

Washington Research Council

= Report Highlights =

December 1988

Paying for Long-Term Care

The number of elderly is expected to increase faster than the total population for the next several decades. With this increase come increasing demands on the state budget for long-term care services and increasing pressure on lawmakers to review alternatives for cost control. The Washington Research Council report, **Paying for Long-Term Care**, reviews the state's program for those unable to afford the cost of the care, looks at demographic trends, discusses major factors affecting what the state pays for long-term care and suggests some potential areas for cost control.

Most long-term care is provided informally — by family and friends — and many people can afford to finance formal care through private means. However, when the money runs out and for those who cannot afford it in the first place, government helps pay for long-term care.

Nursing home care represents about 76 percent of the state's long-term care budget for 1987–89. While nursing homes are partially funded through federal Medicaid match, most community based long-term care programs are funded through state-only funds. Long-term care represents about 3.2 percent of the 1987–89 state general fund budget.

Demographic Changes

The population of those 65 years of age and older is increasing faster than the total population — 43 percent compared to

30 percent between 1988 and 2010. The fastest growing group is people 85 years of age and older — they are expected to more than double over the next 22 years (see figure). This is the population that is most likely to need long-term care. As a result, caseloads are expected by most to grow rapidly between now and 2010. The demands this places on the state's long-term care program foreshadow what will happen as the baby-boom population reaches retirement age. The front end of the baby boom will just be reaching age 65 in 2010.

Nursing Home Reimbursement

How much nursing homes are reimbursed for the care they provide is determined by a statutory formula. The formula is intended to meet the federal mandate of reimbursing nursing homes for their costs. Nursing home industry representatives contend that the formula fails to meet that mandate. In addition, there is disagreement as to whether the formula adequately funds nursing services, limits the advantages of competition, fails to provide incentives for efficient operation, and provides incentives to invest in nursing homes.

Number of Nursing Home Beds

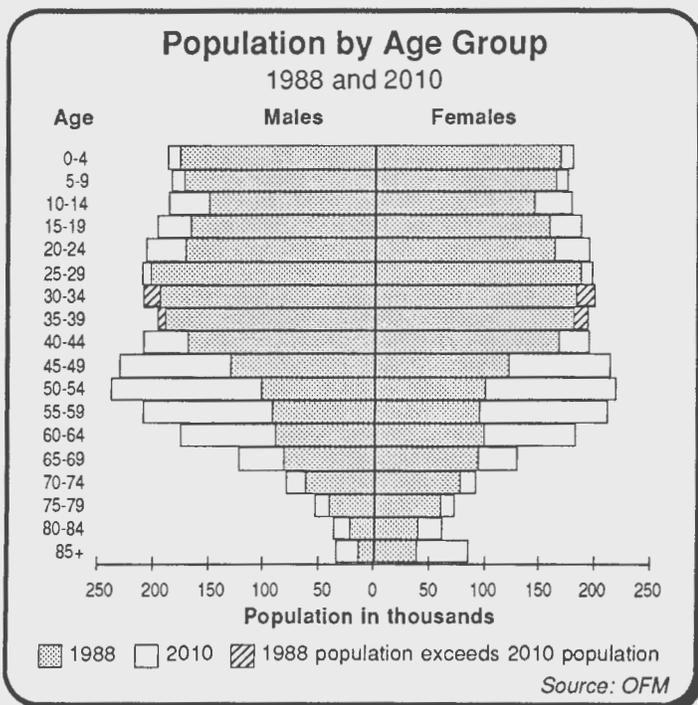
The number of licensed nursing home beds and hospital long-term care units in the state is determined through the certificate of need process (CON). Stated as a ratio of the number of beds to the number of people 65 years of age and older, it is one way the state can control its nursing home caseloads (by limiting the number of beds). The State Health Coordinating Council is currently recommending lowering the bed ratio in conjunction with increased funding for community-based care alternatives.

Potentials for Cost Control

Given the demographic situation and the rising costs of health care in general, long-term care is expected to place increasing demands on the state budget. Based on our research there are at least two courses of action which could slow the growth in long-term care costs and which warrant consideration: to further constrain the supply of nursing home beds and shift resources to expanded community-based care alternatives; and to open up the supply of nursing home beds, by eliminating CON, and allow the market to respond to demand for nursing home care. These alternatives, plus some options for privatization, are summarized below.

Lowering Bed Ratio and Restricting Supply

Community-based long-term care programs are less expensive than nursing home care and substitution of



community-based care for nursing home care on a one-to-one basis could save the state money. By maximizing individual self-reliance, community-based services can extend the time before people have to resort to more expensive nursing homes. There is little information, however, on the number of persons currently in, or destined for, nursing homes who could receive the necessary care in the alternative settings.

For greater use of community-based care to be an effective cost control measure, the bed ratio would need to be reduced. This would relieve the state from having to pay for empty beds through the reimbursement formula, and the reimbursement formula would need to be changed so that low occupancy rates do not result in higher per bed costs. Both of these options are being proposed by DSHS officials.

Latent Demand for Alternatives

Recent studies show that increased community-based care doesn't necessarily save money, however. Some people are not willing to enter a nursing home, but would accept help in their own home, if it were available. A survey of 16 community-care demonstration projects by Peter Kemper of the National Center for Health Services Research concluded "expanded public financing of community services beyond what already exists is likely to increase costs. Small nursing home cost reductions are more than offset by the increased costs of providing services to those who would remain at home even without the expanded services."

Case Management

Savings may occur in programs that use case management and pre-admission screening, targeting those applying for admission to a nursing home. Because patients who enter nursing homes as private-pay patients often reduce their assets to Medicaid-eligibility levels in three to 12 months, some have suggested pre-screening and case management for all long-term care recipients, regardless of the payment source. If community-based care is appropriate, this could reduce the state's costs by extending the amount of care which could be purchased with the private funds.

Medicaid for Personal Care

Currently, most community-based care is paid for with state funds, without federal match. However, federal Medicaid funds could be used to provide a variety of these services. The problem is that anyone who meets eligibility criteria would be entitled to receive those services, making it difficult to control caseloads. Also, federal dollars mean meeting federal requirements and, in some cases, this can mean spending more money to comply with new requirements.

Eliminating CON and Opening Up the Supply

Eliminating CON, which controls the number of nursing home beds, would likely result in more beds. And nursing home care, according to some, has the potential to be higher quality and lower cost in an open market. The states which have eliminated their certificate of need requirements have not yet demonstrated much measurable success in the form of lower prices or higher quality. However, they have not been in operation long enough to understand the total effects and there are factors, like the national nursing shortage, which

complicate an already complex issue. Although a detailed review was beyond the scope of this work, this is an important part of the health care environment and the potential for this course of action is worth further exploration in Washington.

Additional Opportunities For Privatization

Privatization already plays a major role in the state's long-term care delivery system, through contracting with private nursing homes and other private alternative care providers. However, the current reimbursement system, together with an artificially restricted supply of nursing home beds, eliminates most of the advantages of contracting.

Using Volunteers

When eligibility in the chore services program was restricted in 1981 a volunteer chore program was initiated to help meet the needs. Volunteers are also used to help consumers understand the implications of the long-term care insurance they consider purchasing.

