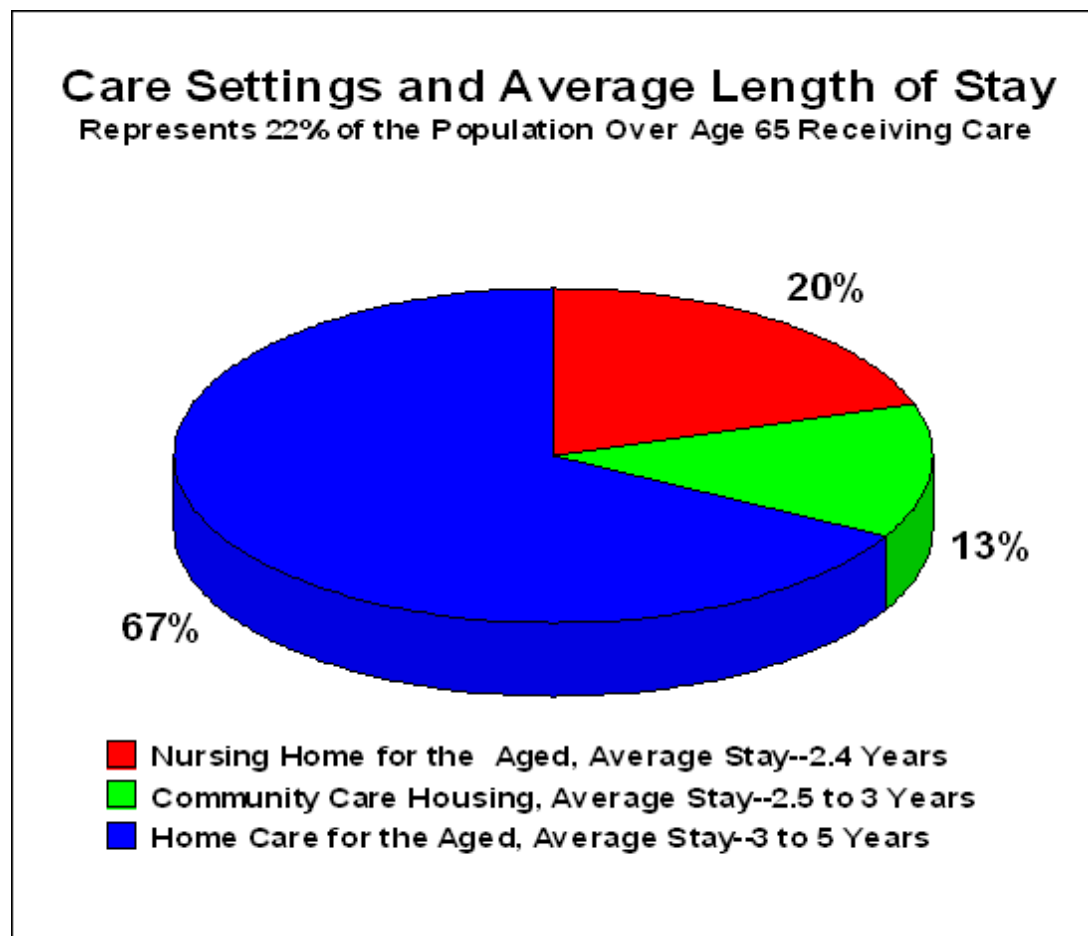
*"As our society ages, the question of how we finance long term care services will become even more pressing. About 9 million adults currently receive long term care assistance, either in community settings or in nursing homes. Over 80 percent of those adults reside in the community, not in institutions. Among those 85 and older, about 55 percent require long term care assistance. Nearly 60 percent of elderly persons receiving long term care assistance rely exclusively on unpaid caregivers, primarily children and spouses. Only 7 percent of the elderly rely exclusively on paid services".*

The chart below indicates that **as much as 22% of the population over age 65 could be receiving long-term care services**. It should be noted however, that much of this care can be provided by an informal caregiver. That still may not be an easy task. **About 61% of informal caregivers report providing at least 20 hours or more a week of care, and 27% provide more than 50 hours a week of care.** At least 7% or more of the aging population is receiving care from formal caregivers in assisted living or in a nursing home. In addition, with the current proliferation of non-medical, paid home care services, probably a high percentage of those receiving care in the home are paying for the fulltime or occasional services of a formal caregiver.

