

Quality, Funding Issues

STATES
GRAPPLE
WITH SET-
BACKS THAT
COULD AFFECT
HOME- AND
COMMUNITY-
BASED CARE
OPTIONS.

Meg LaPorte

Hit Home Care

The days of arguing for the cost-effectiveness of home- and community-based services (HCBS) over institutional care should be over, according to Brian Burwell, vice president of Thomson Reuters and a national expert on Medicaid and long term care financing. “We shouldn’t have to make this argument anymore,” he said at a recent AARP meeting on HCBS. The predominant sentiment of the meeting participants was that states and the federal government know that expansion of HCBS is “the right thing to do.”

Secretary of Health and Human Services Kathleen Sebelius touted the benefits of HCBS during her confirmation hearings in April. She cited the recent findings of a *Health Affairs*

study, in which the authors conclude that expansion of HCBS reduces institutional spending and produces savings over the longer term.

“This study further confirms that the tools Congress provided in this area are key ingredients to relieve states of the financial burden for long term care and also provide quality long term care to Medicaid beneficiaries,” she said.

Indeed, HCBS programs are now viewed as a panacea to curbing long term care spending, improving the care of the frail elderly, and creating an infrastructure of long term care supports within the states.

States Get On Board

And states have responded with fervor. Between 1995 and 2007, the national rate of Medicaid spending

on HCBS more than doubled—from 19 percent to 41 percent. As of 2005, the latest year for which data are available, all states operated Medicaid home health benefit and multiple HCBS waivers, according to the Kaiser Commission on Medicaid and the Uninsured.

Kaiser reports that nearly 2.8 million individuals received Medicaid HCBS in 2005. Among these recipients, more than 1 million were served through 1915(c) waivers, 924,259 individuals received home health care benefits under the mandatory state program, and 794,642 received personal care services through the optional state plan benefit.

It is worth noting that despite the precipitous growth of HCBS programs, per person expenditures vary widely among states. For example, the national per person spending on Medicaid HCBS averaged \$12,627 in 2005, Arkansas spent \$5,822 per person, and Rhode Island's average was \$37,052 per person, Kaiser says.

Thus, not all states have experienced the same boost in HCBS growth. For at least eight states, more than 40 percent of Medicaid long term care funds for older people and adults with physical disabilities went to HCBS in 2007. Nineteen states logged in with 20 to 40 percent of their Medicaid long term spending going to HCBS, Kaiser reports.

Stumbling Blocks Crop Up

Notwithstanding the enthusiasm over HCBS, a confluence of factors may present challenges to the continued expansion of such programs. To begin with, states have been hit hard by the economic crisis, forcing them to trim spending on many programs and services, including Medicaid HCBS programs, with further cutbacks likely.

Although additional Medicaid funds from the American Recovery & Reinvestment Act of 2009—the economic stimulus legislation passed by Congress earlier this year—were given to states for Medicaid services,

other factors such as concerns about capacity and quality are also exacerbating the situation. According to a 2007 research synthesis by Avalere Health, a health care consulting firm based in Washington, D.C., “HCBS investment at the expense of facility-based services may result in future capacity issues as demand for higher-acuity services increases,” the report says.

What's more, with quality oversight of HCBS inconsistent across the states, further expansion “could put people at risk and invest additional state dollars in unclear quality outcomes,” Avalere says.

The Budget-Balancing Struggle

Unlike the federal government, which consistently runs on a deficit, states must balance their budgets each year. This has been particularly difficult for

most states this year, with 47 expected to have budget shortfalls for fiscal year 2010 and/or the next year or two, according to the Center on Budget and Policy Priorities (CBPP).

In addition, combined budget gaps for the remainder of this fiscal year and state fiscal years 2010 and 2011 are estimated to reach more than \$350 billion.

Making matters worse is the likelihood that recovering from the current fiscal dilemma will be difficult, says CBPP. “Housing market declines have already depressed consumption and sales taxes as people refrain from buying furniture, appliances, construction materials, and the like,” says a recent CBPP report on state budgets.