Facilitating Self-Help and Insurance

Encouraging private financing of long-term care is another type of privatization where public expenditures are reduced or eliminated through the use of private funds. Long-term care insurance, which helps to pay for extended care in a nursing home or nursing services in private homes, is one form of this.

Long-term care insurance is not inexpensive and many seniors do not think they will need nursing home care or believe that it will be covered by Medicare. According to the National Conference of State Legislatures, states could play a role in educating people about what is covered by Medicare and what is included in a "good" long-term care policy.

The role of long-term care insurance in cost control may be limited, however. A 1988 Brookings Institution study concluded that "private sector financing options...are unlikely... to have more than a small effect on Medicaid expenditures."

Encouraging Informal Caregiving

Programs which encourage informal provision of care, thereby reducing or delaying the need for public support, represent another potential area of cost savings. In Washington this is currently limited to the respite care program. Some states pay family members to encourage informal care or offer tax incentives for provision of care to relatives or friends.

Summary

The list of cost control potentials, then, includes opening up both the supply of nursing home beds and the supply of alternative-care options; regulation of alternative-care options to assure quality; reimbursement systems which protect both consumers and providers of long-term care, as well as the taxpaying public; case management to assure appropriate service provision; effective and widespread consumer information; and incentives for informal caregiving.

The Washington Research Council is an independent public policy research organization which promotes efficient and effective government in Washington. To order a copy of the full report on long-term care, contact the Research Council office at (206) 357-6643.

Paying for Long-Term Care

Overview

The number of elderly is expected to increase faster than the total population for the next several decades. With this increase come increasing demands on the state budget for long-term care services and increasing pressure on state lawmakers to review alternatives for cost control and potentials for greater quality of life.

What steps can be taken to control the costs of long-term care? What issues are involved in determining how best to serve the needs of the growing elderly population? These are some of the important questions confronting today's decision makers.

This report reviews the state's long-term care program for those unable to afford the cost of the care, looks at demographic trends, discusses major factors affecting what the state pays for long-term care and suggests some potential areas for cost control.

Most long-term care is provided informally, by family and friends. Formal provision of care, in nursing homes, adult family homes, and through various community-based services, is financed primarily by private payments and government programs. In part due to the entitlement nature of Medicaid, nursing home care takes priority in the budget and other programs are funded as funds allow. Although gaining in visibility in recent years, private insurance makes up a small portion of total expenditures.

Long-term care for the elderly currently makes up about 3.2 percent of the state general fund budget. Under the current program mix, long-term care would grow to 3.7 percent of the budget in the 1989-91 biennium. The major cause of the increase is higher nursing home costs.

According to Department of Social and Health Services (DSHS) officials, the statutory, cost-based reimbursement formula used to determine how much nursing homes are paid is the major cause of rate increases. And rate increases are, in part, the result of the costs of complying with government regulations, nursing home industry representatives say.

The nursing home bed ratio and daily rates for nursing home care are related through the reimbursement formula. Lower occupancy rates in nursing homes will result

in somewhat higher daily costs for the state because of the way in which the formula reimburses fixed costs.

The cost increases could be lessened through greater use of community-based alternatives. The magnitude of the cost savings would depend upon the eligibility requirements and services provided. Use of federal Medicaid funding for personal care could further reduce the state's costs, provided that lawmakers accept the federal regulations which accompany the federal funds. For this to result in significant cost savings, the number of nursing home beds for every 1,000 state residents aged 65 years or older (nursing home bed ratio) would have to be reduced and the way the formula reimburses fixed costs would have to be changed.

Formal assessment of needs and development of an appropriate plan of service (case management) has been suggested for private-pay patients, as well as for those patients who are supported with public funds. This is due, in large part, to the incidence of patients who enter as private consumers, deplete their assets, and then become eligible for Medicaid.

Greater use of community-based alternatives by private-pay clients might extend the amount of care people could afford before their income and asset levels are reduced to the level where they are eligible for public assistance. Although difficult to measure accurately, this is estimated to occur in three to 12 months on average.

This report summarizes some of the major issues facing the state's long-term care programs and offers some potential areas for cost control. Cost control opportunities which warrant further consideration by policymakers include making greater use of community-based services, such as adult family homes and chore services; encouraging competition in both the nursing home industry and the community-based care industry; modifying the reimbursement formula to protect the state from paying for unused nursing home capacity; using case management to target the appropriate provision of services; and encouraging private sector options such as long-term care insurance and informal caregiving through information distribution, regulation, and incentive programs.

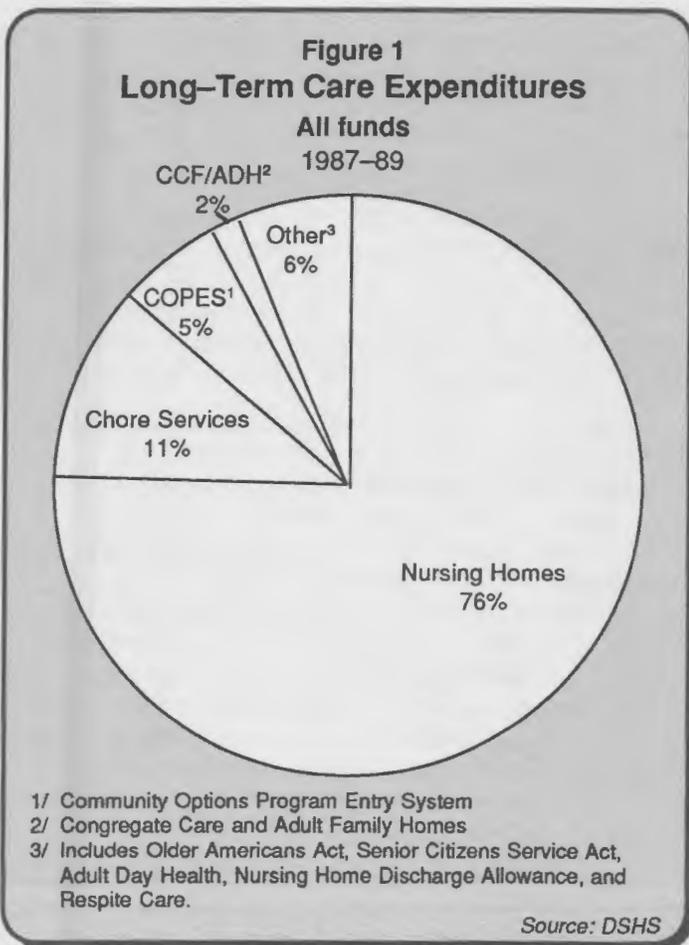
Paying for Long-Term Care

The majority of long-term care services are provided in the home by family and friends and many people can afford to finance formal care of one kind or another through private means. However, when the money runs out and for those who cannot afford it in the first place, government helps pay for long-term care.

Although nursing home care is the most common form of long-term care, accounting for 76 percent of the state's long-term care budget for 1987-89, other government-financed long-term care programs in Washington include congregate care facilities, adult family homes, chore services and respite care (see figure 1).