<b>Estimating The Number And Percentage Of Elderly Receiving Long Term Care</b>			
<i>Living arrangement for care recipients over age 65</i>	<i>Estimated number of long term care recipients over 65 (in millions)</i>	<i>% of total care recipients over age 65</i>	<i>% of the total population over age 65</i>
<b>Nursing Home for the Aged</b>	1.62	20.00%	4.40%
<b>Community Housing With Care</b>	1.05	13.00%	2.90%
<b>Home Care for the Aged</b>	5.40	66.90%	14.70%
<b>Totals</b>	<b>8.07</b>	<b>100.00%</b>	<b>22.00%</b>
<b>Age 65 And Older</b>			

<b>Population</b>  (2005 Estimate: Census Bureau)	<b>36.7</b>	
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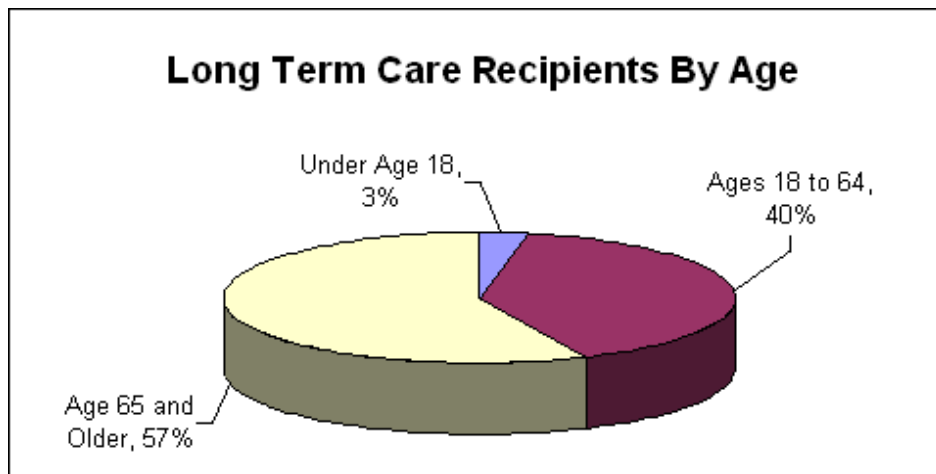
Explanation of the data: The literature is replete with estimates of adults receiving care in nursing homes ranging from 15% to 25% of the total. We have chosen a figure of 20%. In 1999, according to the CDC nursing home survey, 1.47 million elderly were residing in nursing homes. Since the number of elderly nursing home residents has only been increasing slightly over the last 6 years, we used a 10% increase for 2005 arriving at the figure of 1.62 million who are elderly nursing home residents. Using this number we have extrapolated the number of elderly receiving care in the community. To determine the number of elderly receiving care in community housing with care we looked at estimates from assisted living organizations varying from 1.0 million residents to 2.0 million residents. The reason for such a wide range is that many community care housing arrangements are in single owner homes where the owners are providing care for fewer than five people. Most of these small care providers don't advertise and there is some concern they don't license. It is therefore difficult to track the number of people receiving community care but not living in their own homes or in the homes of family members. We chose a number halfway between the two at 1.5 million residents receiving community care. But the national long-term care survey in 1999 indicated only about 70% of residents living in community housing with care are actually receiving care services. Thus the number of 1.05 million residents. All other numbers and percentages were extrapolated from actual census data and from the numbers already mentioned. Since a large number of care recipients are under the age of 65 we don't come up with as many people receiving long-term care as indicated in the excerpt from the house committee report above.



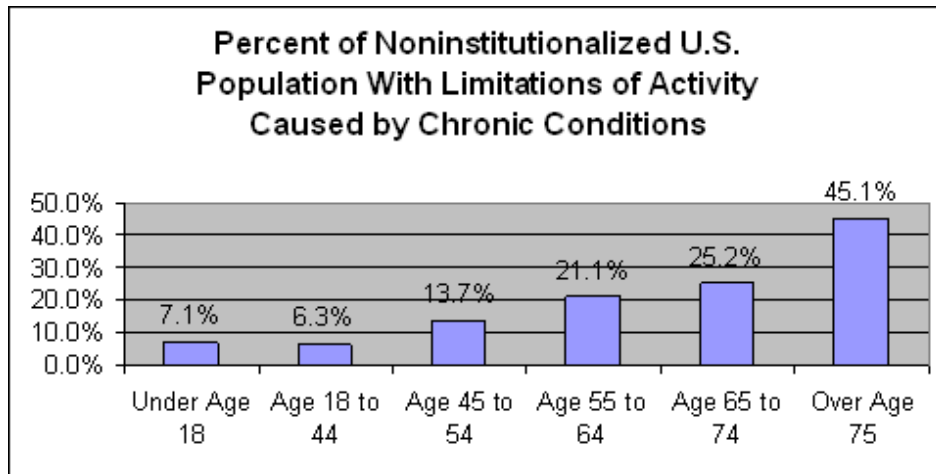
The data for the chart below were taken from an AARP research article and represent the year 1995. It should be noted that long-term care-recipients below the age of 65 are not typically part of the workforce or ever were. For the most part these are people who were born with developmental disabilities or mental retardation or developed these conditions early in life. They are healthy otherwise and may live a normal life span which could be scores and scores of years. Most long-term care-recipients over the age of 65 were healthy and functioning prior to developing a need for care. For these people the need for care seldom lasts longer than three to five years after which many will die. Since care-recipients under age 65 may live six to ten times longer than the elderly care-recipients, the younger folks tend to accumulate in numbers and skew the statistics. This often leads to misinterpretation of data describing the age populations receiving care.