“Property tax revenue is also affected, and local governments will be looking to states to help address the squeeze on local and education budgets. As unem-

Demand To Swell For Long Term Care

The facts are not new—baby boomers will drive demand for long term care in unprecedented numbers over the next two decades. According to AARP's “Across the States” report, from 2007 to 2030 the population aged 65 and older is projected to grow by 89 percent, while the oldest old—individuals 85 years and older—will grow by 74 percent in the same time span.

This group will have higher rates of disability and be much more likely to be widowed and without someone to provide assistance with daily activities, AARP says.

Looking beyond the next 21 years, the oldest old will grow at an even faster pace. This is when the baby boom generation will begin turning 85. Between 2030 and 2050, this age group is projected to increase by another 118 percent.

AARP notes that age is not the only factor affecting the need for and access to long term care services.

Demand is also driven by social and economic characteristics like income, assets, education, marital status, and the availability of a family member or friend to provide care.

One-third of people age 75 and older live alone—meaning there is no one in the household to care for them if they should need assistance with activities of daily living. People living alone are also more likely to have to move to a care facility if they need long term care.

Slightly more than half of people age 65 and older have incomes at or below 300 percent of poverty, an income level that makes them financially vulnerable and unlikely to be able to afford to pay for long term care services out of pocket.

Education level is one of the strongest predictors of the likelihood of needing long term care, AARP notes—and less than 20 percent of people age 65 and over have a bachelor's degree or higher.

Table: Number of older people and adults with physical disabilities receiving HCBS compared with nursing facility care 1999 to 2004.

Type Of Service	Medicaid Recipients			
	1999	2004	#Change	%Change
HCBS	935,160	1,337,010	+401,850	+43%
Nursing Facilities	1,615,695	1,707,572	+91,877	+6%

Sources: "A Balancing Act: States Long Term Care Reform" AARP Public Policy Institute, July 2008

ployment continues to rise, tax revenue will weaken further, and there will be further downward pressure on sales tax revenue as consumers are reluctant or unable to spend."

Most states are already drawing on their rainy day funds and reserves, and a number have virtually depleted their budget stabilization funds, CBPP says.

Economic downturns also present a challenge to Medicaid because demand for services typically grows during a recession. And as a recent report from AARP's Public Policy Institute notes, as demand grows for Medicaid services, so, too, will spending at a time when state revenue is declining. As a result, further cuts will be necessary, which makes the optional Medicaid services such as HCBS vulnerable.

Cost-Cutting Steps Taken

Some states are already wielding the axe in the direction of HCBS. At least 21 states and the District of Columbia are either cutting or significantly increasing the cost of medical rehabilitative, home care, or other services needed by people with low incomes who are elderly or have disabilities.

In Florida, for example, nursing facility reimbursement has been frozen and staffing standards relaxed. In addition, the state has cut Medicaid reimbursement for community-based services, such as housekeeper and meal services for the elderly.

Nevada has tightened eligibility requirements for nursing facility care. Massachusetts is cutting home care, geriatric mental health services, and

prescription drug assistance, while Tennessee has reduced community-based services for people with intellectual disabilities, as well as nursing services for some adults with serious disabilities.

Vermont has reduced some home-based services such as housekeeping and shopping for people who are elderly or have disabilities. Such services could "help people stay in their own homes and possibly delay or avoid more expensive nursing home care," CBPP says in its report.

Utah has reduced Medicaid provider rates for hospitals, skilled nursing, and dentists. Arizona has eliminated independent living supports for 450 elderly residents and respite-care funding for 130 caregivers.

Meanwhile, Michigan has made across-the-board cuts to long term care services, including nursing facilities and HCBS programs. According to the *Detroit News*, Medicaid payments to hospitals, doctors, nursing facilities, and others will be reduced by \$53 million.

The state has put HCBS waiver slots on hold and stopped funding its nursing facility diversion program altogether as of June 1, says Gail Clarkson, chief executive officer (CEO) of Medilodge, Washington, Mich., a multifacility provider. "I don't see it getting any better any time soon," she says.

