The Budget Resolution: The Devil's in the Details

By Herbert P. Weiss

Having missed the April 15th deadline by which to pass a budget resolution, on May 2, the Clinton administration and GOP leadership announced a compromise on the fiscal 1998 budget, one that would balance the federal budget by 2002.

Overcoming sharp partisan bickering over tax cut proposals and how to rein in rising costs in the Medicare, Medicaid and Social Security programs, the House and Senate in mid-June passed landmark legislation to balance the federal budget. The Senate approved their budget-cutting bill by a vote of 73–27 and the House bill passed by a vote of 270–162. The last time Congress passed sweeping budget legislation intended to balance the federal budget was in 1969.

House and Senate leaders in conference committee along with White House officials will meet after July recess to craft a compromise budget bill—versions of the House and Senate bill differ from each other in many details. Once a conference report is passed by Congress it will be sent to President Clinton to be signed into law.

Although the budget plan easily passed in both chambers of Congress, the "devil is in the details," warned Jeff Eagan, Director of the Long-Term Care Campaign, a coalition representing 150 consumer groups advocating quality long-term care services.

Proposed Budget Cuts Hit Nursing Facilities

Under the House bill cuts to the Medicare program will reach the $115 billion mark (or 8.5% over the next five years), with the Senate cutting $117.8 billion. These spending cuts will be made mostly by slashing $100 billion in payments to hospitals and providers. The elderly would be hit with increased Medicare premiums bringing $15 billion into federal coffers. Establishing new prospective payment systems would trim payments to skilled nursing facilities by $10.5 billion and to home health agencies by $18 billion, over five years.

"Long-term care providers are taking the largest hit of Medicare cuts as a percentage," added Robert Greenwood, manager of public affairs for the American Association of Homes and Services for the Aging. According to Greenwood, $10.5 billion in cuts is an unrealistic amount because a prospective payment system cannot meet this target.

Greenwood suggested that the new prospective payment for skilled nursing facilities be phased in over six years rather than four. "Providers need time to buy the new equipment and train staff," he said. The Health Care Financing Administration (HCFA) needs additional time to collect the data and to develop procedures to design a fair payment system, he added.

Under both bills, the Medicaid program is also put on the chopping block to help control costs. The House bill calls for $12.6 billion in cuts over five years while the Senate chops $16.9 billion. Both enable states to implement managed care and other revisions in their Medicaid plans without having to obtain a waiver from HCFA.

Even with an intense last-minute lobby of nursing home trade groups, both House and Senate budget bills repealed the Boren Amendment, a federal law that requires state Medicaid reimbursement to meet the program costs of efficiently and economically operated facilities.

CONTINUED ON PAGE 43

"The Boren Amendment ... represented a commitment on behalf of the federal government to see that the costs for high quality care were covered. Now the policymakers have chosen to no longer honor that commitment."

—Paul Willging, Executive Vice President of the American Health Care Association

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Herbert P. Weiss, NHA, is a Providence, Rhode Island-based writer covering aging and health care issues.

The Devil's in the Details

CONTINUED FROM PAGE 6

While repealing the Boren Amendment, both House and Senate budget bills require states to implement a public notice and comment period for rate changes. The House bill freezes reimbursement rates for 18 months, beginning October 1, 1997. Finally, the Senate bill requires the Secretary of Health and Human Services to conduct a study (within four years of enactment) on the methodologies states use to set rates and to determine how those methodologies will affect access to services, quality of services and safety of beneficiaries.

"Part of the federal standards initiative was a provision called the Boren Amendment, which represented a commitment on behalf of the federal government to see that the costs for high quality care were covered," said American Health Care Association Executive Vice President Paul Willging. "Now policymakers have chosen to no longer honor that commitment." According to Willging, without the Boren Amendment, states are not required to cover the costs of care to more than a million impoverished nursing facility residents.

Lori Owen Smetanka, of the National Citizens Coalition for Nursing Home Reform (NCCNHR), counters, "any Medicaid reimbursement system should include a method for accountability that determines if facilities are actually providing the care and services for which they are paid." She noted that NCCNHR developed a method to determine accountability which was not included in either House or Senate bill.

Consumers Uneasy About Budget Deal

According to Eagan, aging consumers are concerned about a provision in the Senate bill that would impose a $5 per visit copayment for most home health visits—this would generate $5 billion in revenues for federal coffers. Under current law, there are no copayments.

"This copayment is a sickness tax on some of our most frail elderly," Eagan says. Those using home care services are usually low income widows over age 75. "The sicker you are the more you pay." Eagan noted that the provision caps the copayment at $760 annually.

Another hot issue for aging advocacy groups is Medicare eligibility for home-bound elderly. Fifty organizations signed a letter drafted by the National Council on the Aging (NCOA) to call on Congress to delete the language in a House Ways and Means Committee budget proposal that would restrict eligibility for home care services provided to home-bound Medicare recipients.

Consumers warned that this proposal would restrict four million recipients from leaving home more than five times a month, more than three hours at a time and more than 16 hours a month. However, the final House budget bill calls for a study by HHS on the issue.

"The home-bound definition proposal was not well thought out. When people took a look at it they realized that the bill just didn't make sense," Howard Bedlin, NCOA's Vice President of Public Policy, told ACHCA. "NCOA certainly will work hard to make sure that the study is conducted properly to take into account patient needs," Bedlin said. ❖❖

Medicare Budget Proposals Side by Side

Issue	House	Senate	Compromise
Age of Eligibility	no change (65)	gradually increase to 67	no change (65)
Medical Savings Accounts	500,000 participants $6,000 deductible no cap on out-of-pocket spending	100,000 participants $1,500–2,250 deductible $3,000 cap on out-of-pocket spending	no provision
Premium Structure	no change (25%)	increases based on income	no change (25%)
Home Health Copayments	no change (no copayment)	$5 per visit, capped at $760 (no copayment)	no change
Balance Billing Protections	no limits on physician charges	no limits on physician charges	no change (charges limited to 115% Medicare rate)

Source: National Council on Aging, June 27, 1997

Boren Axed from 1997 Federal Budget Act

By Herbert P. Weiss, NHA

The Balanced Budget Act of 1997 was signed into law on August 5 by a very happy President Clinton during a White House Rose Garden ceremony. It contains several provisions affecting the health care profession, not all for the better, say some special interest groups.

Under the final budget accord, Medicare spending will be slashed by $115 billion, or 8.5% over five years, mostly by cutting $100 billion in payments to hospitals and providers. Increased Medicare premiums would bring about $15 billion into federal coffers.

The agreement establishes a Medicare prospective payment system. This system would trim Medicare payments to nursing facilities by $9.2 billion and to home health agencies, $16.2 billion.

"We can live with a prospective payment system (PPS) for nursing homes phased in over a four-year period," said Michael Rodgers, Senior Vice President of the American Association of Home and Services for the Aging (AAHSA), adding that the association had pushed for a more gradual six-year phase-in of PPS.

According to Rodgers, AAHSA will closely monitor the creation of PPS as it moves into the regulatory arena. The nonprofit provider group calls for the new payment system to reflect the cost of providing care to medically complex patients, to recognize regional differences for providing care and to make adjustments for updating the inflationary costs each year.

The new budget law also cuts $14 billion from the Medicaid program over five years by allowing states to implement Medicaid managed care and other revisions in their Medicaid plans without having to obtain a waiver from HCFA.

Rodgers noted that the final budget package also includes a repeal of the current $150 million cap on financing with tax-exempt bonds. Now new financing using 501(c)(3) bonds are not subject to any cap

CONTINUED ON PAGE 19

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A sampling of provisions found in the Budget Act of 1997 of interest to nursing home providers:

- Beginning in 1999, Part B rehabilitation therapy services are capped at $1,500 per year per service with a market basket update that applies until 2002.
- A Bipartisan Medicare Commission is established to report back to Congress by March 1, 1999, on the long-term structure and financial solvency of the Medicare program.
- Skilled nursing facilities will bill for all covered services provided to residents under Medicare Part B with payments being made to the facilities (expect for physician and physician-related services).
- Hospitals discharge planners are required to notify patients of postacute alternatives to hospitals and of any financial interest the hospital may have in the provider getting the referral.
- A nursing assistant can now petition to have his or her name removed from their state's nurse aide registry if the action that caused them to be placed on the registry did not reflect a pattern of abuse.
- States may impose alternative remedies to bring about compliance without being required to repay the federal government what the state would have received in civil money penalties.
- Social Security benefits are restored to legal immigrants, many who reside in nursing homes and housing for the elderly. Legal immigrants who were in the country as of August 22, 1996 and subsequently became disabled would qualify for SSI if they meet income requirements.
- The PACE program and Social Health Maintenance Organizations will be expanded.

Source: Materials provided by American Association of Homes and Services for the Aged, American Association of Retired Persons and American Health Care Association, 1997.

ful in the early 1990s and were able to structure large portfolio financings with experienced and qualified operators at very aggressive spreads.

Insurance Companies

For many years, insurance companies, especially Canadian firms, have been making nursing home loans. However, the early 1990s saw these companies pull out of the market because of other realty-related problem loans. Their underwriting tends to be strongly operator-focused, with typical real estate loan-to-value and coverage requirements slightly greater (75% loan-to-value, 1.3-1.4 minimum debt service coverage ratios).

These companies' spreads are considerably lower than conduits with minimum spreads of 150 basis points over Treasuries to maximum spreads of 250 basis points. However, with few exceptions, insurance companies have been slow to embrace senior housing. Insurers currently loan solely on congregate care facilities and congregate care with assisted living attached.

Credit Companies

These institutions are intrigued with senior housing. Although their participation is limited, they are especially attracted to increased pricing opportunities. They have embraced congregate housing and, to a lesser extent, assisted living. However, their level of commitment has been disappointing and more of a "toe-stubbing" effort for upper-end multi-facility operators. These institutions can take advantage of the unregulated nature of an emerging industry that can see profit opportunities.

As an industry that is based on need and driven by service, senior housing and health care offers plenty of opportunities. By working with experts who know how to facilitate senior housing and health care financing, both lenders and owners will benefit. ❖❖

CONTINUED FROM PAGE 7

limitations. Existing debt may be refinanced but will be subjected to the $150 million dollar cap.

Boren Amendment Repealed

Nursing home groups mourn the repeal of the Boren Amendment, a federal law enacted in 1980 that required state Medicaid reimbursement to meet the program costs of efficiently and economically operated facilities.