Long-term care is most often associated with the elderly, but it can also include the developmentally disabled, people with mental health problems, and those disabled by accident, such as spinal cord or brain injuries, or long-term illness, such as acquired immune deficiency syndrome (AIDS). Services provided to the elderly through the division of Aging and Adult Services are the primary focus of this report.

Long-term care services are not inexpensive. Even for a person financially well-off, an extended illness and confinement to a nursing home can deplete resources. Prices, which range from \$50 to \$100 a day, average about \$22,000 a year.



According to the 1985 National Nursing Home Survey, 48 percent of nursing home residents 65 years of age and older relied on public funds to pay for their care at the time of admission (of those whose stay was at least one month in length). Of this, Medicare, the federal insurance program for those over 64 years of age or disabled, was a small amount. Medicare covers acute illnesses and pays for skilled nursing care under certain circumstances for a limited period of time. The largest government program was Medicaid, an income-based program. Other sources of payment, including long-term care insurance, represented less than 3 percent of the total at the time of admission.

For those whose primary source of payment upon admission was their own resources — about 50 percent according to the survey — it is estimated that private resources may be exhausted in three to 12 months on average. They thus become eligible for government assistance. In the words of one DSHS official, "almost everyone is eventually a public-pay patient."

Government Funding

Most government long-term care programs in Washington are funded through DSHS. Medicaid is the largest single public funding source for long-term care in this state. This federally matched, state-operated program, established under Title XIX of the Social Security Act of 1965, will provide funds for about 81 percent of the long-term care services in the 1987-89 biennium. Medicaid recipients are required to contribute most of their income, social security benefits for example, to the cost of their care.

In Washington Medicaid pays for nursing home care, adult day health, case management and the Community Options Program Entry System (COPES). (Medicaid also funds a variety of other health-related services for eligible low-income persons which are not part of the long-term care program.) About 30 percent of Medicaid dollars in Washington will be spent on nursing homes during federal fiscal year 1987-88 (FY 1988). The federal match rate for Medicaid depends on a state's per capita personal income. For Washington the match has historically been slightly more than 50 percent.

In order to be eligible for Medicaid a client must have assets and income below federally defined levels. Once someone has become eligible for a Medicaid-funded program, he or she cannot be dropped from the program as long as eligibility requirements are met — it is an "entitlement."

In the past it has been possible for a nursing home resident to transfer assets to the non-institutionalized spouse and thereby be eligible for Medicaid. Recent changes in federal regulation require reductions in Washington's current asset transfer levels, potentially resulting in savings for the state. These changes in the Medicare program may also increase slightly the amount of long-term care funded by Medicare.

The major government-funded long-term care programs for the elderly in Washington are discussed on page 4.

Long-Term Care and the State Budget

The state's long-term care budget for the 1987-89 biennium is \$657 million. About half of this, \$330 million, is from the state general fund (see table 1). That's about 3.2 percent of the total state general fund budget for 1987-89.

The cost of the state long-term care program grew twice as fast as the state budget between 1983-85 and 1987-89 — 56 percent compared to 28 percent for the state general fund budget — and, according to DSHS estimates, the cost of maintaining the required level of services without program changes or enhancements in the next biennium will require an additional 34 percent. This spending level would bring the long-term care budget to an estimated \$438 million in state funds, 3.7 percent of the available state general fund revenue for the 1989-91 biennium, based upon the November 1988 revenue forecast. Higher nursing home reimbursement rates account for much of the growth in the state's long-term care budget.

According to a 1987 report from DSHS, "these escalating expenditures for nursing home care are driven automatically by Medicaid entitlement and by the statutory reimbursement

system." In particular, DSHS officials say the fastest growing areas of the reimbursement are property and return on investment. According to Kris Dyrud of All Seasons Living Centers, much of the cost increase in the last few years is from costs associated with new nursing home beds. Those construction costs are driven, in part, by government regulations such as building codes, Dyrud said. Also, property cost reimbursements are higher for newer nursing homes due to general construction costs and being on the front end of the depreciation schedule

DSHS has submitted a budget request for the 1989-91 biennium which differs from the status quo program in an effort to control costs. Final approval of program changes lies with the legislature. Among the proposals are use of federal Medicaid funds for community-based care, lowering the number of nursing home beds as a share of the elderly population, and revising the reimbursement formula to limit reimbursement for unused bed capacity.

Demographic Outlook

With lifespans increasing due to medical advances, the elderly population is growing. Many of the traditional providers of informal long-term care have entered the job market or are themselves elderly and unable to provide the necessary support.

The population of those 65 years and older is increasing faster than the total population and the fastest growing group is people 85 years of age and older. While the state's total population is expected to increase about 30 percent between 1988 and 2010, those 65 years of age and older are expected to increase 43 percent and the 85 years and older population will more than double. The demands this places on the state's long-term care program foreshadow what will happen as the baby boom reaches retirement. The front end of the baby boom will just be reaching age 65 in 2010.

As a share of the state's total population, those 65 years of age and older are currently about 12 percent of the total and are expected to increase to 13 percent in 2010. The sub-population of those 85 years of age and older is currently 1 percent of the total and expected to increase to about 2 percent in 2010 (see figure 2). At the same time the percent of the total population of working age — those aged 25 to 64 years — who will be the ones to support future public programs, will also increase from 52 percent to 55 percent.

The people most likely to need nursing home care are those 85 years of age and older. According to the 1985 National Nursing Home Survey, less than 5 percent of people 65 years of age and over are in a nursing home at a given time. The percentage increases with age: 1 percent of those 65 to 74 years of age, 6 percent of those 75 to 84 years of age, and 22 percent of those over 85 years of age were in nursing homes in 1985. Elderly women are the most common nursing home residents, due in part to longer life expectancies for women and the greater tendency of people without spouses to enter nursing homes, according to the survey.

Table 1

Washington State Long-Term Care Budget

(All funds, in millions)

Program	Biennium			
	83-85	85-87	87-89 ¹	89-91 ²
Nursing Home Care	\$319.2	\$389.9	\$499.5	\$697.4
Older Americans Act ³	20.8	20.7	21.7	22.0
Sr Citizen Svcs Act ³	14.1	15.1	15.0	15.4
Chore Services	48.4	57.9	71.1	76.3
COPES Program	10.0	25.5	35.0	54.2
CCF/AFH ⁴	9.8	9.9	11.3	12.4
Adult Day Health	1.2	1.4	1.8	1.9
NH Discharge	0.1	0.0	0.1	0.1
Respite Care	0.5	1.1	1.1	1.2
Total	\$424.0	\$521.4	\$656.6	\$880.7
Non-NH Total	104.9	131.5	157.1	183.3
	83-85/ 85-87	83-85/ 87-89	87-89/ 89-91	
Change in Total	23.0%	54.8%	34.1%	
Change in NH	22.2	56.5	39.6	
Change in Non-NH	25.4	49.8	16.7	

^{1/} Adopted

^{2/} Estimated required level (status quo programs)

^{3/} Funding source used for a variety of community-based services for the elderly including meals, in-home care, referral and transportation.

^{4/} Congregate Care and Adult Family Homes.