AARP is attempting to ward off further cuts by urging states and the federal government to continue funding HCBS initiatives. Lina Walker, with AARP's Public Policy Institute, would like to see states retain their HCBS

funding, but "we also need to address the elephant in the room," she said at the AARP meeting, "which is that it could potentially cost more money for states to provide HCBS."

Lack Of Oversight Raises Concerns

Troubling for some providers and observers is the fact that, despite the rapid growth of HCBS programs, it has not been accompanied by the creation of quality assurance initiatives to keep up with the complex web of providers and services that currently make up the HCBS infrastructure.

Gathering data on HCBS quality can be extremely challenging, according to the Avalere report, because services are delivered in peoples' homes and communities among widely dispersed sites.

HCBS waiver service delivery networks often consist of a range of overlapping sets of providers.

"For example, they typically include state and local public agencies; large and small private-sector provider organizations; several case managers; individual personal assistants and attendants; clinicians; and, increasingly, neighbors and other community members who support individuals," the report says.

Moreover, although nursing facilities face rigorous oversight and regulation, HCBS programs do not have a quality data collection process. And gathering such data is difficult: State HCBS program data uniformity is nearly non-existent, Avalere notes.

Other experts agree. Breaking out the data needed to report adequately on HCBS is difficult, says Burwell. "States report differently regarding aging and disability data; there is not a common nomenclature, particularly by age," he says.

"When I started in the '80s, I said we need basic information on state long term care data. And since then I've become very cognitive of the integrity of the data; that's why we have footnotes [in our reports]. Many people don't read the footnotes, but I want to

caution people that the data still aren't perfect," he says.

National Data Lacking

A 2004 Government Accountability Office (GAO) study found that no comprehensive nationwide data are available on states' quality assurance systems for quality of care provided through HCBS waivers.

"In the absence of detailed federal requirements for HCBS quality assurance

systems, states' waiver applications and annual reports often contained little or no information on the mechanisms used to ensure quality, raising a question as to whether CMS [the Centers for Medicare & Medicaid Services] had adequate information to approve or renew some waivers," GAO said.

Oversight weaknesses and quality-of-care problems were also identified by GAO in its review of oversight reports, annual state waiver reports, or state

audit reports. Some of the quality-of-care problems cited by GAO include: failure to provide authorized or necessary services, inadequate assessment or documentation of beneficiaries' care needs in the plan of care, and inadequate case management.

According to GAO, 11 applications for the 15 largest waivers serving the elderly identified three or fewer quality assurance mechanisms. None of the 11 waivers mentioned impor-

The Impact Of Alzheimer's Disease

Alzheimer's disease is the sixth-leading cause of death in the United States. An estimated 5.3 million Americans are currently afflicted with this devastating and incurable disease, according to the Alzheimer's Association.

Most experts recommend that patients with late-stage Alzheimer's be placed in residential treatment or hospice because of the rigorous caregiving needs that arise at that point in the disease.

Researchers believe that by mid-century someone will be struck by Alzheimer's every 33 seconds. Adding to the growing statistics is the knowledge that the number of Americans surviving into their 80s and 90s and beyond is expected to increase because of advances in medicine and medical technology, as well as social and environmental conditions.

Since the incidence and prevalence of Alzheimer's disease and other dementias increase with age, the number of people with these conditions will also grow rapidly, leading to increased demand for appropriate nursing care.

Incidence Grows

Following are some projections about the growth of Alzheimer's:

- By next year, the number of

people with Alzheimer's disease is expected to increase to 454,000 new cases per year; by 2029, to 615,000; and by 2050, to 959,000.

- The population of people 85 years and older currently comprises nearly 50 percent of the individuals with Alzheimer's disease, or about 2.7 million people. By the time the first wave of baby boomers reaches age 85 years

(2031), there will be an estimated 3.5 million people aged 85 and older with Alzheimer's.

- The number of people aged 65 and older with Alzheimer's disease is estimated to reach 7.7 million in 2030, more than a 50 percent increase from the 5.1 million aged 65 and older who are currently affected.