Under the new law, states must submit their proposed Medicaid rates and the methodologies under which their rates were established to public process. In addition, the Secretary of Health and Human Service must submit a report to Congress in four years detailing the impact that state process has on access, safety and quality.

The repeal of the Boren Amendment, which takes effect October 1, was a loss for nursing home and other health care provider groups, Rodgers said. He conceded that the political muscle of state governors doomed provider efforts to retain the existing federal law in the final budget package. "Long-term care providers and hospitals were sacrificed to the vagueness of state systems in setting up reimbursement systems," he said.

With the repeal of Boren, Rodgers predicts that there may be a growing access problem and decreased quality of care provided by nursing facilities as states begin to ratchet down Medicaid rates.

Elma Holder, founding director of the National Citizens Coalition for Nursing Home Reform (NCCNHR), stated that her consumer watchdog group is disappointed that the final budget agreement did not reflect the group's recommendations to link Medicaid reimbursement to the actual delivery of care that meets state and national standards.

"In essence, our proposal sought to convert Medicaid from a corporate entitlement to an assurance of mutual accountability between state and providers," she said.

"The new public review process for proposed rates is a positive step," Holder added. She hopes that ombudsmen and informed citizens will use this new advocacy tool as effectively as possible to ensure that residents receive quality care.

Budget Act Tweaks Transfer of Asset Law

Finally, the Budget Act revises last year's "Granny Goes to Jail" law that imposes criminal penalties on individuals [usually elderly] who "knowingly" and "willfully" transfer their assets for less than fair market value within three years of applying for Medicaid.

According to Maryanne Keenan, a legislative representative at the American Association of Retired Persons, her association successfully lobbied Congress to clarify the criminal penalty for transferring assets in the Health Insurance Portability and Accountability Act of 1996. As written, the Act could scare away older people from applying for Medicaid or scare them into purchasing expensive insurance products that they could not afford, Keenan noted.

Keenan stated that the newly enacted FY 1998 budget reconciliation bill imposes a criminal penalty only on a person who, "for a fee, knowingly and willfully counsels or assists" someone to dispose of assets, when disposing of assets results in a period of Medicaid ineligibility of three years or less.

"The criminal penalty on the Medicaid applicant was misplaced and inappropriate," Keenan charged. She believes that the new law will better protect Medicaid applicants. ❖❖

Home Care Takes Massive Hits in Balanced Budget Act

By Herbert P. Weiss

The loudly chanted mantra "Preserve Medicare," combined with bipartisan support to make program changes and a widespread belief that providers were overpaid, quickly led to passage of The Balanced Budget Act of 1997. Although home care groups such as the National Association for the Support of Long Term Care (NASL) fought hard to blunt the impact of the new budget law's impact on quality and access, Larry Lane, president of NASL, said that their concerns went largely unheeded during the budget debates.

Budget Cuts Payments to Preserve Medicare

Under the final budget accord, Medicare spending is slashed by $115 billion. Cuts will mostly ($100 billion) be in the form of reduced payments to hospitals and providers. Savings will not come from increasing the age of Medicare eligibility, $5 copayments for home health visits or means-tested premiums. Increased premiums will bring in the other $15 billion.

The final agreement enacts immediate interim payment reform and requires a Medicare prospective payment system (PPS) for home health agencies by October 1, 1999. The interim reform is effected with cost reporting periods begun October 1, 1997. This system trims Medicare payments to home care agencies by $16.2 billion (about 11%) over five years.

"What will happen to the quality of services delivered and who will get access to those services?"

—Larry Lane, President National Association for the Support of Long Term Care

Hospice payments will be cut by $200 million during the same period. The Health Care Finance Administration (HCFA) was charged with developing normative standards on duration and frequency of home health services. Services that exceed the norms will be denied payment.

Shifting some of the home health benefits from Part A to Part B is expected to extend the life of the Medicare trust fund from 2001 to 2007. As of February 5, 1998, venipuncture (blood monitoring) will no longer be a qualifying service for Medicare home care benefits and will instead be a separately billable Part B service.

Beginning October 1, 1997, home health agencies are reimbursed the lesser of their actual allowable costs, the cost limits or the per-beneficiary annual limit. The new blended agency-specific, per-beneficiary annual limit will be applied, in the aggregate, to the agency's unduplicated census count of Medicare patients.

Finally, the budget law tries to recapture savings resulting from the 1993 freeze of home health cost limits by eliminating consideration of any costs increases that occurred between July 1, 1994, and July 1, 1996, when updating future cost limits.

The final budget accord also cuts $14 billion from the Medicaid program over five years. Savings are achieved by eliminating the Boren Amendment, which requires certain levels of payment to hospitals and nursing homes, and by allowing states to implement Medicaid managed care and other revisions in their Medicaid plans without having to obtain a waiver from HCFA.

Budget Law Hits Providers, Consumers

"The law is laden with victims and it is not just providers who will get hurt," Lane told *Balance*. "Providers will always figure out how to run their businesses at the payment level they get," he added, noting that the question now becomes, "What will happen to the quality of services delivered and who will get access to those services?"

According to Lane, the final budget law creates financial incentives for providers to care for those who require fewer services. He warned that payment changes leave Medicare beneficiaries at great risk, especially those who are frail and have multiple restrictions on activities of daily living.

Home care agencies will be hit hard by the elimination of the venipuncture service as a qualifying benefit, warned William Dombi, Vice President for Law at the Washington, D.C.-based National Association of Home Care, a trade group representing 6,000 home care agencies. An informal survey of agencies reveal that a fairly large number of patients, up to 40%, could be disqualified from home care benefits because of this policy change, he added. "During the next six months we will build up a strong enough case to get Congress to repeal this provision."

Dombi applauded the creation of a PPS for home care agencies. "While the creation of PPS rates cause serious concern to some, at least agencies will now have an opportunity to make a profit if they are efficient and provide appropriate care to patients. Today, the better you are the less money you receive."

Finally, Dombi expressed concern about reforms based on cutting back cost limits and establishing a per patient limit using fiscal year 1993 data on 98% of the agency's costs per beneficiary. He noted that since fiscal year 1993, visits per patients have increased 22%. To financially survive, agencies will now have to look very seriously at the type of patient they accept.

It would be a policy disaster for HCFA to prematurely develop normative standards for the duration and frequency of services it will pay for, Dombi said. "Every time HCFA has tried to box home care patients into one category or another, it has been a detriment to the patient," he said.

Home Care's Big Win

Calling it a "sick tax," consumers and home care trade groups were successful in eliminating Medicare Part B copayments in the final budget law. A provision in the Senate bill would have imposed a $5 per visit copayment for most home health visits to generate $5 billion in revenue. Under the current law, there are no copayments, but Dombi predicts that the push to enact them will intensify since the benefit is primarily financed through general revenue funds.

Home care groups are pleased that the budget law requires hospital discharge planners to provide a list of all home health agencies that serve the area in which the patient resides and that request to be listed as available. Also, hospitals must disclose information to the Secretary of Health and Human Service on referrals made to entities in which they have a financial interest. ◆◆

Budget Provisions Affect Home Health Agencies

Some provisions of interest to home health agencies in the Budget Act of 1997 are—

- ✓ Medicare +Choice Provider Sponsored Organizations are established to allow a group of providers to form their own network to enroll and treat beneficiaries for a capitate amount. Advocates believe that this approach is better for Medicare beneficiaries because providers, rather than insurers, are responsible for making delivery and financial decisions.
- ✓ Hospitals discharge planners are required to notify patients of post-acute alternatives to hospitals. Discharge planners must also notify patients of any financial interest the hospital may have in the referral.
- ✓ The PACE program and Social Health Maintenance Organizations are expanded.
- ✓ In October 1998, the Department of Health and Human Services will release a study on "homebound" eligibility definition under the Medicare Home Care benefit.
- ✓ Each explanation of benefit form must contain a federal toll-free number to allow a beneficiary to report fraud and abuse. The beneficiary will be given 30 days to request an itemized bill for Medicare services from the appropriate carrier or fiscal intermediary.
- ✓ The Department of Health and Human Services will implement a competitive bidding demonstration project for Part B services.
- ✓ The General Accounting Office is required to report on the operations of the new Medicare fraud and abuse control program by June 1, 1998.

Source: The National Association of Home Care, August 1997.

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OIG Report Critical of Prescription Drug Use in Nursing Homes

By Herbert P. Weiss

Nursing home industry groups were caught by surprise on November 17 when the HHS Office of the Inspector General released a controversial report critical of prescription drug use in the nation's nursing homes. The report also included an investigation of Texas nursing homes, where OIG investigators found that 17% of the patients got wrong dosages or inappropriate prescription drugs.

While the OIG report stated that most nursing home residents are no longer chemically drugged to control disruptive behaviors, most certainly a result of OBRA '87, thousands of elderly still receive "inappropriate drugs." The report details the findings of a random, statistically valid sample of consultant pharmacists at 17,000 nursing facilities.

According to the OIG report, inappropriate prescribing and inadequate administration or monitoring of medications often leads to problems for residents. Problems include constipation (reported by 81% of pharmacists responding), falls (66%), delirium (41%), depression (39%) and urinary incontinence (26%).

Inappropriate uses of antipsychotics, anxiolytics, sedatives and hypnotics still occur in some nursing facilities, the report noted. Of the consultant pharmacists surveyed, more than one quarter reported some patients receiving medically inappropriate prescriptions for such drugs. More than 15% said that some physicians prescribe medically inappropriate antidepressants. Finally, one third say antidepressants are sometimes prescribed without an appropriate diagnosis and that few or no physicians endure their maintenance at appropriate levels.

The OIG findings also include the following:

Administrative problems create obstacles to safe drug use. Errors included the absence of specific usage directions, incomplete orders, failures to update medication administration records with dosage or schedule changes, physician signing orders that are not current or correct, failure to include orders on the medication administration record, misplaced medications and continuation of a medication in disregard of stop orders.

Serious shortcomings in the quality and thoroughness of monthly medication reviews also put residents at risk of drug interactions, overmedication and bad reactions. More than half of the reviews do not even consider the resident assessment (65%) or plan of care (56%). One third of survey respondents note that they have difficulty obtaining a patient's diagnosis and necessary lab reports for medication reviews. Finally, drug reviews are not documented in records readily available to nursing facility staff.

Consultant pharmacists have too little contact with residents, their families and nursing assistants. Two thirds report not providing drug education to residents or families. Nearly half report not doing so for the facility's nursing assistants or mediation aides.