Source: DSHS

Washington's Long-Term Care Programs

Nursing home care is the largest single program in the state's long-term care budget, 76 percent of total expenditures in 1987-89 (see figure 1). In FY 88 the program served more than 16,600 patients on an average day. The state program is partially funded through Medicaid match from the federal government. Eligibility is determined by meeting the federally defined income and asset levels. The state pays for care at more than 270 skilled nursing and intermediate care facilities around the state. Payment rates are set according to a statutory reimbursement formula. As of July 1988 these rates ranged from a low of \$35 a day to a high of more than \$100 a day, depending on the area and age of the facility.

The state funds care in **adult family homes (AFHs)** and **congregate care facilities (CCFs)** for people meeting state program requirements. During the 1987-89 biennium the state will spend about \$11.3 million for these services. In FY 88 the average monthly caseload was about 1,700 people in CCFs and about 800 people in AFHs. There is no federal match for these programs currently, except for those people in Community Options Program Entry System (COPES). AFHs and CCFs can be less expensive on a daily basis than nursing homes — \$15 to \$20 a day compared to an average of \$56 for nursing home care for state payment levels. AFHs provide a family-like environment for up to four adults with limited nursing services available. CCFs provide supervision of day-to-day activities. CCFs and AFHs also house mental health and developmentally disabled clients.

Medicaid helps finance selected community-based long-term care services through the **COPES waiver**. In FY 88 the average monthly caseload for this program was 2,615 people. COPES is designed to prevent placing individuals in institutions unnecessarily when they prefer to remain in the community and may safely do so. Covered services include in-home personal care, congregate care, adult family home care, and case management. Recipients must otherwise be eligible for nursing home care and the cost of the services must be less than 90 percent of the statewide average nursing home rate.

According to the National Conference of State Legislatures "states must apply to the Health Care Financing Administration (HCFA) ... for permission to offer waiver services. The applications must describe services, recipients, and financial accountability, and comply with extensive reporting requirements. Applications must meet the test of cost effectiveness..." Under the waiver states may experiment by targeting specific geographic areas and have additional flexibility with eligibility requirements.

The COPES program has the same level of care, asset and income requirements as the Medicaid nursing home program. Entrance into this program is limited by the number of clients approved by the HCFA.

A number of states offer additional personal and community-based care programs through the Medicaid personal care option. Although eligibility cannot be restricted, as it can under the waiver, and services must be offered statewide, use of this option avoids some of the paperwork of the waiver process. Also, services must be prescribed by a doctor and have a medical component.

Additional use of Medicaid for personal care is currently being explored by DSHS. Officials estimate that about 40 percent of the people currently in AFHs, CCFs, and receiving chore services through state-funded programs would be eligible to have these services paid for under Medicaid personal care, allowing the state to serve additional people without a substantial increase in cost. As with the nursing home program, however, caseloads could be difficult to control under this financing mechanism.

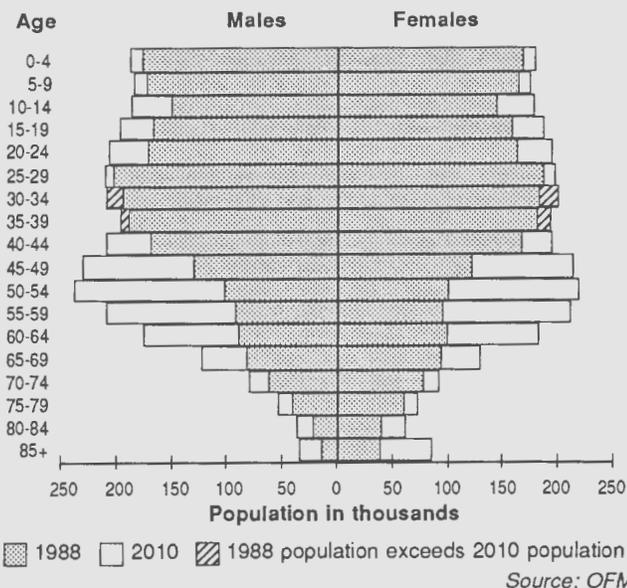
Washington finances similar services to those potentially funded through Medicaid personal care largely through state funds not matched by the federal government. The largest single program is the **chore services program**. This program, designed to maintain elderly, chronically ill, developmentally disabled or other disabled adults in their own homes and prevent unnecessary (and more expensive) residential care placement, accounts for 11 percent of the long-term care budget, \$71 million, in 1987-89. Caseload growth and eligibility requirements have been restricted in recent years to control costs. The current chore services caseload is about 12,600 people and entrance is limited.

After reaching a peak of more than 14,000 clients in 1981, eligibility was tightened and 4,000 clients were declared ineligible. The **volunteer chore program** was instituted to help absorb the impact of this change. This program is funded through the Senior Citizens Service Act and links volunteers with people "whose need for chore services is not being met by the chore services program." The program currently serves about 3,000 clients at a cost of about \$3 an hour (for administration and training).

The **caregiver respite program** was initiated as a pilot program in 1984. It is currently offered in three areas — Spokane, Vancouver and Bellingham — and is designed to provide breaks for informal caregivers in a variety of settings. This program was designed to encourage informal care and reduce the need for residential placement (and thereby public expenditures). A report from DSHS to the 1987 Legislature states that: "even a limited amount of respite care has the potential to save the state money in lieu of placing a participant in a long-term care facility."

Other long-term care services administered by DSHS include congregate nutrition, adult protective services, social day care, home-delivered meals, aging network home health program and adult day health.

Figure 2
Population by Age Group
1988 and 2010



The majority of long-term care for the elderly, 60 to 80 percent according to most estimates, is provided in homes by informal caregivers — most often daughters, daughter-in-laws and spouses. As more women enter the work force, participation of informal caregivers is reduced. In addition, as people live longer traditional caregivers may not outlive the people needing care, or may be of advanced age themselves and unable to provide adequate support. The potential reduction in informal care may result in increased reliance on formal alternatives and, ultimately, increased government long-term care caseloads as a percentage of the elderly population.

While most long-term care, about 90 percent, involves the elderly, there are other “at-risk” populations which may be on the rise. In particular, AIDS patients and those sustaining head and spinal cord injuries in automobile or motorcycle accidents are anticipated to increase. The number of people who survive with head and spinal cord injuries is increasing as breakthroughs in medical technology increase survival rates. People with head and spinal cord injuries can represent a significant expenditure because they are generally young and need a long period of support.

Long-Term Care: Major Factors

Two factors that have a major effect on how much the state spends on long-term care services are the nursing home reimbursement formula and the nursing home bed ratio. The nursing home reimbursement formula determines the amount of money spent by the state on a per bed basis. The bed ratio governs the number of licensed nursing home beds and hospital long-term care units (stated in terms of the number of persons 65 years of age and older).

These factors are related: If the state pays for the care of fewer persons in nursing homes (through more aggressive use of community-based alternatives for example) it ends up paying higher per-bed costs because of the way the formula covers overhead costs. In order for the state to achieve cost savings through greater use of lower cost alternatives to nursing homes, this relationship would need to be changed.