- By 2050, the number of individuals

THE REALITY OF LATE-STAGE ALZHEIMER'S

The final two levels of Alzheimer's disease require the most intensive care, as the following details about Stages 6 and 7 of the disease illustrate:

Stage 6: Severe Cognitive Decline

Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with customary daily activities. At this stage, individuals may:

- Lose most awareness of recent experiences and events as well as of their surroundings;
- Recollect their personal history imperfectly, although they generally recall their own name;
- Need help getting dressed properly: Without supervision, they may make such errors as putting pajamas over daytime clothes or shoes on wrong feet;
- Experience disruption of their normal sleep/waking cycle;
- Need help with handling details of toileting (flushing toilet, wiping, and disposing of tissue properly);
- Have increasing episodes of urinary or fecal incontinence;
- Tend to wander and become lost; and
- Experience significant personality changes and behavioral symptoms,

tant approaches, including complaint systems or sanctions. Eighteen of 52 state annual waiver reports reviewed by GAO contained no information on the mechanisms used to help ensure quality.

“Moreover, when waiver applications and annual waiver reports did contain some information, the information was often incomplete,” GAO said.

Burwell notes that CMS does have a number of initiatives aimed at improv-

ing the quality of data reporting, including the development of a taxonomy for HCBS services. He said the Agency for Healthcare Research and Quality is currently developing quality measures for HCBS, particularly around hospitalizations. “We really need valid national data sets,” he says.

CMS claims that HCBS quality has been a focus of the agency since 2001 when a protocol assessing quality of care and services under 1915(c) waivers

was introduced. According to a recent CMS document titled “HCBS Quality Timeline,” 1915(c) waiver staff were given “standardized and comprehensive procedures for assessing quality of care and services provided through these programs.”

For the past eight years, CMS has contracted with Burwell’s company, Thomson Reuters, to provide complementary technical assistance to states on HCBS quality. The contractor

aged 65 years and older with Alzheimer’s is projected to number between 11 million and 16 million—unless medical breakthroughs identify ways to prevent or more effectively treat the disease. Barring such developments, by that date, more than 60 percent of people with Alzheimer’s disease will be aged 85 or older.

Alzheimer’s often requires 24-hour

assistance. According to the Alzheimer’s Association, this round-the-clock care can be too difficult for a sole caregiver. Moving the person to a residential care setting may be the best option.

Most experts, including the Alzheimer’s Association, recommend that late-stage Alzheimer’s patients be cared for in residential treatment or hospice centers because of the rigorous caregiv-

ing needs that arise at that point in the disease. According to the association’s literature, “The amount of time needed to care for the person is one reason for deciding to make the move to a new care setting.”

including suspiciousness and delusions, hallucinations, or compulsive, repetitive behaviors such as hand-wringing.

Stage 7: Very Severe Cognitive Decline

This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement.

Frequently, individuals lose their capacity for recognizable speech, although words or phrases may occasionally be uttered.

Individuals need help with eating and toileting, and there is general urinary incontinence.

Individuals lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their heads up. Reflexes become abnormal, and muscles grow rigid. Swallowing is impaired.

This stage of the disease may last from several weeks to several years. Intensive, around-the-clock help is usually required.

Following is just a sampling of caregiving tips recommended by the Alzheimer’s Association for someone with late-stage Alzheimer’s:

- A person with late-stage Alzheimer’s disease can become bedridden or chair-bound, which can result in skin breakdown, pressure sores, and the “freezing” of joints. Carefully and slowly move the individual’s arms and legs two to three times a day. See a physical therapist to learn the proper method for range-of-motion exercises.
- Relieve body pressure and improve skin moisture by changing the person’s position at least every two hours.
- Learn how to lift the person, and avoid injury by seeing a health care professional about the proper way to lift and turn the person.
- Apply moisturizer gently over bony areas, but do not massage the lotion into these areas.
- Maintain bowel and bladder function.
- Set a toileting schedule.

Source: Alzheimer’s Association Web site, www.alz.org, June 2009

provides individualized support to states for their “quality improvement activities” as well as technical assistance with “manuscripts and products.”

Since 2001, Thomson Reuters has provided technical assistance to 90 waiver programs in 47 states plus the District of Columbia. However, the CMS timeline contains no details about the nature or scope of assistance that was provided to these states.