Industry Calls Report Flawed

"The methodology of the OIG study is seriously flawed and there is no basis for concluding that major regulatory changes are needed in monitoring drug use in nursing homes," stated Dianne Wolman, a policy specialist at the American Association of Homes and Services for the Aging. The survey data, compiled from consultant pharmacists, is based on their recollections over a six-month period and not on actual data from patient charts, she stated.

"The OIG reports don't even define in enough detail what the specific problems might be to even write regulations to solve those problems," Wolman quipped.

But the report hits home in some areas, notes Wolman, stating that there must be better communications for all the players in the nursing home setting. AAHSA also supports the report's recommendation calling for improved drug education for physicians, nurses, patients and families.

There are systems in place in nursing homes that seem to be helping reduce inappropriate drug use, Wolman told *Balance*. "We're concerned that inappropriate drug use is probably a bigger problem for the elderly living in their own

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housing, and there is no procedure for monitoring them."

"Physicians are not up to speed and knowledgeable in their prescribing practices and lack knowledge or training regarding the use of appropriate medications for the elderly, stated Tom Burke, the American Health Care Association's director of community relations. "This story played and sounded like a nursing home problem," Burke added.

He suggested that physicians must be held accountable for many of the medication issues cited. The report's executive summary emphasizes that "prescribing and monitoring of medications is the responsibility of the nursing home resident's physician and that many of the problems and concerns raised in the report are not the result of poor nursing homes."

Larry Lawhorne, president of the American Medical Directors Association, said, "AMDA members are well aware of the unfortunate outcomes that may result from the use of drugs that are inappropriate or not medically necessary." He applauds the Inspector General's recommendation that consultant pharmacists should be required to notify the nursing facility medical director when monthly drug reviews indicate potential problems. At present, there is no such requirement, and medical directors monitoring patient care are sometimes the last to know when a consultant pharmacist identifies problems with drug therapies.

According to Tim Webster, executive director of the American Society of Consultant Pharmacists, even with the charges of flawed statistics, the OIG report puts "medication-related problems" on the nation's policy agenda. Such problems can be very costly but can be prevented through drug reviews, he added. An ASCP study found that the potential cost of preventable medication-related problems in the nations' nursing homes could reach $7.6 billion per year, but the efforts by consultant pharmacists reduce that cost by nearly half.

"While the report indicates there are still problems with the drug monitoring process, at least there is a drug monitoring process in nursing homes," Webster noted. Long-term care providers are actually getting on top of a problem relatively ignored in other care environments.

Sara Burger, acting director of the National Citizens' Coalition of Nursing Home Reform, added, "Drugs are so complicated today that there is no physician or nurse who can know all those answers that a pharmacist would know or know where to get the information. As recommended by the report, you need a good consultant pharmacist to oversee the whole drug arena in a nursing home." ◆◆

Feds Unveil New Data Collection Program to Fight Fraud and Waste

By Herbert P. Weiss

In March, the Department of Health and Human Services launches one of its newest initiatives to fight health care fraud and waste in the Medicare and Medicaid programs. HHS estimates annual losses due to health care fraud at 3-10% of all health care expenditures—between $30 and $100 billion in 1995. When up and running, the Healthcare Integrity and Protection Data Bank (HIPDB), authorized by the Health Insurance Portability and Accountability Act of 1996, becomes the nation's most comprehensive source of adverse action information available on health care providers, practitioners and suppliers.

The law mandates federal and state agencies and health plans to report certain civil judgments, criminal convictions and other final adverse actions taken against practitioners, suppliers or providers to the federally-maintained database (see box). Any health plan that fails to report any required information is subject to a civil penalty of up to $25,000 for each adverse action not reported. In addition, the federal government will publish the names of state agencies that fail to report.

"One Stop Shopping"

In effect, HHS's new tracking system becomes "one stop shopping" for peer reviewers, those conducting licensing and credentialing or those who make certain contracting decisions, says Vivian Chen, ScD, MSW, the policy team leader implementing the federal legislation. It may be prudent for them to make a more comprehensive review of health care providers, practitioners or suppliers with final adverse finding reports in the database, she says.

However, "you have to take this information and carefully read it," Chen advised. HIPDB information should be used in combination with information obtained from other sources when making decisions about employment, affiliation, certification or licensure decisions, she said.

Final adverse actions taken against individuals licensed or certified to practice within a state, against organizations that provide health care services and against suppliers will be reported to HIPDB, Chen said, adding that more than 500 categories of professional licenses and certifications have been identified as potential targets. In the nursing home setting, an array of professionals and certified staff have been subjects: physicians, dentists, registered nurses, licensed practical nurses, pharmacists, nursing home administrators, physical therapists, occupational therapists, certified public accountants—even nursing assistants and medicine aides, if certified by the state.

HIPDB data will only be provided to federal and state government agencies and to health plans, as required by the legislation, Chen stated. This information will not be available to the general public. But those who are the subject of a report will receive a copy at the time the report is entered into the system. In addition, a subject can pay to search the HIPDB for any reports on themselves.

CONTINUED ON PAGE 19

Federal and state agencies and health plans are required to report the following adverse actions to the Healthcare Integrity & Protection Data Bank:

- ✓ Health-related criminal convictions
- ✓ Health-related civil judgements
- ✓ Exclusion from federal and state health care programs
- ✓ Other adjudicated actions established by regulations
- ✓ Federal or state licensing and certification actions (e.g., loss of a license; loss of the right to apply for or renew a license; revocation; suspension, along with length of the action; reprimand; censure; probation; voluntary surrender)

ing it away, you are not empowering people. Even though this sounds obvious, a recent *Wall Street Journal* article reported that in 1997, 30% of employees felt that their interests were ignored by managers who were making decisions that affected them. That's up from 25% in 1996. Remember, if you want to practice winning management, you must always push decision making down to the lower possible level.

3. Downsize.

U.S. executives continue to overdose on downsizing. Why? Because it is one of the fastest ways to improve the bottom line. And if you are managing a public company, it's the fastest way to have your stock go through the roof. Research, however, shows that over the long run, downsized companies are less profitable. For example, a seven-year University of Colorado study showed that companies that downsized had doubled their earnings over a three-year period. However, the same type of companies that did not downsize had quadrupled their earnings over the same period. In short, you gain the competitive advantage through people, not by getting rid of them.

2. Make work painful.

Do you like to have fun? I bet you said yes. Then why is it that so many managers make work painful? So unbearable that 25% of employees in the U.S. hate their jobs to such an extent that they equate it to a prison. Another 56% could take it or leave it, and only 19% love it. Only if you create a climate where people have fun and want to work will you be able to achieve extraordinary performance with ordinary people.

1. Provide equal rewards.

The #1 stupidest thing managers do is provide equal rewards to every employee. It violates the most important management principle of all time: tying rewards to performance—a principle that is absolute essential if you want to build a high performance organization. Re-evaluate your reward and recognition system so that the high performers are rewarded and recognized more often and more generously than your average employees and a whole lot more than your slackers.

There you have it, the top ten mistakes to avoid if you want to build a high performance organization, one that will enable you to achieve quantum leaps in performance, productivity and profitability. ❖❖

To experience Dr. Rinke in person, attend his presentation at the 32nd Annual Convocation in Atlanta on May 4, 1998. His general opening session will provide you with six fail-safe proven strategies to living a happier, healthier, wealthier life. Meet him immediately after his presentation in the exhibit hall where you can purchase autographed copies of his book at a significant discount.

Feds Unveil New Data Collection Program to Fight Fraud and Waste

CONTINUED FROM PAGE 5

Safeguards in the HIPDB System

The HIPDB database should not be considered a place to retry the merits of a case. "Our role is to collect all reported adverse actions that are final and get them into our system so people have access to that information," Chen stated. Information reported by federal and state agencies or health plans is not screened for accuracy, but procedural safeguards are built in. The individual may bring factual information, including reversals of criminal convictions by an appeals court, to the attention of the reporting entity. If the file is not revised within 30 calendar days, a request can be made for the HHS Secretary to review the matter. After the review, the HHS Secretary can remove a dispute, correct the information, leave the information unchanged or place additional statements in the file.

Karen Tucker, ACHCA President/CEO, supports HHS's efforts to keep close tabs on unscrupulous providers, practitioners and suppliers and to stop on rampant fraud and abuse in the Medicare and Medicaid programs. "HIPDB will be a great deterrent to keep these individuals from crossing state lines to initiate fraudulent activities," she said.

Scott Parkin, senior vice president for communications at the American Association of Homes and Services for the Aging, concurs with Tucker's assessment. "We have no problem with the reporting law or its intent. Obviously, if somebody has a record you want to know about that or you can get in real deep trouble," he added. ❖❖

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HCFA Reconsiders, Delays Implementing Consolidated Billing Rule

By Herbert P. Weiss

Responding to intense pressure from nursing home groups, the Health Care Financing Administration has granted a six-month "transition period" for the implementation of Medicare consolidated billing. Meanwhile, the agency has also softened its stance on its requirement for skilled nursing facilities (SNFs) to be responsible for the monitoring of billing of Medicare Part B claims off-site.

Congress mandated the Balanced Budget Act of 1997 as a way to cut skyrocketing fraud in the Medicare program.

Before HCFA announced its 6-month delay for SNFs in a transmittal (No. AB-98-18, April 1998), facilities were faced with "regulatory overload" on July 1 when they were required by the agency to simultaneously implement Minimum Data Set automation, a new Prospective Payment System, Part B fee schedules and consolidated billing.

The recently released April 2 transmittal allows for a "transition period" between July 1 and Dec. 31, 1998, giving SNFs additional preparation time to comply with the consolidated billing provision of the Balanced Budget Act of 1997. The federal law requires SNFs to submit claims for Part B services and supplies rendered to residents. Mandated by Congress as a way to cut skyrocketing fraud in the Medicare program, SNFs will be paid directly and they must pay their Part B providers.

Once implementation begins, SNFs may either choose to use an outside billing contractor or assign their own staff to process the Medicare Part B claims. The federal law now makes SNFs totally responsible for ensuring billing accuracy and completeness of claims (e.g., accurate service codes, correct charge amounts). The SNF is also responsible for assuring that services were delivered and medically necessary and justified on patient records). But facilities are exempt from billing for services and supplies provided by physicians, physician assistants, nurse practitioners, certified nurse-midwives, qualified psychologists, and certified registered nurse anesthetists. Home dialysis supplies and services are excluded.