If statistics were available comparing the number of people needing long-term care for the first time in any given year, the incidence rate for the elderly population would be significantly higher than that for the younger population.

It should also be noted that the younger care-recipients are typically covered by Medicaid and receive payments from SSI. They don't struggle with the same lack of funding issues as the older generation. The reason for a low percentage reporting under age eighteen is because reporting methods for long-term care don't apply to this younger age group.

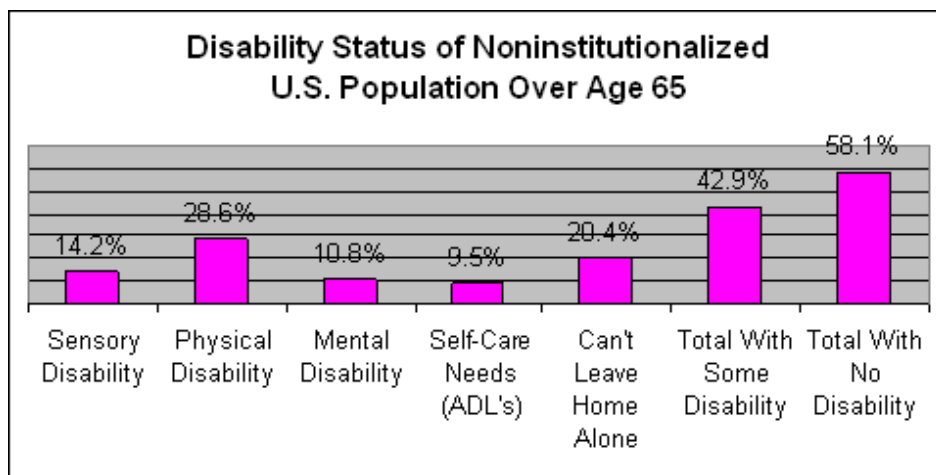


The chart below reveals significant proportions of the population under age 65 may need physical or emotional help from other people. But, as has already been pointed out above, there are some in the population who have developmental disability or mental retardation and this may explain the high number of disabled under age 65. Of particular interest is the fact that close to half of the population over age 75 is disabled. Since more and more people are surviving to age 75 and beyond we can only expect an increased demand for long-term care services in coming years.



Source: 2005 Statistical Abstract Of The United States , Health And Nutrition

The chart below shows a general classification of the types of disabilities people age 65 and older are dealing with. Note the large number of elderly who are afraid to leave their homes by themselves. About one in five elderly can't leave home alone.