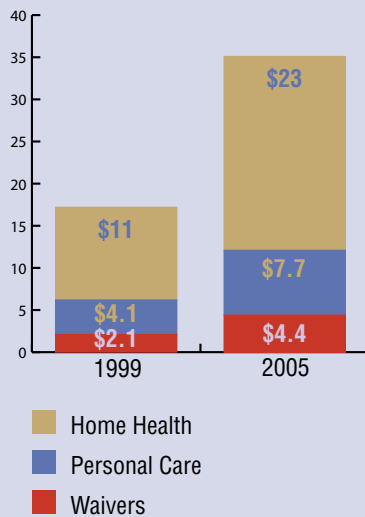
In 2002, CMS launched its Quality Framework—an initiative that “outlines a uniform national format for describing key components of states’ [quality assurance] programs.” In response to the 2003 GAO report, the agency also issued an action plan that requires states to submit “more specific information about their quality improvement programs prior to waiver approval.” This was the only mandatory requirement for states listed on the action plan.

Between 2003 and 2008, CMS issued several additional quality-related documents, including a survey designed to solicit feedback from HCBS waiver participants, a “waiver quality life cycle” schematic that illustrates the application and renewal process, as well as “expectations for continuous communication between states and regional offices” and three iterations of the 1915(c) HCBS waiver application.

The most recent version of the 1915(c) waiver application—version 3.5—was issued last year, according to CMS’ timeline. This version changed the “format and expectations” for reporting how the state would demonstrate it was meeting the quality assurances for 1915(c) waivers. Included in version 3.5 is “information” on proposed performance measures to demonstrate compliance and strategies for systemic improvements. It is worth noting, however, that states’ use of the version 3.5 application is optional.

Last February, CMS launched a National HCBS Quality Enterprise Web site, which is operated through a grant to Thomson Reuters. The site serves as

Chart 1
Medicaid Home- And Community-based Services Expenditures, By Program 1999 And 2005 (in billions)



Source: Kaiser Commission on Medicaid and the Uninsured and UCSF analysis of CMS Form 372 data and program surveys

a repository for all CMS quality-related materials and policy documents on HCBS.

Facilities Still Needed

The American Health Care Association (AHCA) and the National Center for Assisted Living agree that individuals should receive essential long term care services in the most appropriate care setting of each individual’s choice, but remain concerned that claims of budgetary savings may mask added costs in other budget areas while draining essential funds away from care for seniors and persons with disabilities who need skilled nursing care, says Janice Zalen, AHCA senior director of special programs.

In addition, “HCBS payment rates in many states—where such services are covered in residential settings—may not be adequate to cover assisted living and other similar providers’ operating costs,” Zalen says. “And, HCBS programs often have no mechanism to

allow for annual cost-of-living increases necessary to keep up with rising energy and staffing costs.”

The Avalere report found that HCBS expansion has not significantly reduced demand for Medicaid-financed services in any state. “In fact, evidence indicates that the presence of HCBS increased demand,” the report says.

Cost-effectiveness is achieved only when states target HCBS to people who have gone into a nursing facility, the report found: “Evidence of such targeting was found in only a few states and programs.”

Avalere also found that nursing facilities are increasingly meeting a demand among people with greater needs, as well as those requiring rehabilitative care, such as post hip replacement therapy. “Persons receiving HCBS are more likely to have family caregiver involvement and assistance and have fewer needs resulting from cognitive impairment,” Avalere said.

Others point out that home care may not be the most suitable environment for some recipients with multiple health issues because the care demands are so difficult to manage and would require training of caregivers, especially if they are family members.

Howard Gleckman, a senior research associate at the Urban Institute and author of “Caring for Our Parents,” acknowledged in a recent white paper on the future of long term care that while there is widespread preference for consumers to remain at home, providing such care can be extremely difficult for family members.

“It often requires a high level of training in skills such as bathing or transferring a patient and in handling emotional challenges,” the paper says. Few programs offer training for these and other skills required to care for someone at home, Gleckman says.