Pick a Date

A facility must either be ready to begin all Part B billing by July 1,

Tips on Preparing for Consolidated Billing

HERE ARE FIVE SIMPLE TIPS TO PREPARE FOR THE JULY 1, 1999, IMPLEMENTATION OF consolidated billing.

1. Locate Part B suppliers in your community, and determine their reputation for quality, reliability and flexibility. Identify which of these suppliers provide most of the care to your residents.
2. Consider whom you would like to contract with. Determine if you have the staff and data processing capabilities to handle the billing internally or could readily add the capacity.
3. Find out what companies are offering billing services and which you might want to contract with if you decide not to do consolidated billing internally.
4. Calculate the costs of billing internally or going with a commercial billing service. Besides the costs of processing bills and payments, are there other costs to the facility, such as capital expenditures for ancillary services and supplies that would need to come out of the Medicare fee schedule payments before the facility could pay the suppliers?
5. Review all patient records to determine if they adequately document medical necessity for Part B services and their provision. If you have not tracked the provision of Part B supplies and services to your residents in the past, consider implementing systems for doing so now.

1998, or wait through the whole transition period to begin Jan. 1, 1999. Those choosing to delay are expected to use this time wisely to prepare for consolidated billing. In addition, HCFA has directed fiscal intermediaries to begin educating providers on this new requirement.

SNFs beginning prospective payment (PPS) prior to Jan. 1, 1999, may use the six-month extension for all their non-Part A residents receiving Part B services. According to the transmittal, these facilities will be required to submit line item bills "to the best of their ability" for all the ancillary services their Part A residents receive. Suppliers to these facilities may not bill the Part B carrier or DMERC for any resident covered by Medicare Part A/PPS.

However, those SNFs electing the transition will handle all bills for services delivered on or after Jan. 1, 1999, will send them all to the fiscal intermediary, and receive direct payment from the fiscal intermediary.

Finally, HCFA has redefined the services and time periods covered by consolidated billing so that the SNF is no longer held responsible for billing when a resident is formally discharged or is admitted to a hospital or receives home care or outpatient services. However, facilities will still be held responsible for the billing of all hospital services provided as required by the resident assessment or comprehensive care plan.

AAHSA Letter Urged Delay

On the heels of a January 26, 1998, draft memorandum to intermediaries and carriers, circulated by HCFA to trade groups to solicit comments, the American Association of Homes and Services for the Aging (AAHSA) wrote a letter to Health and Human Services Secretary Donna Shalala and HCFA Administrator Nancy Ann Min DeParle urging them to delay the implementation of the consolidating billing rule. In the March 11 letter, AAHSA stated that "consolidated billing posed severe problems to SNFs that ultimately could threaten both access to and quality of care for Medicare beneficiaries."

"We continue to support the goals of consolidated billing," AAHSA President Sheldon Goldberg said, reacting to HCFA's transmittal. "However, I'm glad HCFA listened to AAHSA and our members and decided to provide everyone involved with more time to develop a workable system. ◆◆

Herbert P. Weiss, NHA, is a Providence, Rhode Island-based writer covering aging and health care issues who serves as editor of the Rhode Island Report, the RI Chapter's member newsletter.

Congress Likely to Restore Funding for the Section 202 Program

By Herbert P. Weiss

When Congress reconvenes after a Memorial Day recess, lawmakers will begin the task of hammering out a fiscal year 1999 budget. Housing advocates wait and watch as the House and Senate VA-HUD and Independent agency appropriation subcommittees prepare to mark up bills specifying funding levels for programs administered by the Department of Housing and Urban Development.

Weeks before recess, bipartisan opposition was building over the Clinton administration's fiscal year 1999 budget proposal submitted early this year, which slashed funding for HUD's popular low-income housing program. In the controversial budget plan, funding for new Section 202 housing construction was cut from the current level of $645 million to $109 million. With that figure, HUD was requesting funding for only 1,500 units.

The Senate Appropriations Committee approved $676 million for Section 202 but housing advocates are lobbying to increase that amount to $830 million.

Also, of major concern to housing advocates, the Clinton fiscal year 1999 budget proposed to divert about one-third of the total Section 202 funding of $159 million to vouchers and to fold the entire construction program into the Home Block Grant Program.

The Cuomo Bombshell

In April, HUD Secretary Andrew M. Cuomo's testimony before the House and Senate VA-HUD and Independent agency appropriation subcommittees shocked many lawmakers. In these hearings the Clinton official told surprised lawmakers that a General Accounting Office report found more than $1 billion in excess funds, about $691 million of that excess funding in the Section 8 Moderate Rehabilitation Account. While HUD Secretary Cuomo did not offer to withdraw or modify the Clinton budget proposal's dismal funding levels for Section 202, he suggested that Congress use the excess funds to increase funding levels for Section 202 in the fiscal year 1999 budget.

With the Clinton administration's strong opposition to modifying or revising its budget proposal's Section 202 funding levels, the shift of funding will likely take place between the two HUD programs during the appropriations process, according to Robert Greenwood, associate director of public affairs for the American Association of Homes and Services for the Aging (AAHSA).

"We had mixed feelings about the Clinton administration's opposition to increasing Section 202 funding levels," Greenwood told *Balance*. But HUD Secretary Cuomo did reveal a potential way for Congress to raise funding levels, he added.

At press time, the Senate Appropriations Committee approved $676 million for Section 202. But Greenwood expects the House Appropriations Committee to move quickly to finish before Labor Day, especially with the congressional elections looming in early November.

Housing advocates still hope that Congress will approve $830 million, an amount allocated in fiscal year 1996.

Senate, Housing Advocates Rally for Senior Housing

On April 2, by an overwhelming bipartisan vote of 98 to 2, the Senate passed a Sense of the Senate amendment offered by Chairman Christopher S. Bond (R-Missouri) and Ranking Minority Member Barbara A. Mikulski (D-Maryland) of the VA-HUD Appropriations Subcommittee. This amendment urged Congress to increase Section 202 funding levels to at least $645 million per year through the year 2003. Meanwhile, the Senate amendment was successfully incorporated into the Senate budget (S.Con.Res. 86). While a Sense of the Senate does not carry the force of federal law, it sends a powerful message that the Senate intends to protect the housing program.

A recent survey of 470 communities found more than 52,000 persons on current Section 202 waiting lists, and an average wait for an apartment for over two years.

More than two weeks after passage of the Sense of the Senate amendment, Senators Bond and Mikulski, along with Reps. Rick Lazio (R-NY), Marcy Kaptur (D-OH) and Carrie Meeks (D-FL), joined the Elderly Housing Coalition and seniors at a rally to increase the visibility of Section 202.

At the event, the Elderly Housing Coalition, composed of 30 national groups with interests in housing, released the results of a new public opinion poll showing the popularity of senior housing. "Ninety percent of those polled, in all age groups all across the country, said they would support maintaining or increasing federal assistance to help nonprofit organizations build more senior housing," said Michael Perry, a vice president at Lack, Sosin, Snell, Perry & Associates, a national policy research firm. "Eighty percent of the respondents also agreed federal dollars invested in senior housing enables seniors to live more independently and save Medicare and Medicaid dollars," Perry added.

With the elderly being the fastest growing segment of the nation's population and with aging baby boomers accelerating this trend, there is a growing need for senior housing, Steve Protulis, executive director of the national Council of Senior Citizens, told the crowd at the rally. "There are at least eight senior citizens waiting for every bed in low-income housing facilities across the United States. In 2030, there will be many more. And as the elderly population continues to explode, the need for federal funding to build more low-income housing will only become more dire."

Reflecting the need for Section 202 housing, Protulis said: "A recent survey of 470 communities found more than 52,000 persons on current Section 202 waiting lists, and an average wait for an apartment for over two years."

Members of the Elderly Housing Coalition say that senior housing is not just a place for seniors to live, but often it is a source of services that allow seniors to continue to live independently and stay out of nursing homes. The housing advocacy group urged the Clinton administration and Congress to restore Section 202 funding to $830 million, up from the administration's request of $159 million. ◆◆

Herbert P. Weiss, NHA, is a Pawtucket, RI-based writer covering aging and health care issues and a member of ACHCA's Rhode Island Chapter.

AAHSA Chief Steps Down
To Seek New Professional Challenges

By Herbert P. Weiss

In less than two months, nonprofit providers will witness the end of an era. Sheldon Goldberg, president of the American Association of Homes and Services for the Aging (AAHSA), will step down as the group's long-time leader. In 1982, after serving as executive director of the Wisconsin Association of Homes for the Aging, Goldberg assumed leadership of AAHSA. He saw his staffing gradually increase from 25 to 96 as membership grew and as the association took on a broader range of long-term care issues. His budget, originally $2 million, topped $17 million this year, making the association one of the largest long-term care organizations inside the beltway.

Beginning October 1, Goldberg will serve as president and chief executive officer of the Jewish Home and Hospital of New York (JHH), a 1,600-bed facility with divisions in Manhattan, the Bronx and Westchester. JHH is among the nation's oldest and largest nonprofit organizations and is considered one of the most prestigious health care and rehabilitation centers in the country. It offers a continuum of long-term care services ranging from skilled nursing homes to senior housing, from walk-in clinics to day care services.

"We couldn't be happier to have Sheldon on board," says the chairman of JHH's board of trustees, David A. Jones, who views the AAHSA chief as "a visionary and strategic leader in the long-term care field."

Jones believes that Goldberg's "overall stature in the industry and outstanding management and leadership skills will serve him well" as his group's new chief executive officer. He has successfully led "a national industry association and has presided over the growth and diversification of a complex and far-flung national enterprise," Jones adds.

Goldberg tells *Balance* that in his new position he will oversee a health care system with more than 3,000 employees and a budget of $200 million. He is excited about JHH's commitment to medical research and the organization's long-time efforts to forge relationships with local universities and medical schools to enhance staff training. But more important, he says, "There is an absolute and genuine commitment of the organization, its staff, and board of trustees to be the most outstanding health care system providing nursing home care along with a continuum of services."

Goldberg's Successful Track Record

During his long, distinguished 16-year career at AAHSA, Goldberg turned the nonprofit provider group into a powerful player that shaped the nation's long-term care public policy agenda. *Contemporary Long-Term Care* recently recognized his efforts by naming him one of the top 20 people who have positively influenced the field of long-term care during the past 20 years.