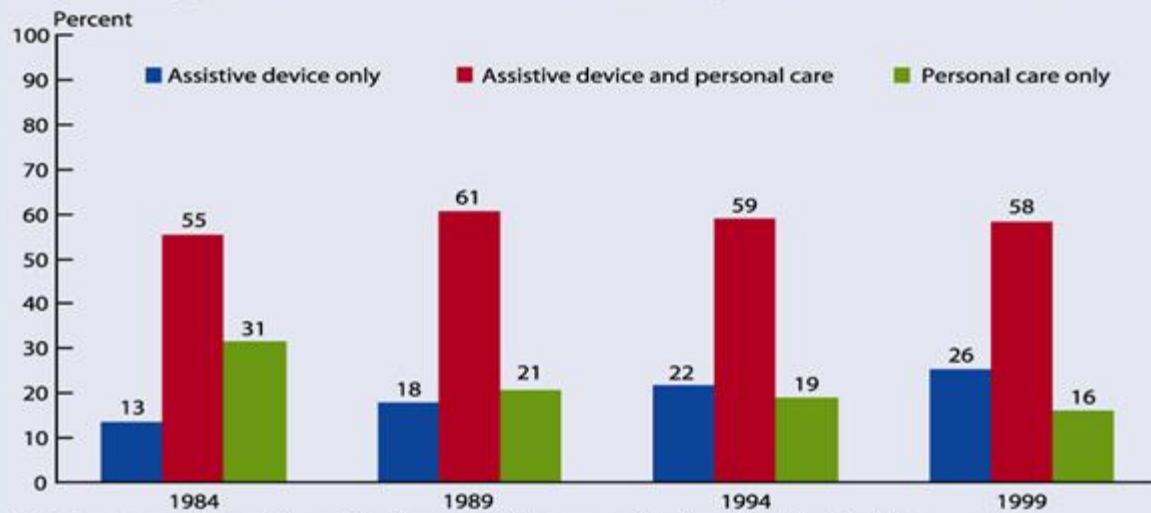


Source: 2005 Statistical Abstract Of The United States , Health And Nutrition

**The 2 following charts were taken from a presentation for the congressional hearing cited below:**

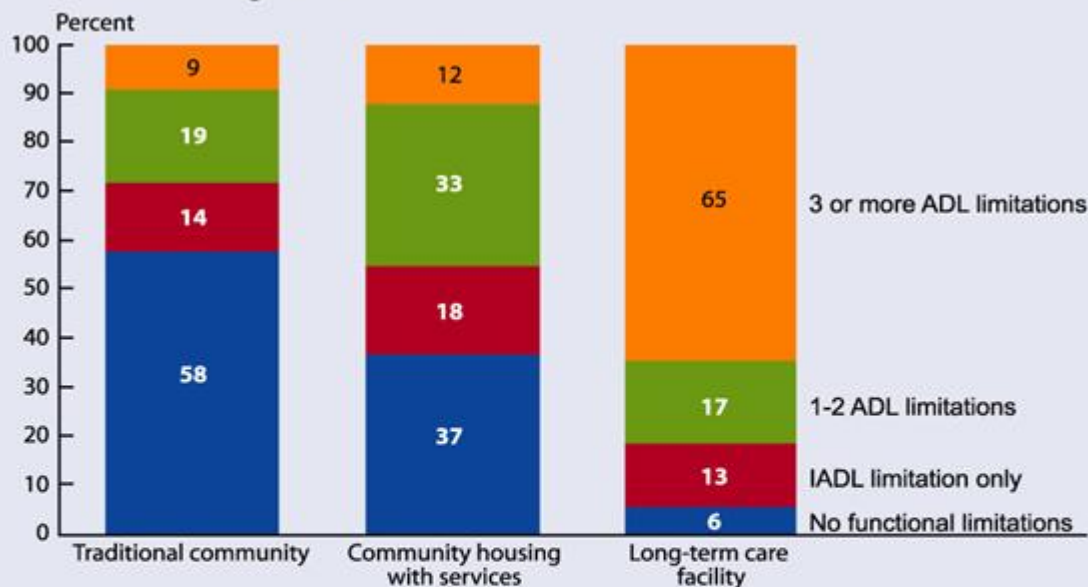
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### Distribution of Medicare enrollees age 65 and over using assistive devices and/or receiving personal care for a chronic disability, 1984, 1989, 1994, and 1999



Note: Personal care refers to paid or unpaid assistance provided to a person with a chronic disability living in the community. Reference population: These data refer to Medicare enrollees living in the community who report receiving personal care from a paid or unpaid helper, or using assistive devices, or both, for a chronic disability. Source: National Long Term Care Survey.

### Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2002



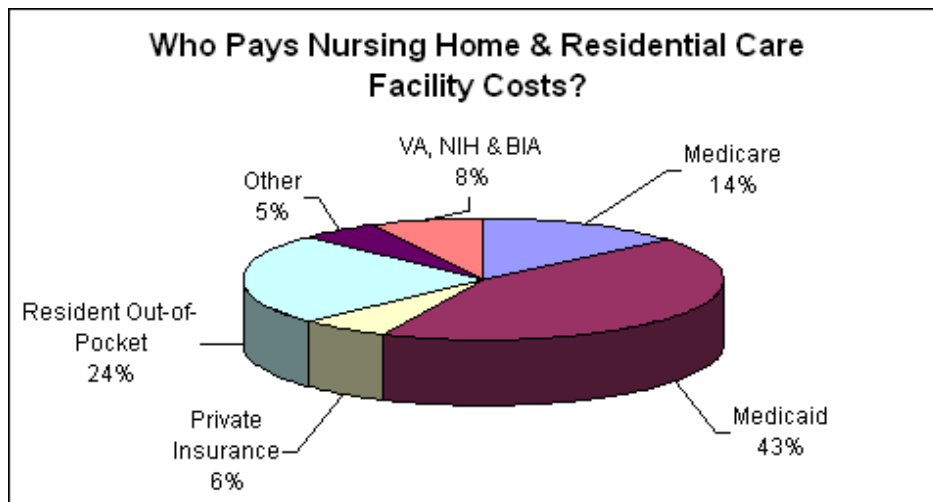
Note: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and other similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, help with medications. Respondents were asked about access to these services but not whether they actually used the services. A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds and is licensed as a nursing home or other long-term care facility and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. IADL limitations refer to difficulty performing (or inability to perform, for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, managing money. ADL limitations refer to difficulty performing (or inability to perform, for a health reason) the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, using the toilet. Long-term care facility residents with no limitations may include individuals with limitations in certain IADLs: doing light or heavy housework or meal preparation. These questions were not asked of facility residents. Reference population: These data refer to Medicare enrollees. Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