Nursing Home Reimbursement Formula

The largest single long-term care program provided by the state is the Medicaid nursing home program. The state reimburses nursing homes for their costs based upon a formula that is written in state law. It is intended to fulfil the federal requirement that reimbursement rates meet the costs of efficiently and economically operated nursing homes in providing quality care.

The cost reimbursement system is one area where states have some ability to control Medicaid costs through the type of reimbursement method used. According to DSHS officials, this is difficult in Washington because the formula is set in statute and attempts to make legislative changes are difficult.

The formula is based upon six “cost centers” which are used to measure the activities of nursing homes: nursing services, food, administration and operations, property, return on investment, and wage enhancement. Assuming an occupancy rate of at least 85 percent, daily rates are set for the upcoming year based on the prior year's costs in each cost center — a prospective system (see box, page 6).

Formula Not Problem Free

While the formula has been modified since it was adopted, it is not problem free. A number of problems with the formula have been identified by both state officials and nursing home representatives.

Does It Cover Costs?

The intent of the formula is to meet the federal mandate of reimbursing nursing homes for their costs. Several lawsuits against the state's former reimbursement program led to adoption of the current method, however, nursing home industry representatives claim that it still fails to adequately reimburse costs. There are currently two class-action lawsuits against the state challenging the formula. They will be tried jointly in 1989. According to Dyrud, “we are not paid cost. We are paid the lower of cost or the prospective rate.” Nursing home representatives point out that the relationship between costs and quality can't be divorced. Beyond a point you can't cut costs without cutting quality, they say.

Nursing Services

One area of contention is nursing services. According to Robert Ball, executive director of the Washington Health Care Association, the trade association representing most for-profit nursing homes in the state, the regulation of nursing costs, combined with a shortage of trained nursing person-

nel, puts nursing homes at a competitive disadvantage with other health care providers. Nursing homes, he said, have trouble attracting quality nursing staff, which can lead to high turnover rates.

The legislature approved minimum wage levels for nursing home staff to help control this high turnover. They are funded through the wage enhancement cost center. However, those wage rates are not high enough, according to Ball.

If nursing home clients have extraordinary needs requiring extra staff attention, nursing home operators may be compensated for the extra personnel that they must hire to provide the services. However the formula is slow to reimburse homes for these costs, according to Mike Wills of DSHS. Ball estimates an 18-month lag in the payment cycle.

Property

Another area of concern for the nursing home owners is the way in which the formula reimburses property costs. Nursing homes may be depreciated only once in the reimbursement formula. According to Steve Maag, former legal affairs director for the Washington Health Care Association, after about 15 years a nursing home has been substantially depreciated and is no longer an attractive investment — the property

reimbursement and return on investment are no longer sufficient to pay the debt service.

According to Maag, this may lead to the situation where it is a better deal to build a new nursing home, which can be fully depreciated, than it is to buy an older facility with little depreciation value. Because the property component of the reimbursement is higher on newer nursing homes, this could lead to increased costs for the state.

However, Wills explains that if nursing home operators are in the business for the long term, "the existing system of property reimbursement is superior." He points out that under the current system operators are paid more during the early years of facility operation, making the arrangement attractive to operators who are just starting up and whose debt may be heavy.

Aaron Katz of HealthSystems Resources, a Seattle consulting firm, points out that removal of the ability to depreciate the nursing home after the first time removes the financial incentive to buy and sell nursing homes. And, "that's the way it should be," according to Katz. Frequent changes in ownership of facilities can lead to lower quality, he said.

A 1986 report by the Legislative Budget Committee examined the property portion of the reimbursement formula. The

Nursing Home Reimbursement Formula Cost Centers

The **nursing services** cost center covers the wages and benefits of the nursing staff. This cost center is "lidded" in two ways: It cannot increase more than the medical component of the consumer price index (CPI) and a limit is set on the number of nursing contact hours for which the state will pay. This limit is dependent on the needs of the patients.

In the **food** cost center, each nursing home is paid a flat rate for the costs of bulk and raw food and beverages. For FY 89 this rate is \$3.62 a day.

Administration and operations (A&O) includes operating costs not covered by nursing services and food, including property management and other support services. Costs in this cost center are limited by the operating costs of all nursing homes in the state. Operators whose costs exceed the 85th percentile are paid no higher than that rate.

The **property** cost center reimburses operators for depreciation of assets used in the provision of nursing home care. Buildings are depreciated on a 30-year schedule and depreciation schedules on other types of property depend upon the estimated life of the asset. Sale of a facility does not reestablish the depreciation base; the depreciation schedule of the seller is inherited by the purchaser. Thus, the state participates in the purchase of the asset only once. It was hoped that this would encourage long-term ownership of facilities. Concern has been expressed that this provision will lead to early divestment of older facilities and higher costs associated with new construction.

Return on investment has two parts: a financing allowance and a variable return allowance. The financing allowance is determined by multiplying the net invested funds of each facility by a fixed rate of return on investment, currently 11 percent. (Net invested funds is defined as the net book value of tangible fixed assets employed in providing patient care plus an allowance for working capital equal to 5 percent of the allowable costs of the contractor for the previous calendar year.) The rate of return on investment is set by the legislature and reevaluated every two years.

The variable return allowance was designed as an incentive for efficiency. It is determined by grouping the facilities based on their costs for A&O and property for the previous reporting period. A rate of return is assigned to each facility based on the group it is in. Those with operating costs in the lowest quarter receive an additional 4 percent of their rates for nursing services, food, A&O and property. Those with costs in the highest quarter receive a 1 percent rate of return on the rates for those areas.

The **wage enhancement** cost center is based on the cost reported by nursing homes of bringing employees up to a minimum wage level as well as a component to fund increases for those employees already above the minimum. The minimum wage for nursing home employees was established by the legislature at \$4.76 an hour as of January 1988. This rate will increase to \$5.15 an hour as of January 1989.

study concluded that at the present time there is no need "to change the property portion of the state's nursing home reimbursement system" based on finding "inconsistent and incomplete indicators as to the presence of a problem." They suggested collection of additional information to allow analysis the issue, he said.

Return on Investment

Some observers feel that the current rate of return on investment, 11 percent, is too high. This rate is set by the legislature and examined every two years. One potential option is to tie the rate of return to some official measure of investment returns, such as treasury bill rates. This could prevent a situation where the state is locked into paying a high rate of return set at a time of peak interest rates.

The return on investment portion of the formula includes a variable return allowance which is designed to be an efficiency incentive. DSHS staff indicate, however, that it could be more effective. There are no penalties for inefficiency, only a lower reward than might otherwise be possible. Nursing homes with high administration and operations costs and property costs receive a 1 percent return under the variable return on investment, rather than some higher amount for more efficient performance.

Reimbursement Formula and Privatization

All nursing home care in the state long-term care program, with the exception of that which takes place in veterans' hospitals, is "contracted out," as is the provision of many of the community-based alternatives to nursing homes, such as CCFs, AFHs and chore services. However, nursing homes and other care providers are not very different from extended public agencies. Their income is based on the statutory reimbursement formula without the administrative controls which accompany other government programs. It may well be the worst of both worlds: it lacks the competitive aspects of the private sector but has the administrative regulation of the public sector. Dyrud of All Seasons points to an additional issue, "(we) don't have a lot of benefits that go with government programs, retirement benefits for example."