Goldberg has chaired the Leadership Council of Aging, a coalition of 40 Washington, DC-based groups on aging who work together to shape policy on aging, and serves on the U.S. Board of the International Leadership Center on Longevity and Society. In addition, he has served as president of the National Assembly of National Voluntary Health and Social

Welfare Organizations, on the board of the National Health Council, and as a member of the Brookings Institution's Advisory Panel on long-term care.

Under Goldberg's watch, AAHSA became a proponent of the long-term care continuum concepts, recognizing that long-term care services represent not only nursing home care but also an array of community-based services. His strong support of AAHSA's professional certification of retirement housing professionals, and retirement community accreditation through the AAHSA Accreditation Commission has helped to improve public credibility of Continuing Care Retirement Communities, and the commission's lobby efforts paved the way for congressional support and growth of the senior housing and assisted living marketplace.

Goldberg also worked to make capital financing available to members through the AAHSA Development Corporation. He spearheaded the association's successful efforts to establish the International Association of Homes and Services for the Aging and the first association-sponsored assisted living development corporation.

Sheldon Goldberg will resign after 16 years as president of the American Association of Homes and Services for the Aging (AAHSA) to serve as president and CEO of the prestigious Jewish Home and Hospital of New York, beginning October 1.

A Final Note . . . Thoughts About Boren

WHILE HE HAS HAD MANY SUCCESSES DURING HIS TENURE as AAHSA president, one of Goldberg's disappointments was watching state governors eliminate Boren, a federal law that required states to pay a facility for reasonable costs. Consumers failed to support providers in their efforts to save the Boren amendment, he says.

"Long-term care is the greatest bargain in health care today," adds Goldberg. Consumers must not continue to mistakenly believe that you can operate a facility and provide quality of care only "on a wish and a prayer—you need economic resources." As he leaves the long-term care arena, Goldberg hopes that in the future a stronger coalition of consumer and provider organizations will demand that facilities get fair treatment from a reimbursement standpoint. But he acknowledges that providers must continue to work toward providing the quality of care their patients deserve. Society must realize that "long-term care is very demanding work and it must be valued," he says.

Colleagues Give Farewells

Goldberg's departure signals the "passing of an era," says AAHSA chairman Stephen E. Proctor. "He is a fountainhead of ideas that over the years have grown into new membership services and educational ideas," he adds.

"Sheldon could visit any one of our members, from the smallest to largest, and really fit in," says Proctor. That's a remarkable quality; it has enabled him to stay fresh and contribute wonderfully to AAHSA for more than 16 years, he notes.

"Sheldon did a remarkable job of bringing AAHSA's influence into the nursing home arena," says Elma Holder, founder of the National Citizens Coalition for Nursing Home Reform, a watchdog consumer advocacy group that lobbies on behalf of the nation's nursing home residents. "We trust that in his new position he will do an equally impressive job of maintaining a high-quality model of family and consumer connection with the Jewish Home and Hospital in New York."

In his new job "Sheldon will be in a special position to help ensure that a large number of frail elders receive high-quality care," Holder says, urging him to work closely with New York area consumer groups to improve the care of New York area–based nursing homes.

Paul Willging, executive vice president of the American Health Care Association, reflects: "Sheldon, who is leaving AAHSA, provided 16 years of effective leadership. He expanded opportunities to his members in the areas of financing, group purchasing, and insurance. I wish him well as CEO of the Jewish Home and Hospital of New York."

Willging adds: "Sheldon and I shared a mutual vision of collaboration between our two organizations. His strong belief that we could accomplish more united than as separate organizations is one of my earliest recollections of working with Sheldon."

Finally, ACHCA President and CEO Karen Tucker reflects on working closely with her counterpart at AAHSA. "Sheldon has provided strong leadership and continuity in the field of long-term care with an emphasis on quality and concern for the well-being of the elderly," she says, noting that he has been a loyal friend to ACHCA. "We will miss having him at AAHSA but look forward to his ongoing contributions in the sacred work of long-term care in his new position." ◆◆

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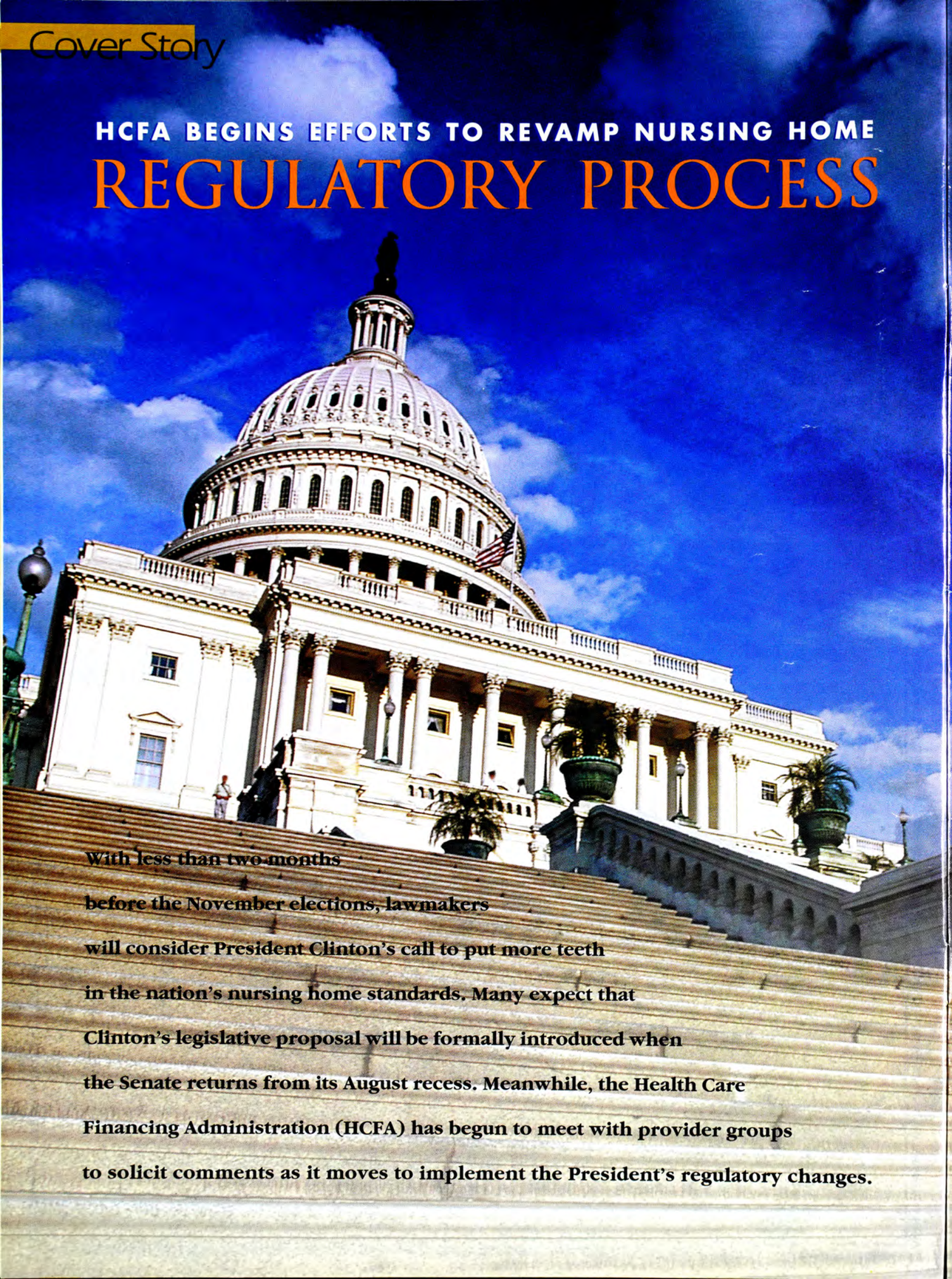
HCFA BEGINS EFFORTS TO REVAMP NURSING HOME

REGULATORY PROCESS



With less than two months before the November elections, lawmakers will consider President Clinton's call to put more teeth in the nation's nursing home standards. Many expect that Clinton's legislative proposal will be formally introduced when the Senate returns from its August recess. Meanwhile, the Health Care Financing Administration (HCFA) has begun to meet with provider groups to solicit comments as it moves to implement the President's regulatory changes.

By Herbert P. Weiss

The administration is calling for tougher nursing home inspections, civil monetary penalties, and increased federal oversight of state survey agencies.

Cover Story

A CALL FOR CHANGE

At the July 21 press conference unveiling his nursing home reform initiatives, President Clinton brought representatives of seven provider and consumer groups together in the Oval Office to announce his new efforts (14 legislative and regulatory proposals) to crack down on poor care in the nation's 17,000 nursing homes.

President Clinton called on Congress to require criminal background checks for nursing home staffs and to create a national abuse registry. He also urged lawmakers to swiftly reauthorize the ombudsman program under the Older American's Act. In addition, he proposed that a new category of employees be allowed to feed residents.

New administration actions that would strengthen the Health Care Financing Administration's (HCFA) nursing home regulatory efforts were also unveiled by the President. Specifics include tougher nursing home inspections (staggering surveys, targeting chains with bad records, and prosecuting egregious violations); immediate civil monetary penalties under certain circumstances; increased federal oversight of state survey agencies; new HCFA oversight to prevent bedsores, dehydration and malnutrition; and finally, the use of quality indicators based on the Minimum Data Set.

The rationale for new regulatory penalties and inspections and tougher oversight to be implemented by HCFA is explained in a 617-page report. The report, which contains more than 300 pages of appendices, was released by Health and Human Services (HHS) Secretary Donna E. Shalala at the July 21 press conference. Mandated by the fiscal year 1996 HHS Appropriations Bill, the report put the brakes on the nursing home industry's push for private accreditation. The report concluded that private accreditation was not effective in protecting the health and safety of nursing home residents. In more than half of the 179 cases in which both HCFA and the private Joint Commission on Accreditation of Healthcare Organization (JCAHO) inspected the same nursing homes, JCAHO failed to detect serious problems identified by HCFA, the report noted.