“The inability of families to manage these care needs, and the frequent physical decline of caregivers themselves, often result in recipients moving to institutional care,” he says.

Gleckman reiterated his point during the AARP meeting in June: Medicaid HCBS “is not dealing with transportation and housing,” he said. Without meeting these needs, a successful placement “won’t happen.” He speculated that without such supports in place, he was unsure if HCBS recipients are getting quality care.

Research Finds Savings

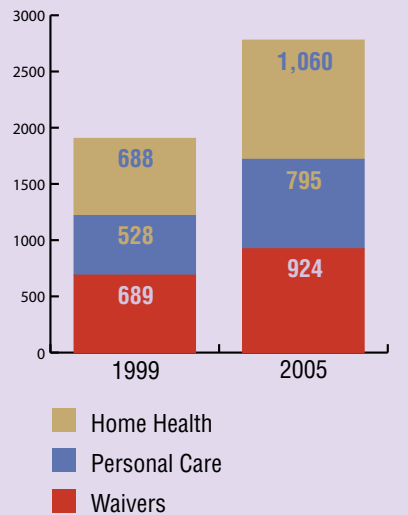
The *Health Affairs* study cited by Sebelius contains the most recent research on the cost-effectiveness of HCBS. Entitled, “Do Institutional Long Term Care Services Reduce Medicaid Spending?” the study looked at the impact of the growth of HCBS on overall long term care costs and concluded that “expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings.”

The study’s authors, H. Stephen Kaye, Mitchell LaPlante, and Charlene Harrington, claim that as states shift their mode of service delivery away from institutional services and toward HCBS, they can serve more people at a lower aggregate cost. On average, the cost of providing HCBS to an individual is lower than the cost of providing institutional services, the authors say.

The researchers also found a lag between the expansion of non-institutional HCBS services and a subsequent, compensatory reduction in institutional spending, resulting after several years in lower total long term care spending than in states that did not expand HCBS programs. “Real savings in institutional costs occur only when the number of Medicaid-financed nursing home residents is reduced, a process that can take years,” they said.

Other recent research has found that some states are having difficulty reaching the enrollment goals of the Money Follows the Person (MFP) HCBS demonstration program. The MFP program, which is set to expire in 2011, targets Medicaid enrollees who have been institutionalized for at

Chart 2
Medicaid Home- And Community-based Services Participants, By Program 1999 And 2005 (in thousands)



Source: Kaiser Commission on Medicaid and the Uninsured and UCSF analysis of CMS Form 372 data and program surveys

least six months in nursing facilities, hospitals, intermediate care facilities for people with developmental disabilities, and other institutions. As of June 2008, 30 states and the District of Columbia were participating in the program.

A recent report from Mathematica Policy Research found that MFP demonstration goals are difficult to reach because the targeted individuals’ medical conditions are too complex or are highly dependent on nursing care.

“MFP transition targets in some states may be difficult to achieve because the targeted individuals have complex medical conditions or high levels of functional dependence and therefore require more help finding appropriate housing and community services,” the study found.

Providers Embrace Ancillary Services

As HCBS programs have expanded over the past two decades, nursing facility providers have taken their own innovative approaches to expanding

their operations to include ancillary home care or community-based programs.

It is rare today to find a multifacility provider that does not have an ancillary component, whether it be assisted living, independent living, home care, adult day care, or a combination thereof.

A recent survey of senior living trends confirms that seniors housing providers are planning to expand their service offerings. The survey, conducted by Mather Lifeways, includes a total of 107 senior living providers, representing 435 senior living communities in 13 states. Among the future programs and services considered by respondents is a continuing care retirement community-type model—also known as “CCRCs without walls,” where services are available but not necessarily on site.

Among the top five most important trends providers identified in the survey were offering HCBS, issues related to residents “aging in place,” the need for more affordable services and housing, flexibility and choice in seniors housing options and programs, and wellness programs for residents.

The survey also identified the emergence of small house or Greenhouse models for long term care residents—a concept aimed at transforming nursing facilities into more homelike settings.

Also cited among the trends was decreased numbers of nursing facility residents, along with increased numbers of independent and assisted living residents.