A Washington Research Council special report on privatization published earlier this year concluded that the key to cost savings through contracting out was maintaining a competitive environment and writing contracts which reward efficiency gains. The current statutory reimbursement formula, by reimbursing homes for their costs and providing little incentive for cost control, eliminates, for the most part, the advantages of privatization. In addition the formula is difficult to change, in part because of the political nature of the legislative process.

Occupancy Levels

According to DSHS officials, an additional problem with the existing reimbursement system is that little money can be saved when the state reduces the number of nursing home placements. The per capita cost of nursing home care is kept

lower when occupancy is higher because the fixed overhead costs are shared by a larger number of patients. By reducing occupancy rate below the current average, overhead costs are spread over fewer patients, per capita costs go up, and the total bill does not change substantially. DSHS is proposing to raise the occupancy floor for the purpose of calculating payment levels from 85 percent to 92.5 percent.

Cost Control and the Reimbursement Formula

Budget figures indicate that the formula is a major barrier to cost control. While nursing home caseloads are expected to increase only 5 percent in the 1989-91 biennium, the cost of the nursing home program is expected to increase by about 40 percent. Between 1981 and 1987 the annual average growth in nursing home daily rates was about 7 percent while the general level of prices in the Seattle area increased about 3 percent annually. According to DSHS the fastest growing cost centers are property and return on investment. The rate of growth is not gradual: new beds generally cost more than existing beds, causing average daily rates to step up. Newly authorized beds are a major reason for the increase in costs going into the 1989-91 biennium. According to nursing home industry representatives, one reason for the increase in property costs is meeting federal and state regulations, something over which they have no control.

While the reimbursement formula has problems as it relates to cost control, the state is not going to save a major amount of money by changing the formula, according to Wills. The average cost of \$22,000 a year is not going to be substantially reduced. And if more people are diverted to alternate-care settings, the people in nursing homes are going to be, on average, more disabled and require more extensive and expensive care.

Nursing Home Bed Ratio

The nursing home bed ratio is another important variable which affects what the state pays for long-term care. The State Health Plan establishes a nursing home bed ratio, stated as the number of nursing home beds per 1,000 people in the state 65 years of age and older. Once the statewide bed ratio has been established, beds are allocated throughout the state.

According to Ball, basing the number of beds on the population aged 65 years and older fails to take into account the use of beds to care for younger patients, such as those with AIDS or developmental disabilities. The AIDS problem is currently being examined by the Long-Term Care Advisory Group of the Washington State Health Coordinating Council (SHCC).

The SHCC, an agency appointed by the governor and staffed by DSHS employees, writes the State Health Plan and is responsible for regulating a variety of health care services. In 1987 it set a target ratio of 53.7 nursing home beds. This ratio applies to all licensed nursing home beds and hospital long-term care units, regardless of funding source. According to Dan Rubin, executive director of the SHCC, the target

bed ratio approximates the national average. Charles Reed, DSHS assistant secretary for aging and adult services, points out that while the target bed ratio was based on the national average at the time it was adopted, the average has since declined and the average bed ratio on the west coast is lower, about 45 beds per 1,000 people.

According to a 1987 DSHS report, as of April 1986 the bed ratios among the states ranged from a low of 3.9 beds per 1,000 in Arizona (which has limited participation in the Medicaid nursing home program) to a high of 93.6 beds in Minnesota. Washington ranked 25th with a bed ratio of 52.8 beds per 1,000. (Listings of bed ratios from different sources may differ according to how beds are classified and the population estimates used.)

Michael Saslow of Oregon's Senior Services Division says this variation cannot be attributed to differences among populations. Saslow argues that there is no reason to assume that the disability levels of elderly populations in different areas are significantly different.

Moreover, he argues that rates of nursing home utilization are tied to bed supply, rather than patient need. A study conducted in Monroe County, NY determined that an appropriate nursing home ratio would be about 30 beds per 1,000 persons over age 65. According to Reed, "when beds are built they are probably going to be filled. Once you fill those beds, you have to pay for them. Even though people may enter as private-pay, public programs pay in the long run as residents spend down (their private resources) and become public patients."

Oregon has set a target bed ratio of 40 beds per 1,000 population age 65 and over. It is based on the need of 30 beds per 1,000, and allows for use of beds by those under 65 years

of age and for local variation in demand. The remainder of their long-term care needs are met by extensive use of community-based alternatives, many of them funded through the Medicaid waiver (see Oregon's Long-Term Care Program, page 9).

The SHCC is currently considering a recommendation to lower the target bed ratio to 45 beds per 1,000 people aged 65 years and older as of 1990. Because it is a significant reduction in the number of beds, this recommendation of the council's Long-Term Care Advisory Group is accompanied by a strong recommendation to the legislature that funding be increased for community-based care alternatives.

Certificate of Need

The number of licensed nursing home beds in the state is controlled through the certificate of need process (CON). By limiting the number of beds, the state can control nursing home caseloads.

While CON may have a role in limiting long-term care costs by limiting caseloads, it also creates an artificial economic environment. Prices are not determined by the market forces of supply and demand. Eliminating the CON process would result in increased supply. Economic theory would then predict that competition would increase, causing prices to decrease, quality to improve, or both.

However the health care arena may be one in which this is not the case. There are arguments on both sides of this issue (see Certificate of Need — Pro and Con). Ball of the WHCA does not feel that eliminating CON is a good idea: "when we step into human services, free enterprise is no longer successful." According to Katz of HealthSystems Resources, evidence that competition in the health care industry leads to cost control is not easy to find. In part, this is because bills are often paid by insurance, rather than directly by the consumer, he said, and when the consumer is making a decision an element of emotion enters into the equation — cost may come second to quality and level of care. In addition, he noted that, particularly for older adults, it may be difficult to sort out the system — to what extent can the consumer be informed? Finally, with the entitlement nature of Medicaid, controlling the number of beds is one way the state has of controlling nursing home caseload growth. Eliminating CON could mean giving up some of this control.

Recently a few states eliminated their CON programs, essentially deregulating the supply of nursing home beds. In Utah nursing home beds have "mushroomed" since the CON was eliminated in 1986, according to Anne Workman of the Utah Department of Health. Occupancy rates are down, there has been little or no change in cost, and quality may have declined somewhat, she said. In Arizona the situation is similar. According to Cal Lockhart of Arizona's Health Services Department, the number of beds has doubled, occupancy rates have declined from about 90 percent to about 70 percent, and there has been some deterioration in quality since the CON was eliminated in 1982. The quality problems stem, in part, from the nursing shortage, according to Lockhart

Certificate of Need — Pro and Con

For certificate of need:

- Provides an additional mechanism (beyond eligibility requirements) for the state to regulate caseloads, and thereby control costs
- Allows review of capital expenditures for proposed nursing homes
- Recognizes that government pays for about half of the nursing home services purchased
- Provides a quality check through review of past performance during application process

Against certificate of need:

- Is not necessary in order to insure quality of service or management of caseload growth
- Restricts market entry, supply and competition and equates to rationing
- Protects inefficient and poor quality providers
- Is not necessary in order to discourage overuse — nursing homes are the solution of last resort
- Is not necessary in order for patients to make informed decisions about service purchases

— there are not enough nurses to go around. Katz said the nursing shortage was a problem in Washington as well and that the shortage hits nursing homes particularly hard because the jobs there are low on the status ladder — wages and quality of work environment tend to be lower than at other health care facilities.