HCFA MEETS WITH INDUSTRY

The political prodding of Congress has forced HCFA to move quickly to implement regulatory changes. On August 19, 1998, less

Left to right: Mike Rogers, American Association of Homes and Services for the Aging; Alan G. Rosenbloom, CEO, American Association of Homes and Services for the Aging; Patricia Smith, AARP; Max Richtman, National Committee to Preserve Social Security; Donna E. Shalala, Secretary of Health and Human Services; William J. Clinton, President of the United States; Nancy-Ann Min Deparle, Administrator, Health Care Finance Administration; Annabel Seidman, National Council of Senior Citizens; Dan Schulder, National Council of Senior Citizens; Sarah Greene Burger, National Coalition for Nursing Home Reform; Toby Edelmon, National Senior Citizens Law Center; Victoria Wagman, National Council on the Aging.

than a month after President Clinton's press conference to announce nursing home reforms, the agency held a two-hour meeting in the HCFA complex in Washington, D.C. HCFA Administrator Nancy-Ann Min DeParle and key agency staff met with representatives of the American Association of Homes and Services for the Aging (AAHSA) and the American Health Care Association.

The tone of the meeting was "matter of fact," says Susan Weiss, AAHSA's vice president and counsel for public policy, noting that HCFA staff acknowledged they were under pressure from Congress to move quickly to follow an aggressive 11-month timetable to implement the Clinton regulatory initiatives. Although the meeting was "constructive," AAHSA came away with some major concerns, Weiss adds.

In an eight-page letter to DeParle, AAHSA endorsed several of the administration's proposals, including background checks, but only if accompanied by the means to implement them; enforcement focused on facilities with a history of noncompliance; additional training for surveyors in states in which the system is not functioning properly; the compilation of best practices for helping residents with weight loss and dehydration; and an increase in non-nursing staff to assist with nutrition and hydration. AAHSA noted that the association has been calling for many of those changes for several years.

AAHSA strongly opposed the redefinition of "poor performing facilities" because HCFA's proposal may disproportionately weight the significance of G-deficiencies, which could be relatively minor ones. Because the concept of "harm" is too subjective, the association asked HCFA to reconsider the proposed redefinition. AAHSA also questioned the imposition of individual penalties for each violation in a survey because of the potential that multiple revisits by state agencies would be necessary. If implemented, AAHSA charged, the redefinition of "poor performing facilities" would put a greater burden on surveyors with no guarantee of quality improvements. Moreover, the group says, it could create an "administrative and judicial nightmare."

AAHSA also voiced concern about HCFA's plan to impose civil monetary penalties for each instance of serious or chronic violation without linking the amount of the penalty to the number of noncompliance days. Fines are not always the most effective penalties. Remedies such as "monitoring, bans on payment for new admissions, and directed plans of compliance" could be considered.

AAHSA supports additional training for surveyors along with revisits for serious violation, but is concerned that HCFA does not have the resources for multiple revisits for separate remedies for separate violations.

Finally, concerning the posting of deficiency reports on the Internet web site, AAHSA fears that the data could mislead consumers. A review of a prototype web page has revealed that outdated survey data have been posted in some states. The nonprofit trade group recommends that deficiencies under appeal to survey agencies and waivers for life safety violations be posted. ◆◆

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Federal Report Calls for NATIONAL CRIMINAL BACKGROUND CHECKS

By Herbert P. Weiss

In the midst of partisan bickering over the Starr Report, the Republican leadership's call for President Clinton's impeachment, and the campaign for Congressional seats, the Senate begins deliberations on one of the Clinton administration's legislative proposals designed to improve the quality of care in the nation's 17,000 nursing homes.

In July, as part of his legislative and regulatory package to revamp the nursing home enforcement system (see the cover story in the September 1998 issue of *Balance*), Clinton called on Congress to require criminal background checks on nursing home staff and to create a national abuse registry. The White House suggested creating a criminal background check system similar to S. 1122, the "Patient Abuse Prevention Act," written by Sen. Herbert Kohl (D-WI). That bill would improve patient protections and the oversight of nursing home quality of care.

OIG Calls for Screening Registries

A September 14 hearing of the U.S. Special Committee on Aging put the spotlight on the need for mandated criminal background checks of nursing home workers.

At the hearing, the committee released a report by the Department of Health and Human Services' Office of the Inspector General (OIG) that targets nursing home abuse by people with criminal records working in Illinois and Maryland facilities. The report found that in Maryland, 5 percent of

the current nursing home workers had a prior conviction for crimes such as assault, child abuse, robbery with a deadly weapon and drug violations. The federal study also found that in both states, between 15 and 20 percent of those convicted of elder abuse had prior criminal convictions.

The OIG report called on the Health Care Financing Administration (HCFA) to establish federal requirements and criteria for performing criminal background checks. It recommends that HCFA assist in developing a national abuse registry and help states expand their current registries. The registries should include those employees in federally reimbursed facilities who have abused or neglected residents or misappropriated their property.

The OIG report also called on Congress to enact legislation to allow the national abuse registry to be included in an expanded version of the current Healthcare Integrity Protection Data Bank, developed in response to the Health Insurance Portability and Accountability Act of 1996.

In testifying in support of his bill, Sen. Kohl charged that "the golden years have turned into a dark nightmare" because nursing home residents often face abuse, neglect and theft from staff with criminal backgrounds. The Wisconsin senator said that

only 33 states have systems to conduct criminal background checks within their borders. He noted that in many instances criminals can cross state lines to find employment in nursing homes of states that do not have those systems in place. In addition, he said, "state registries are often not comprehensive or well maintained."

Although Sen. Kohl conceded that the vast majority of nursing home staff are qualified and caring individuals, he called on Congress, through passage of his legislative proposal, to protect the vulnerable frail elderly from criminals who happen to find employment in nursing homes.

Chairman of the Senate Committee on Aging, Charles Grassley (R-Iowa), expressed skepticism about the OIG report's recommendation that HCFA take the lead in creating a criminal background check system. "Given HCFA's performance on nursing home neglect [in California nursing homes], I'm not confident that we can expect any better on nursing home abuse," he said. Sen. Grassley was referring to a General Accounting Office report released on July 27 that documented severe neglect in many California nursing homes resulting from an ineffective survey and enforcement process overseen by HCFA.

Nursing Home Groups Support New Resident Protections

Lee Bitler, director of human resources for the Hershey, Pennsylvania-based Country Meadows Corporation, told the panel that the American Health Care Association (AHCA) supported a national background check system. In explaining AHCA's approach to developing that system, Ms. Bitler urged Congress to nationalize the nurse aide registries that contain background information on nursing assistants to give facilities access to other states' registries. The nationwide "one-stop shopping" system must be easy and inexpensive to use. And, she said, education and prevention components to the system are essential.

Abuse or neglect of residents in even one nursing home should not be tolerated and the government and nursing home operators have a responsibility to put in place the best system of prevention possible, said the Rev. Richard Reichard, executive director of the National Lutheran Home for the Aged in Rockville, Maryland, testifying for the American Association of Homes and Services for the Aging (AAHSA).

Only 33 states have systems to conduct criminal background checks within their borders; criminals can cross state lines to find employment in nursing homes of states that do not have those systems in place.

"AAHSA has long supported the creation of a national system so that health care workers would not be able to hide criminal backgrounds merely by moving to another state," Reichard said, as he urged the panel to create a national criminal background check system for the whole long-term care continuum, from hospitals to home health care, not just for nursing homes.

Reichard also strongly supports including a "hold harmless" provision, so that homes cannot be sued by potential employees who may be harmed by erroneous information in their background check.

"It would be unfair to expose nursing homes to legal liability for erroneous information provided by the government or a private firm that conducts background checks," Reichard said.

In Summary

If the Kohl bill is not passed in the 105th Congress, look for the legislative proposal to be reintroduced next year, Lynn Becker, a spokesperson for Sen. Kohl tells *Balance*. "Hopefully," she adds, "the administration will include the National Background Check Registry as part of its next Budget Proposal, which is expected to be submitted to Congress in February 1999." ◆◆

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As 105th Session Ends, Congress Passes Massive Omnibus Spending Bill

By Herbert P. Weiss

In the past several weeks, the White House and Congressional Republican leadership hammered out a massive $486 billion omnibus budget bill, (the filed bill weighed 40-pounds and had more than 4,000 pages), consolidating 8 of 13 appropriations bills, to finance most federal programs for the fiscal year 1999 that began Oct. 1.

Weeks of intense back room negotiations ended with the overwhelming passage of the final omnibus budget bill in the House on Oct. 20. The Senate signed-off the measure one day later. Congress was forced to pass six continuing resolutions to fund federal agencies to avert a government shutdown because lawmakers were not able to meet the mandated Oct. 1 deadline for passing all 13 appropriation bills.

When the dust settled President Clinton walked away from the negotiating table with $1.1 billion in the sweeping budget bill to hire new 100,000 teachers and millions of dollars to increase funding for the Head Start program, after school programs, youth summer jobs and child literacy initiatives. However, Clinton caved into Republican demands for more local control for hiring teachers and gave up his push for tax credits to rebuild, modernize and reduce overcrowding in more than 5,000 local public schools. On the other hand, in the final spending package Republicans won $8 billion for increased military spending, a $690 million antidrug package, reorganization of the State Department, and the elimination of funding to the United Nations Population fund, which provides family planning services and contraceptives to third-world countries.

Partisan skirmishes over policy issues occurred throughout the two sessions of the 105th Congress, beginning with the reprimand of House Speaker Newt Gringrich for using tax-exempt money to promote Republican causes and ending with President Clinton facing a full-scale impeachment hearing in the House after the November elections. Even as the majority party, Republican leadership could not muster enough votes to get tax cut legislation passed. On the other hand, Democrats failed to pass the widely-popular patients bill of right to regulate health maintenance organizations, raise the minimum wage, or to regulate tobacco products. A Republican filibuster in the Senate ended bipartisan efforts in Congress to overhaul the campaign finance system.

Meanwhile, the Republican-controlled Senate failed to vote on 225 Administration nominees for positions ranging from Court of Appeals judges to the Commissioner of the Food and Drug Administration. Seventy five of these nominees have been approved by committee but have not been placed on the Senate calendar.

A Mixed Bag for LTC

"As far as the future of long-term care, the 105th Congress is not a do-nothing Congress," Robert Greenwood, associate director of public affairs for the American Association of Homes and Services for

To the relief of nursing home providers, Congress successfully resisted the Clinton Administration's efforts to use user fees on nursing homes to fund the survey and certification process.

the Aging, told *Balance*, because last year's Balanced Budget Act laid the framework for the future financing of nursing homes through a Medicare prospective payment system and an interim payment system for home care agencies.

According to Greenwood, an interim payment system compromise was included at the last moment in the massive omnibus bill to provide some financial relief for home care agencies providing efficient care in fiscal year 1993. Also, a mandatory 15 percent cut for home care agencies was postponed.