Many providers have embraced a diverse approach and made it successful, in addition to allowing them to create better continuity of care for residents.

“Being able to provide the entire ancillary continuum of care services allow[s] us the opportunity to better case manage our residents’ care,” says Holly Botsford, public relations manager for Brookdale Senior Living, Brentwood, Tenn. The company’s ancillary care services were developed

specifically for the independent and assisted living resident, Botsford says. “We have the expertise to meet their needs and believed we could provide higher-quality services with a better outcome.”

Diversity “allows the patient to receive the most appropriate services relative to what their needs are,” says Bob Donovan, president of AseraCare, the home care division of Golden Living, Fort Smith, Ark. “It really works to both the patient’s and the organization’s advantage to provide that level of continuity.”

AseraCare plans to extend its home care reach into markets where it already has skilled nursing facilities (SNFs). “We’ve made a strategic decision that we want to be a provider of post-acute care services,” says Donovan. “And so having SNFs and having Aegis therapy providing rehab inside and outside an institutional setting, as well as having hospice services, Medicare-certified home health, and potentially private-pay services, really gives us the opportunity to be a collaborator of post-acute care services and provide a kind of continuum of care for potential patients in those markets.”

In those markets where Golden does not have SNFs, says Donovan, Asera Care and Aegis are looking at “innovative models where [AseraCare] potentially could become a service provider to institutions, whether that be home care-oriented services or rehab-oriented services, among others.”

Benedictine Health Care, a nonprofit long term care provider based in Duluth, Minn., is well on its way to creating a new home care model that would balance out its nursing facility services. “One initiative we are working on is to change our mix from institutional to a mix of HCBS and institutional,” says Steven Chies, Benedictine’s senior vice president of long term care services. Chies says he is currently working on a strategy to develop a better model.

“We’re not going to certify or buy home health agencies,” he says, “but

we’ll change the way we look at it.”

One concept that Chies says he has considered is working with a health maintenance organization or integrated health delivery system to create a club approach where people pay a monthly fee to have access to the system.

States Get A Bargain

Although Chies is excited about Benedictine’s foray into more home- and community-based models of care, he still feels strongly about the value of nursing facilities. “From a strictly monetary standpoint, [nursing facilities are] the cheapest way to provide care to people. I’ve seen home care cheaper, yes, but it depends on the situation,” he says, adding that while institutional care may not be for everyone, “there are people who are 80 to 85 years old who don’t want to live at home.”

Chies adds that when he started in the long term care business 30 years ago, the prevailing sentiment was that home care was cheaper and nursing facilities should be closed. “If we’re such an expensive buy, then why are we still here?” he says.

Mark Petersen, CEO of Petersen

Health Care, Peoria, Ill., also believes in the value of nursing facilities to the states. “I still think today that nursing homes are the best value for what you get—and for the taxpayers’ value,” he says. “When you consider everything that goes into the care they’re getting for that price, I think...nursing homes are shouldering the burden of the low pay states provide.”

Petersen Health is also expanding into ancillary services. “We’re looking to expand into pharmacy and therapy because we can keep that money in house and also provide better services with our own employees taking care of our own residents,” Petersen says.

Philadelphia-based NewCourtland, a nonprofit provider of long term care services, is taking a slightly different approach: It recently divested of five of its seven nursing facilities in favor of concentrating its efforts on home- and community-based settings.

NewCourtland’s president, Gail Kass, has been working toward this goal since the 2005 White House Conference on Aging. “I left the conference with a very raised consciousness about a different kind of senior coming along with a different set of expectations who needed a different set of services,” she says. “I came home with a lot of energy. We became very active building a strategy for moving out into the community.”

Kass, who has been with the organization for 30 years, is still a proponent of nursing facility care. She believes that at some point down the road nursing facilities will play a different function for a different population of people.

She contends that, at a certain point, unless someone is very wealthy “like Ronald Reagan and you can have around-the-clock attention at home,” people with Alzheimer’s disease will cease to be able to live independently in the community. “They will have to go to nursing homes,” she says. “And I think that the future of nursing homes will be about that population.” ■