Potentials for Cost Control

Long-term care for the elderly currently makes up about 3 percent of the state budget and the number of elderly, especially those most at risk of residential placement — persons over 85 years of age — is expected to increase as a share of the total population over the next 20 years. The needs for long-term care of younger people with AIDS and head injuries may also increase. As a result, caseloads are expected by most to grow rapidly between now and 2010, when the baby-boom population will just be reaching retirement age.

Based on our research there are at least two courses of action which could slow the growth in long-term care costs and which warrant consideration and analysis. The first is to further constrain the supply of nursing home beds and shift resources into expanded provision of community-based care alternatives. This is the general course of action which will be pursued by DSHS in the upcoming legislative session.

The second, which has received much less attention or evaluation, is to open up the supply market of nursing home beds, by eliminating the certificate of need process, and allow the market to respond to demand for nursing home care. These alternatives plus some additional options for privatization are summarized below.

Lowering Bed Ratio and Restricting Supply

Community-based long-term care programs are less expensive than nursing home care and substitution of community-based care for nursing home care on a one-to-one basis could save money. There is little information, however, on the number of persons currently in, or destined for, nursing homes who could receive the necessary care in the alternative settings. According to testimony at hearings held by DSHS on long-term care, nursing home care is the choice of last resort for most seniors.

For greater use of community-based care to be an effective cost control measure, the bed ratio would need to be reduced. This would relieve the state from having to pay for empty beds through the reimbursement formula. Or the reimbursement formula would need to be changed so that low occupancy rates do not result in higher per bed costs. Both of these options are being proposed by DSHS officials to the legislature in 1989.

Latent Demand for Alternatives

Recent studies show that increased community-based care doesn't necessarily save money, however. Some people are not willing to enter a nursing home, but would accept help in their own home, if it were available. A survey of 16 community-care demonstration projects by Peter Kemper of the National Center for Health Services Research concluded "expanding public financing of community services beyond what already exists is likely to increase costs. Small nursing home cost reductions are more than offset by the increased costs of providing services to those who would remain at home even without the expanded services."

Oregon's Long-Term Care Program

Oregon has a target nursing home bed ratio of 40 beds for every 1,000 people aged 65 years and older. This contrasts with Washington's current target of 53.7 beds.

Oregon's lower bed ratio was adopted as part of a policy that it is not necessary to house seniors in nursing homes if alternatives can be provided. This policy is, in part, an effort to control escalating nursing home costs the state experienced in the late 1970s. And the state achieved a 6 percent reduction in Medicaid nursing home cases between 1979 and 1986.

In order to achieve this reduction, Oregon developed and implemented a comprehensive long-term care plan in conjunction with aggressive use of the Medicaid waiver. Major components of the program include an assessment instrument, case managers, pre-admission screening teams, relocation teams (to assist nursing home residents to reenter community settings), diversion and resource developers (to assist with placement in appropriate community settings), and client care monitoring. Oregon makes use of adult foster homes and provides in-home services as part of the program.

According to Richard Ladd, administrator of the Oregon Senior Services Division, "Oregon uses a social model for service delivery that promotes and maintains independence. We want to support and enhance the client's ability for self-care... and actively include them in planning for care provided by others."

However, a reduction in the number of Medicaid-paid nursing home residents doesn't necessarily mean a reduction in costs. The program is serving more clients and nursing home caseloads have gone down. Nursing home spending has not decreased, however, and per client costs have increased in both community and institutional settings. Citing concerns about quality and access to the necessary level of care, the for-profit nursing homes have challenged Oregon's extensive use of adult foster homes.

Nursing homes are fairly strictly regulated and inspected once a year. Complying with these regulations costs money. The community-based settings are less regulated and cost less, however with greater use of community-based settings will likely come more regulation, increasing future costs of community-based care.

Case Management

Most of the projects studied added services without attempting to control nursing home usage. Significant cost savings were found in a few of the programs examined and these savings occurred in programs which used case management and pre-admission screening, targeting those applying for admission to a nursing home.

Because patients who enter nursing homes as private-pay patients often reduce their assets to Medicaid-eligibility levels in three to 12 months, some have suggested pre-screening and case management for all long-term care recipients, regardless of the payment source. According to Reed of DSHS, "another characteristic of the system which can have a major impact on costs is whether private-pay patients go through the same system as the public-pay group...unless you have private-pay pre-placement screening, the backdoor to the long-term care system is open and you cannot control it...the low- to middle-income group who enter as private-pay will have a big impact on the cost of the system." He suggests that nursing homes could be required to assess the financial situation of all new patients and refer those who would "spend down" in six months or less to the case managers. If community-based care is appropriate, this could reduce the state's costs by extending the amount services which could be purchased with the private funds.

Medicaid Waiver for Personal Care

Currently, most community-based care is paid for with state funds, without federal Medicaid match. However, federal Medicaid funds could be used, as they have in other states including Oregon, to provide homemaker services, personal care services, adult day health services, habilitation services, and respite care. The problem, many contend, is that, similar to other federal Medicaid programs, anyone who meets eligibility criteria would be entitled to receive those services, making it difficult to control caseloads.

In addition, federal dollars mean meeting federal requirements and, in some cases, this can mean spending more money to comply with new federal requirements or losing the federal match. An example of this is the portion of the Omnibus Budget Reconciliation Act of 1987 which applies to long-term care. According to DSHS estimates, complying with these regulations will cost an additional \$20 to \$40 million in state funds in the coming biennium and, if the state doesn't comply, it could lose federal funds.

Eliminating CON and Opening Up the Supply

Eliminating the certificate of need process, which controls the number of nursing home beds in the state, would likely result in more nursing home beds. And nursing home care, according to some, has the potential to be higher quality and lower cost in an open market. Careful crafting of complementary regulation would likely also be necessary to avoid problems, however. The certificate of need process for nursing

homes is one which has not been thoroughly reviewed since it was established in the early 1970s. The federal requirement for this process was recently removed and some states have acted to eliminate their CON programs since that time

The states which have eliminated their certificate of need requirements have not yet demonstrated much measurable success in the form of lower prices or higher quality. However, they have not had time to achieve a state of equilibrium and there are factors, like the national nursing shortage, which complicate an already complex issue. The potential for this course of action is worth further exploration in Washington.

Additional Opportunities For Privatization

Privatization already plays a major role in the state's long-term care delivery system, through contracting with private nursing homes and other private alternative care providers. However, the current reimbursement system, together with an artificially restricted supply of nursing home beds, eliminates most of the advantages of contracting. In addition to rethinking the reimbursement formula and the certificate of need program, other opportunities for cost control in long-term care through privatization may exist.