To the relief of nursing home providers, Congress successfully resisted the Clinton Administration's efforts to use user fees on nursing homes to fund the survey and certification process. AAHSA argued that this would result in an unfair new tax on nursing homes, Greenwood said.

Greenwood added that Congress did not reauthorize the popular Older Americans Act in this budget proposal although they did provide some increased funding for nutrition programs in an earlier continuing resolution. "It is important to reauthorize this program to take into account the changing needs of an aging America," he noted.

Because Congress did not take up the managed care patients bill of rights legislation, no return to home legislation was passed in the 105th Session, Greenwood stated, adding that the AAHSA endorsed legislation would have allowed residents of retirement communities, assisted living facilities and nursing facilities to return to their home facility after a hospital stay. Many times the patient's health plan forces them to go for care at another subacute treatment site. "We were successful in raising awareness of the issue to members of Congress who have already started to devising next years strategy to pass the legislation," he noted.

"Although Congress was aware of the problems concerning inadequate reimbursement for nontherapy ancillary services and therapy caps under the prospective payment system, they did not resolve these issues before adjournment," Greenwood said, noting that lawmakers were hesitant in opening up the prospective payment system legislation for amendment because of regulations complexity.

Finally, Greenwood stated that time ran out before Congress could pass a national system which would allow nursing home operators to run criminal background checks on prospective employees. "We expect this to be a high priority issue for the next Congress."

Sara Burger, executive director of the National Citizens Coalition for Nursing Home Reform, concurs: "For something that is so vital to the safety of vulnerable elders it is unbelievable that Congress couldn't come together to pass criminal background check legislation. Yet, they were able to agree on renaming the Washington National Airport." ◆◆

Herbert P. Weiss, NHA, is a Pawtucket, RI-based writer covering aging and health care issues and a member of ACHCA's Rhode Island Chapter.

National Report Calls for More Teeth In Implementing Enforcement Remedies

By Herbert P. Weiss

Although the nursing home reform law is on the books, the Health Care Financing Administration (HCFA) got failing marks in its efforts to effectively implement enforcement remedies, according to a newly released report by the Commonwealth study, authored by the National Senior Citizens Law Center (NSCLC), a Washington, DC-based law office. The scathing report charges that "enforcement in most states has become increasingly rare and limited, more a matter of rhetoric and theory than actual practice."

Last February, NSCLC released part one of the study, titled "What Happened to Enforcement?" which described and analyzed how the federal government implemented the enforcement provisions of the nursing home reform law. On October 16, NSCLC released part two, "The Experiences of Five States," a 150-page report providing case studies of Georgia, Michigan, New York, Texas and Washington State to identify factors that promote or block effective enforcement of federal quality standards.

Federal Enforcement With No Bite

According to Toby Edelman, NSCLC staff attorney and report author, federal rules and particularly informal guidance in the State Operations Manual created a weak enforcement system for states such as New York and Texas that had delayed their implementation of the enforcement provisions of the nursing home reform law until HCFA prorogated its rules in 1994. This finding is similar to what the General Accounting Office reported in July, she says. "In its report on California, the state granted a grace period to 98% of facilities cited with deficiencies. Congress very clearly rejected a system that condoned corrections before sanctions because such a system had not worked in the past to bring about compliance."

Edelman believes that the rules and HCFA's guidance also undermined the enforcement practices of states, such as Georgia, that implemented the federal legislation before the federal guidance was issued. From 1989 to 1995, Georgia effectively implemented the federal law's enforcement requirements, imposing significant remedies. Since 1995, very few remedies have been imposed using the federal system, she says.

Meanwhile, Edelman notes that federal oversight scrutinized states particularly Michigan, that identified deficiencies and imposed remedies, rather than those states that cited few or no deficiencies and imposed few or no remedies. Other states have taken notice of this, she adds, noting that many states believe that taking enforcement action and imposing remedies can create controversy and bring attention to their survey process.

Finally, Edelman adds that only Washington State whose enforcement practices focused on state licensure law, has remained relatively unaffected by the federal enforcement system. "Since 1989, Washington State has used remedies authorized by state licensure laws (e.g., stop placement and civil

money penalties collected in full) which imposes remedies for the existence of deficiencies without first granting a grace period. The federal enforcement system is a complimentary system used primarily for facilities that fail to correct their deficiencies."

To fix the problems on the federal level, Edelman calls on HCFA to rewrite its State Operations Manual to require swift and effective use of remedies along with reducing excessive complexity and unnecessary paperwork. In addition, she notes that the report calls for stronger federal oversight of the survey process, convening conferences and forums for federal and state surveyors to share effective enforcement practices, increasing federal and state survey budgets and federally mandating a system of quality improvements.

At the state level, the NSCLC report calls for the creation of an enforcement system that imposes sanctions for noncompliance, rather than solely for failure to correct deficiencies. Also, workgroups can provide advice on how to develop appropriate uses of civil money penalties.

Consumer, Provider Reactions

"We're glad to see someone has done a detailed examination of the enforcement process in five states," says Sara Burger, executive director at the National Citizens Coalition for Nursing Home Reform, because "now we can see what works and what doesn't so the survey system can be improved to protect residents."

Burger adds, "Washington State has been an good example of effective enforcement and should serve as a model for both federal and state enforcement systems." She notes that Georgia, before the federal system took effect, was doing a very effective job of using the remedy, bringing temporary managers into facilities. "We would like to see enforcement done in a way that does not close facilities but rather brings them into compliance with the law."

At the state level, the NSCLC report calls for the creation of an enforcement system that imposes sanctions for noncompliance, rather than solely for failure to correct deficiencies.

As to the use of monetary fines, the American Association of Homes and Services for the Aging (AAHSA) believes that fines are not always the best way to bring homes back into compliance, notes Robert Greenwood, AAHSA's associate director of community public affairs.

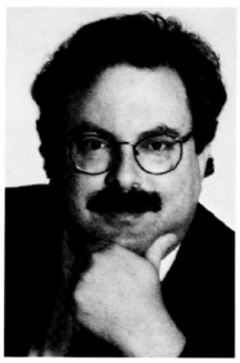
According to Greenwood, "It makes sense to have an array of sanctions and for states to use the sanctions that will best work. But the bottom line is that we really are talking about a small number of facilities that are chronically out of compliance. The survey system should treat them differently than other homes."

To obtain a copy of the report, write to NSCLC, 1101 14th Street, NW, Suite 400, Washington, DC, 20005. ◆◆

Herbert P. Weiss, NHA, is a Pautucket, Rhode Island-based writer covering aging and health care issues and a member of ACHCA's Rhode Island Chapter.

Clinton's State of Union Speech Gives Good News to Aging Baby Boomers

By Herbert P. Weiss



The intense partisan bickering fueled by the House impeachment of President Clinton, was briefly put on hold for 77 minutes as the politically popular Democrat gave a very upbeat assessment of the nation's health in his State of the Union Address.

At 9:00 p.m., on January 19,1999, a relaxed Clinton, appeared in the chamber of the House of Representatives to give his address, just a short 10 minute walk from the Senate where he earlier that day was being tried for misconduct in office. The President used this media opportunity to send a message to millions of television viewers that he was still firmly in command of the nation, even with intense Republican efforts to kick him out of office through the rarely used impeachment process.

Effectively using his Presidential bully pulpit, in a 7,600 word speech Clinton called on Congress to pass scores of appealing legislative policies, from increasing the minimum wage by a $1; improving public education by requiring teachers performance exams and the rating of schools; hiring more 30,000 to 50,000 more police officers over a five-year period; drug testing of prisoners; reducing environmental pollution; protecting the privacy of medical records; to enacting a patient's bill of rights for enrollees of health maintenance organizations. Clinton also urged lawmakers to expand the popular Family and Medical Leave Act to require companies with 25 or less workers to grant time off for family activities and emergencies.

Proposed Fixes for Social Security, Medicare

Fixing the Social Security system won't be easy to accomplish and bipartisan support is crucial to him succeeding, President Clinton acknowledged. He told lawmakers, "I reach out my hand to those of you of both parties in both houses and ask you to join me in saying: We will Save Social Security now."

In the sixth year of his leadership, President Clinton announced his ambitious plan to save the Social Security and improve the Medicare program, warning Congress that by 2013, payroll taxes will no longer be sufficient to cover monthly payments and by 2032, the Trust Fund coffers will be empty. As to his solution, the President proposed transferring $2.7 trillion (62 percent of the projected budget surpluses) over the next 15 years to fix the ailing Social Security system.

Moreover, Clinton called for another 11 percent of the surplus, or $500 billion, to help Americans to create Universal Savings Accounts, a new 401(k)-like savings plan that would allow workers to invest some of their Social Security monies into the stock market. Even the Social Security system itself should be allowed for the first time to invest in America's booming stock market, the President urged, predicting that all of his initiatives would keep the Social Security program solvent through 2055.

As to Medicare, the President called for 15 percent of the federal budget surplus, about $650 billion, to be used over the next 15 years to ensure the fiscal soundness of the Medicare Trust Fund through the year 2020. If no action is taken to prop up the Medicare program, Congressional reports predict that the program is expected to run out of money by 2008.

To expand health care access, Clinton also supported a proposal to allow persons age 55 and older who lost their health coverage to be given a chance to buy into Medicare.

ernment programs to ensure that massive numbers of seniors in the 21st century have access to the housing and health care they will need," says Michael Rodgers, senior vice president of government affairs at the American Association of Homes and Services for the Aging. "To be successful, we must also engage the private sector and put in place mechanisms that allow individuals to take personal responsibility for their retirement and long-term care needs."

"Besides addressing Medicare and Social Security [in the State of the Union speech], it is significant

To help families defray the costs of long-term care, Clinton proposed a $1,000 long term care tax credit to make home care and care giver services more available to those who need them.

To help families defray the costs of long-term care, Clinton proposed a $1,000 long term care tax credit to make home care and care giver services more available to those who need them.

In the GOP response, Rep. Jennifer Dunn (R-Wash) argued that saving the Social Security program could be easily accomplished through a 10 percent across-the-board cut in income tax rates and the elimination of the "marriage penalty," a tax policy that is often cited to increase the taxes of newly married couples.

Aging Baby Boomers Benefit from Clinton's Proposals

Nursing home groups warmly welcome President Clinton's call to the nation to prepare for the impending senior boom.