## Who Provides It and Who Pays?

The following was taken from the same presentation from the congressional hearing cited earlier:

*"In 2004, according to CBO, approximately \$135 billion was spent on long term care for the elderly. Sixty percent of this amount was financed through Medicaid and Medicare, one third through out-of-pocket payments, and the remainder by other programs and private insurance. This funding excludes the significant resources devoted to long term care by informal caregivers (primarily spouses and children). The CBO estimates that informal care is the largest single component of long term care".*

Estimates of the equivalent cost of informal care provided by family or friends run as high as \$300 billion or more a year. If the Federal government were providing this care instead of unpaid caregivers, the combination of funds already expended and the potential costs would be the third largest single budget item exceeded only by Social Security and defense spending.



Source: 2005 Statistical Abstract Of The United States , Health And Nutrition

The chart below was taken from the same presentation from the congressional hearing cited earlier:

The chart below tracks all categories of health care costs for the elderly. There are four categories that pertain to long-term care services.

**The first of these bars is titled "hospice"**. Hospice care is paid exclusively 100% by Medicare. This typically covers an hour or less a day for palliative care for a terminal condition. Additional hospice coverage could be covered out of pocket or by long-term care insurance if a caregiver chose to do this.

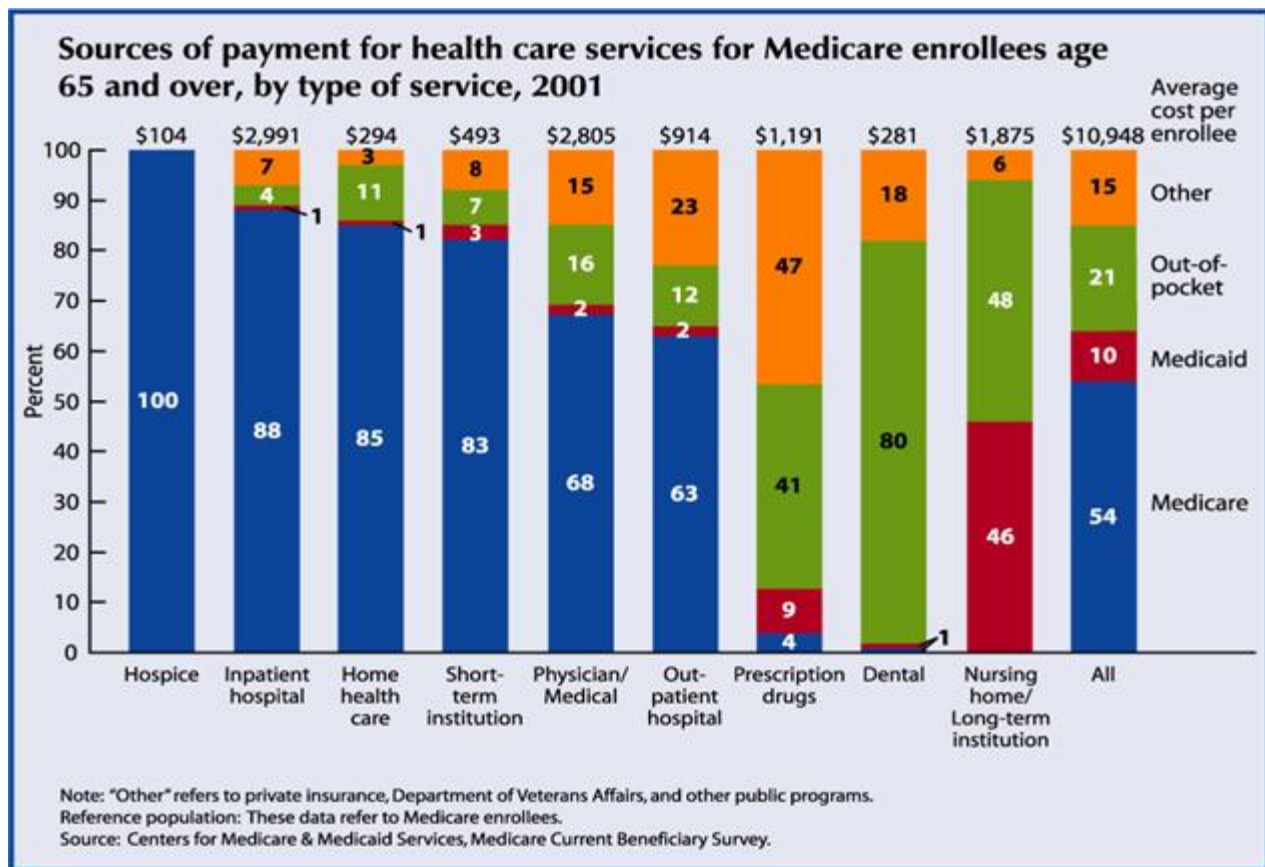
**The second category is called "home healthcare"**. This is the kind of care covered on a temporary basis and under prescription from a doctor and normally paid by Medicare. Of note is the fact that 15% of this care is not covered by Medicare. The other costs may be covered by the veterans administration, the national institutes of health,

the bureau of Indian affairs or private insurance. This care is provided by companies called Home Health Agencies. These companies provide the skilled and custodial care as part of a plan of care prescribed by the doctor and limited to a certain period of time (money is usually provided for a 60 day period).