Using Volunteers

When eligibility in the chore services program was restricted in 1981 a volunteer chore program was initiated to help meet the needs. It is funded through the Senior Citizens Service Act. The senior health insurance benefit advisor (SHIBA) program, established by the Office of the Insurance Commissioner, also uses trained volunteers to help consumers understand the implication of the long-term insurance they consider purchasing.

Facilitating Self-Help and Insurance

Encouraging private financing of long-term care is another form of privatization where public expenditures are reduced or eliminated through the use of private funds. One form of this is long-term care insurance, which helps to pay for extended care in a nursing home or nursing services in private homes.

New regulations in Washington state on long-term care insurance went into effect as of January 1, 1988. Ed Ives, deputy commissioner for public information of the Office of the Insurance Commissioner, says he is now comfortable in saying that you can't buy a bad long-term care policy in this state.

Long-term care insurance is not inexpensive, with premiums ranging from \$500 to \$2,000 a year. According to James Braziel, a planner with Estate and Financial Planning of Chico, California, "the cost of the plans can be prohibitive for low-income, low-asset clients. Those people would be better off acquainting themselves with the 'spend down to Medical (California's Medicaid program)' strategy."

And there is a policy dilemma for lawmakers. Do they encourage everyone not currently eligible for Medicaid to purchase long-term care insurance, regardless of their asset levels, in order to save the state money? At present the state's primary role has been to regulate and provide information to help prevent the sale of "bad" policies.

One commonly cited barrier to long-term care insurance playing a major role in the financing of long-term care is a lack of perceived need for it: Seniors do not think they will need nursing home care or believe that it will be covered by Medicare (which accounts for only a small percentage of actual nursing home payments). According to the National Conference of State Legislatures, states could play an important role in educating people about what is covered by Medicare and what is included in a "good" long-term care insurance policy.

A 1988 study by the Brookings Institution concluded that "private sector financing mechanisms for long-term care could grow substantially.... Nevertheless ... private sector financing options cannot do the whole job....(and) are unlikely to be affordable by a majority of elderly, to finance more than a modest proportion of ... expenditures, or to have more than a small effect on Medicaid expenditures and the number of people who spend down to Medicaid financial eligibility."

Encouraging Informal Caregiving

Programs which encourage informal provision of care, thereby reducing or delaying the need for public support, represent another potential area of cost savings which is also a form of privatization. In Washington this is currently limited to the respite care program in Spokane, Vancouver and Bellingham.

Some states pay family members a minimal amount to encourage informal care or offer tax incentives for private provision of long-term care to relatives, friends or neighbors. Expanding the federal income tax credit for dependent care to

cover persons who are not legal dependents or for care which is not necessary for employment, or some type of tax credit through the state property tax are potential alternatives.

Summary

This paper has outlined our current system of long-term care in Washington, how it is financed, some of the key problems with the current system and some suggestions for potential cost saving which warrant further exploration. Based on our research, greater use of community-based alternatives appears to hold the most promise for controlling costs and improving quality of life. By maximizing individual self-reliance, community-based services allow potential for more independent living and extend the time before people have to resort to the more expensive nursing home alternative.

Under the current system, bed ratios would need to be lowered and the reimbursement formula altered, in order for state nursing home costs to be controlled. And given the latent demand which most assume exists for community-based care, actual costs will likely go up as alternative-care caseloads grow. Careful targeting of who is to receive state-financed services would help to control this. The certificate of need process, which regulates the number of nursing home beds, is a key factor in the equation which has to date gone almost unquestioned. Although a detailed review was beyond the scope of this work, this is an important part of the health care cost environment and warrants deeper understanding.

The list of cost control potentials, then, includes opening up both the supply of nursing home beds and the supply of alternative-care options; regulation of alternative-care options to assure quality; reimbursement systems which protect both consumers and providers of long-term care, as well as the taxpaying public; case management to assure appropriate service provision; effective and widespread consumer information; and incentives for informal caregiving.

Bibliography

Grimaldi, Paul L., *Medicaid Reimbursement of Nursing-Home Care*, American Enterprise Institute for Policy Research, Washington, D.C., 1982.

Kemper, Peter, Robert Applebaum and Margaret Harrigan, *Community Care Demonstrations: What have we learned?*, *Health Care Financing Review*, Summer 1987.

Low, Harry J., *LTC to the Rescue*, *Financial Planning*, June 1987.

National Center for Health Statistics, Esther Hing: *Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey*, *Advance Data From Vital and Health Statistics*, No. 135, May 14, 1987.

National Center for Health Statistics, Genevieve Strahan, *Nursing Home Characteristics: Preliminary Data From the 1985 National Nursing Home Survey*, *Advance Data From Vital and Health Statistics*, No. 131, March 27, 1987.

National Conference of State Legislatures, *Long-Term Care for the Elderly: A Legislator's Guide*, May 1987.

National Conference of State Legislatures, *What Legislators Need to Know About Long-Term Care Insurance*, May, 1987.

Rivlin, Alice M. and Joshua M. Wiener, *Caring for the Disabled Elderly: Who will pay?*, the Brookings Institution, Washington, D.C., 1988.

Washington State Legislative Budget Committee, *Special Study: Nursing Home Reimbursement System*, Report No. 87-4, December 1986.

Washington State Department of Social and Health Services, *Respite Care Demonstration Projects: A Report to the 1987 Legislature*, January 1987.

Washington State Department of Social and Health Services, *Toward Managed Long-Term Care: A Progress Report*, October 1987.

Washington State Office of Financial Management, *Forecasts of the State Population by Age and Sex: 1987-2010*, December 1986.

About the Washington Research Council

The **Washington Research Council** is a nonprofit, non-governmental public policy research organization. Its mission is to serve its members by promoting efficient and effective government through independent analysis of public expenditure and taxation policies, coupled with broad dissemination of these analyses. Funding for the **Research Council's** work comes primarily from member dues and private grants. Members include businesses, schools, libraries, individuals and government agencies.

You can share in the **Washington Research Council's** constructive work and contribute to improved government through your investment in a tax deductible membership.

As a **Research Council** member you will receive: The monthly *Notebook* newsletter; up-to-date information and analyses of tax and spending issues through our *Public Policy Briefs*; special reports; and major **Research Council** publications, including *How Washington Compares*, *Washington State Budget Trends*, *The Citizens' Guide to School District Budgeting* and *The Citizens' Guide to Local Government*.

For membership information call (206) 357-6643 or write to the **Washington Research Council**, 906 S. Columbia, Suite 350, Olympia, WA 98501.

The Washington Research Council would like to thank the persons who reviewed this publication. They include: **Robert Ball** of Washington Health Care Association (WHCA), **Kris Dyrud** of All Seasons Living Centers, **Aaron Katz** of HealthSystems Resources, **John Larson** of Hillhaven Corporation, **Charles Reed** of the Department of Social and Health Services (DSHS), **Dan Rubin** of the State Health Coordinating Council, **Mike Wills** of DSHS.

Washington Research Council staff who contributed to this publication were **Barbara A. Cellarius**, senior research analyst; **Elaine L. Ramel**, vice president for research; **Richard S. Davis**, president; and **Kathleen Gillespie**, research intern.

The Research Council has available videos on both long-term care and privatization. For more information contact the Research Council office at (206) 357-6643.