In the last ten years we have seen an astounding growth of companies providing non-medical home care which is not typically covered by government programs but must be paid directly by the family. Costs are also covered if the recipient has long-term care insurance. Many home health agencies are also offering this care as a separate service. There is no plan of care unless these services are sub-contacted under a plan of care by a hospice or home health agency which is sometimes the case. In some states Medicaid will also pay for this kind of care under certain conditions. There is also no limitation on how long Medicaid services can be offered. The data for these services are not represented in the chart below.

**The third category is entitled "short term institution".** This is a misleading title that refers to Medicare nursing home coverage after a three day hospital stay. Note that not all of this care is covered by Medicare. This is because a short term nursing home stay may not have met the three day rule, or did not originate from a hospital or require skilled care, which are all prerequisites for Medicare to pay. The services may also have been covered by other government agencies such as the VA, the bureau of Indian affairs, private insurance or Medicaid.

**The fourth category is "nursing home/long-term institution".** Note the reversal of who pays the bill. In this case it is shared by the family and Medicaid. The other" category might include payments by the veterans administration and the bureau of Indian affairs or private insurance. Many of those paying out of pocket are going through a spend-down process to deplete their assets in order to qualify for Medicaid.



## How Reliable Are National Cost Surveys?

### Nursing Home Phone Sample, Cost Surveys

We recently completed a survey of the cost of all nursing home beds in our state. We then calculated the average cost and the median cost on a weight adjusted basis of the number of beds in a given cost category. Our average cost was significantly and statistically less than a national sample survey for our state in the same year. Our median cost (the halfway point cost of all beds more costly equal to the same number of beds less costly) was significantly less than our average cost and the national survey cost.

We believe that it is not possible to do a reliable sample phone survey of nursing home costs because all nursing homes in a given state are not the same in structure and operation and marketing philosophy. Because of a lack of uniformity, all nursing homes in the state will not follow a standard statistical distribution on costs and therefore a random sample survey will not give reliable results.

We could probably use up six or seven pages describing in detail the factors that affect private-pay bed rates for nursing homes. Also the application of these factors and different state approaches on regulating nursing homes affect the private-pay bed rates from state to state. Here are some of the factors:

- State regulation allowing skilled only or also intermediate care facilities
- The number of beds the nursing home has. Unless the survey results are weighted

per bed, a 20 bed facility at \$160 a day added on to a 100 bed facility at \$120 a day and divided by two is going to make it appear that the average cost between those two facilities for a bed is \$140 a day. But the real cost per bed between the two facilities is the weighted average. Which is \$127 a day.

- The degree to which a state attempts to control the supply of beds and the subsequent occupancy rate
- The number of non-certified nursing homes that cater to the wealthy and charge higher rates
- The number of specialty nursing homes that use a different private pay long term care rate structure
- State Medicaid reimbursement procedure and policy which may affect the setting of private-pay rates
- State imposed staff ratios which may vary from state to state and vary for different types of facilities
- Whether Medicare reimbursement for a particular area is covering actual costs and if that is reflected in private-pay rates
- Whether an existing home has paid its plant costs or is still amortizing those costs
- The cost of liability insurance from region to region and state to state

### **Assisted Living Cost Surveys**

Sample phone surveys for assisted living costs are acceptable as far as they go, but they probably don't reflect the entire assisted living service market. Surveys are not reliable as a comparison from state to state because of the differences in services offered between states.

The term "assisted living" is a marketing tool that refers to a large number of different community living arrangements that also offer care. There is no uniform regulation of these services from state to state. Some states regulate on the basis of number of residents while other states regulate on the basis of services offered. Not all states use the term assisted living for these living arrangements. In the states that control services, some of those states allow very little in the type of services offered and residents in those states must go to a nursing home to receive more extended services. On the other hand, some states allow assisted living to offer nursing home skilled services under certain conditions. Obviously the services offered will affect the cost of care and the cost of an assisted living arrangement. Also in some states assisted living cost includes the cost of long term care services and in other states the cost is charged in addition to room and board.

A large number of operations offering community living with care are invisible to the public. They are small operations that don't advertise and probably fail to register with their state health department. Their residents come to them via referrals from others. For purposes of classification we will call these "board and care " facilities.

These are operations using a residential home and housing residents in bedrooms in the home, sometimes shared with another person. Dining facilities, living room and bathrooms are shared. Some of these operations are employer and employee companies but the vast majority are run by the people who own the home and have taken in aged boarders to supplement their income. Long term care services are usually limited to what the owner operators can handle themselves. To augment services, a number of these operations will bring in home health agencies to help with medical conditions.

Board and care operations naturally have a lower cost of operation and will charge their residents typically much less than the apartment-based assisted living facilities included in national surveys. The surveys will not include these providers because they don't

advertise, they don't list in the phone book and many have failed to license with their health department.

### **Home Health Agency Cost Surveys**

Since 85% to 90% of home health agency cost is covered by government, such surveys are of little use to the public because the government will pay for it.

What would be very useful is if surveys were to include the cost of non-medical home health services. These costs are borne by the public and it would be useful for planning purposes to know what the cost is in a given area. Perhaps the national surveys will add this information in the future.

### **Government Programs Only Pay for About 16% of Long-Term Care**

Government programs such as Medicare, Medicaid and the Veterans Administration will cover the cost of long-term care under certain conditions. Medicare will cover rehabilitation from a hospital stay or limited care at home if there is a skilled (medical) need. The Veterans Administration will cover the cost of nursing home care indefinitely if the veteran is at least 70% service-connected disabled. The VA will also cover other forms of home-based or community-based care if there is a medical need.

Medicaid will cover both medical and non-medical related long-term care but in order to qualify for Medicaid a person has to have less than \$2,000 in assets and income that is insufficient to pay the cost of care. In other words a person must be impoverished. Otherwise Medicaid will not pay.

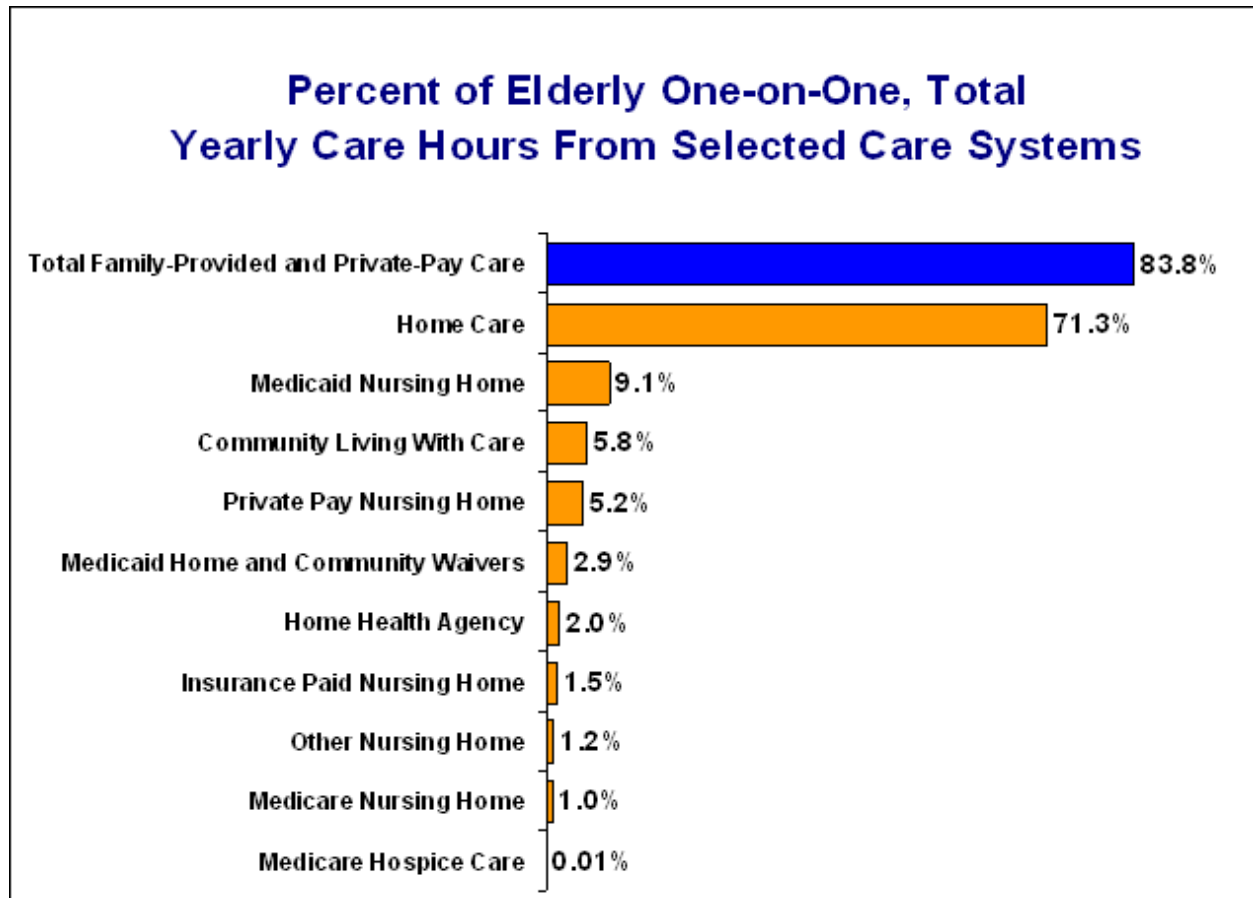
**Based on our analysis of yearly, one-on-one care hours, we estimate that about 84% of all long-term care is not covered by government programs.** This is primarily family-provided home care to help with activities of daily living, or help with maintaining a home, providing meals and support, or care services providing supervision or companionship or providing transportation and shopping services. Care not covered by the government is also care provided from family out-of-pocket payments in nursing homes and assisted living facilities. Families are also hiring more and more aide services to help with care at home.

### **Estimating the equivalent cost of home care**

Based on the chart below about 71% of all long-term care hours are provided in the home by family. (We have excluded home care hours from Medicaid and Medicare programs.) Most of this care is provided free of charge by family members, friends or volunteers. However some is provided by professionals or aides paid from family funds or from insurance. If we were to multiply the total number of home care hours we derived for the chart below times the average hourly cost for home health aides, we would have an equivalent yearly cost of home care in this country. We estimated about 16,556,400,000 hours per year of home care in 2000. The number of elderly has grown about 1% per year since then. This gives us roughly 17,400,943,000 hours in 2005. The MetLife annual survey estimates the cost of home health aides is \$18 an hour.

**Multiplying the two figures together gives us \$313.2 billion of equivalent home care cost.**

This is roughly 3 times the total current amount the state and federal government pays yearly for all long-term care services. If the federal government had to pay all home care costs in this country combined with what it already pays for long-term care, the cost would be the third largest single expenditure in the federal budget exceeded only by Social Security and defense. Many people are pushing the government to do just that.

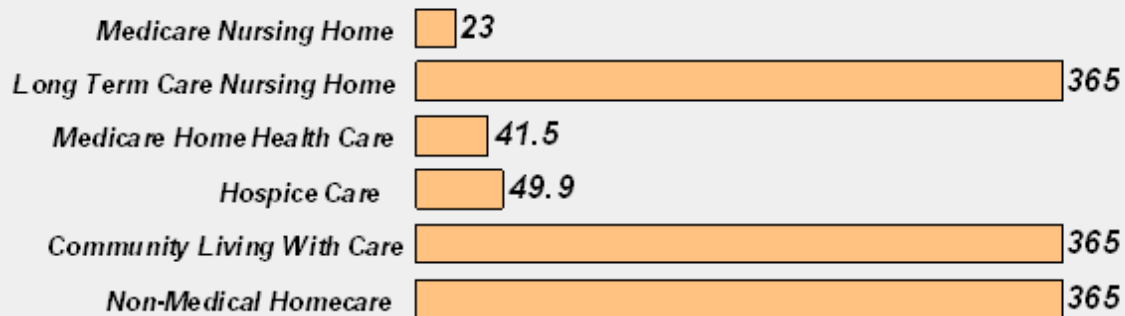


Source: Thomas Day at [longtermcarelink.net](http://longtermcarelink.net)

The chart was derived and extrapolated from a number of sources. Also a number of educated guesses were made in order to complete the data. These were estimates of daily care hours including services such as homemaker and housekeeping services for various care systems. Some of the estimates were based on examples of acuity standards and personal experience. We feel that although the data may contain some error, you can get an appreciation of the amount of care in terms of hours yearly that is provided by the major care systems in this country. The number for home care hours provided comes from the 1999 National Long-Term Care Survey where the respondents indicated the average number of weekly hours provided for care was 42 hours. The hours per patient in nursing homes were estimated from the 2000 survey of nursing home staffing done for Congress. Hours and length of stay for Medicare home care, Medicare nursing home and hospice were taken from CMS sources.

The analysis is for the year 2000. The most complete data set is from surveys and statistics published in 1999 and 2000. There is not a current complete data set available to do this analysis for a more current period.

## Average Length of Stay Per Year (In days)



Source: Thomas Day at [longtermcarelink.net](http://longtermcarelink.net)

The average length of stay for long-term care nursing home residents is 2.43 years. Source: CDC, National Nursing Homes Survey, 1999

The estimated average length of stay for home care is 3 to 5 years depending on the care setting. Source: 1999 National Long Term Care Survey

A 1999 survey done by the National Council for Assisted Living estimates the average length of stay in an assisted living facility ranges from approximately 2.5 to 3 years.

## Estimated Average Hours of One-on-One Daily Care

(Includes Estimated Hours of Housekeeping and Homemaker Services)