"We agree with the President that it will take more than effective government programs to ensure that massive numbers of seniors in the 21st century have access to the housing and health care they will need," says Michael Rodgers, senior vice president of government affairs at the American Association of Homes and Services for the Aging. "To be successful, we must also engage the private sector and put in place mechanisms that allow individuals to take personal responsibility for their retirement and long-term care needs as well as a tax credit for those with long-term care expenses today," Rodgers notes.

"The ball is now in Congress' court," adds Ron Pollack, Executive Director of Families USA, a Washington, D.C.-based consumer health care advocacy group. Pollack believes that the Clinton proposals are a good starting point for policy debate on health care issues facing the nation. "Now, Congress needs to get back to the business of the American people and pass legislation what will improve access to high quality affordable health care for all Americans," he said. ◆◆

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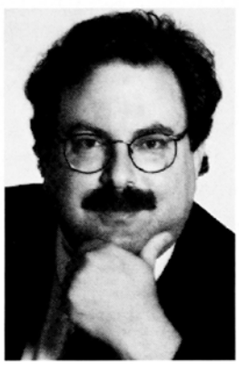
Nursing Home Groups Urge President Clinton, Congress to Fix PPS

By Herbert P. Weiss



As Congress puts the Senate trial of President Clinton behind them, long-term care providers call for a quick fix to the prospective payment system (PPS). Initial concerns about the massive changes in how Medicare pays for skilled nursing home care was registered in more than 400 comments received by the Health Care Financing Administration after the May 12 publication of 65 pages of the interim final rule on PPS. As *Balance* goes to press, the majority of the nation's skilled nursing facilities have now come on-line with PPS.

A Rocky Road to Implementation

With the implementation of PPS in July 1, 1999, providers, fiscal intermediaries and HCFA were on a steep learning curve as they grappled with massive changes as to how Medicare processed claims to pay for skilled nursing facility (SNF) care. Once implementation began many fiscal intermediaries were not able to process PPS claims because their systems were not yet in place. As a result many SNFs who came into the system last July 1999 and later in October 1999 were paid their previous interim rates rather than the newly calculated federal PPS rate. As a result HCFA is now forced to reconcile the difference between the two amounts and facilities might be put in a position to give back money to the agency. Another implementation glitch is the inconsistency in the interpretation of PPS among the fiscal intermediaries and HCFA. However, this problem is being ironed out.

Calls for PPS Payment Change

Moreover, nursing facility provider groups are expressing concern over PPS payment policy that adversely affects the financial viability of their operations and the quality of life of their residents. In one instance, Medicare Part B payment policy puts a $1,500 cap per year on the amount of rehabilitation therapy available to each nursing home resident and PPS payment for expensive non-therapy ancillary is costly but not adequately reimbursed.

In a March 8th letter, Dan Mosca, the American Health Care Association's (AHCA) Chairman of the Board called on President Clinton and Congress to rethink some of its payment policies impacting the quality of care provided by nursing facilities.

According to Mosca, "Proposals by the Clinton Administration to cut as much as $10 billion out of the Medicare budget will jeopardize Medicare beneficiary access to rehabilitation therapy and other critical health services," he warned. The Clinton proposal follows billions of dollars in 1997 Medicare cuts that have "already stretch health providers' ability to meet patient needs," he said.

Additionally, AHCA urged a revision and flexibility of a current HCFA policy, which caps at $1500 per year the amount of rehabilitation therapy available to nursing home residents, regardless of need or physician recommendation. The group cited that the average therapy cost for a stroke patient is about $3,000.

AHCA also called for additional monies to adequately fund non-therapy ancillaries (e.g., ventilator care, chemotherapy, antibiotic IV therapy and other medications).

With the beginning of the new Congressional session, the American Association of Homes and Services for the Aging, calls for lawmakers to pass S. 472, the Medicare Rehabilitation Benefit Improvement Act of 1999. The bill reduces the discriminatory impact of the Medicare Part B Therapy Caps by allowing residents of nursing facilities to receive "reasonable and necessary rehabilitation services" to improve their functioning and quality of life.

AAHSA expresses concern over the last year about the huge fiscal hits specialty nursing homes take when caring for intensely ill residents under the PPS system. Some residents require higher levels of care and services, resulting in significantly higher costs, more than ever expected for the average resident under PPS. For instance, the nursing home group notes that patients with AIDS may require drugs that cost $450 or more per day or a cancer patient could require $1,900 in therapy. In another case, a prosthetic device, costing $5,000 to $10,000, might be necessary to promote independence of a patient. Or ventilator care might cost $100 per day not including the expenses for specialty trained nurses.

AAHSA calls on Congress to require HCFA to develop an outlier or exception policy to pay for required non-therapy ancillary services that far exceed PPS reimbursement. It's a win-win situation for both Medicare beneficiaries who require high non-therapy costs and SNFs who are financially protected by offering these specialty services. Meanwhile, AAHSA suggests that any savings resulting from the PPS, beyond the amount mandated by the Balanced Budget Act of 1997 be made available to pay for outlier cases. ◆◆

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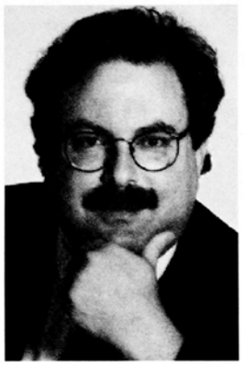
Senate Panel Urges Seniors to Shop Carefully for Assisted Living



By Herbert P. Weiss

As growing consumer demand fuels an explosion in the assisted living industry, a new federal report released at a Senate panel calls for better information to be made available to prospective residents to allow them to become sophisticated shoppers to select facilities that best meet their needs and preferences. The long-awaited report included no recommendations for federal regulation of the $13 billion industry even though provider groups had speculated that this might occur.

The assisted living industry caught the eye of Congress with its growing popularity and rapid growth. Researchers say that 650,000 seniors reside in 11,500 assisted living facilities; this number expected to dramatically increase in the next ten years. By comparison, 1.2 million people in the nation's 17,000 nursing facilities.

THE ASSISTED LIVING INDUSTRY CAUGHT THE EYE OF CONGRESS WITH ITS GROWING POPULARITY AND RAPID GROWTH.

Chairman Chuck Grassley, of the Senate Aging Committee, used the April 26 Senate Aging Committee hearing as a backdrop, urging older consumers to carefully shop for assisted living facilities. "It disturbs me that too many people lack the information they need to choose a facility that's right for them," he told the audience.

"Shopping for an assisted living facility should be just like buying a house. You inspect the goods, read the fine print and protect yourself from unpleasant surprises," Grassley added.

The 55-page General Accounting Office (GAO) report's findings released at this hearing is based on data gathered from California, Oregon, Ohio and Florida. In the report authors surveyed 622 assisted living facilities, examined marketing materials obtained from 60 facilities, and visited 20 facilities to interview assisted living providers, residents and family members. Additionally, regulators were interviewed in the four states. Finally, a random sample of 753 facilities and adult protective agencies in Florida and Oregon provided a glimpse into consumer protection problems.

The GAO report found that assisted living facilities, ranging from small, freestanding, independently owned to large corporate ones, varied widely in admission and retention policies, served a wide range of resident's needs, and provided a variety of services.

Only 50 percent of facilities reported that prospective residents were provided with information as to the amount of assistance with medications they can expect to receive, price change policies, or how health status change affects their status as residents. Meanwhile, only one-third of the facilities were provided a description of the qualifications of facility staff or a listing as to what services were not available. Only 25 percent

of the facilities provided prospective residents with contracts before they decided to apply for admission.

To rectify these problems, the GAO report urged that prospective residents be provided clear and complete information about services, costs and facility policies.

According to the federal report, state licensing and monitoring activities of quality of care and consumer protection in assisted living facilities vary as to frequency and content of inspection. Alarmingly, researchers found that one-fourth of the facilities in the four states were cited by ombudsman or state licensing agencies for five or more quality of care or consumer protection-related deficiencies or violation during 1996 and 1997. About 11 percent of these facilities were cited for 10 or more quality of care or consumer protection-related deficiencies or violations during the same period of time.

TO REGULATE OR NOT REGULATE

As to why the report did not call for the regulation of the assisted living industry, Kathryn G. Allen, Assistant Director, Health Financing and Systems Issues of the U.S. General Accounting Office, told panelists that more study was required before the drafting of such regulations.

"Consumers should continue to have the ability to choose the type of assisted living that best suits their needs," stated Dean Painter, of the American Association of Homes and Services for the Aging, to the Senate Aging panel. Strongly opposing an increased regulatory environment for the industry, the president and CEO of the Eaton Terrace Group in Lakewood Colorado, added, "The present regulatory environment allows innovation and creativity to flourish, which ultimately can give the consumer more options from which to choose."

Painter also called on assisted living providers to remain focused on their commitment to consumer protection and maintain their commitment to disclosure, needs assessment and services planning.

Added Robert Lohr, founder and president of Peridot Enterprises, Inc., testifying on behalf on the National Center for Assisted Living, he called on Senate Aging panel members to not create the same problems federal and state regulators face in regulating nursing homes. "It would be a mistake to burden assisted living with a similar system that doesn't work," he said.

"One of assisted living's greatest strengths is its ability to mold and shape itself to fit the needs of the individual consumer," Lohr noted. "Providers should build individualized service packages for residents, fully inform them what those services are and tell residents exactly how much the services will cost."

ONE OF ASSISTED LIVING'S GREATEST STRENGTHS IS ITS ABILITY TO MOLD AND SHAPE ITSELF TO FIT THE NEEDS OF THE INDIVIDUAL CONSUMER

Lohr warned, "The assisted living industry is in its adolescence and is still maturing and growing. Government policies should nurture this growth, not stunt it." ◆

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Clinton Proposal Begins Debate on Medicare Prescription Benefit

By Herbert P. Weiss

Before the July 4th Congressional recess, in a booming economy that is expected to result in a $3 trillion federal budget surplus over the next ten years, President Clinton called for modernizing Medicare, a promise he made to 34 million elderly beneficiaries and 5 million disabled persons, a pledge especially of interest to the nation's burgeoning middle age baby boomers. While urging Congress to shor up and modernize an ailing Medicare program, projected to be insolvent by 2015, the President proposed the biggest Medicare expansion in more than 30 years, the partial coverage for costly prescription drugs.

MAKING PRESCRIPTION DRUGS ACCESSIBLE

In a June 30th speech in Chicago touting his new Medicare rescue plan, President Clinton told aging professionals and elderly attendees that his new prescription plan is needed more than ever because 15 million seniors are now uninsured as to drug coverage. About 40 percent of these persons are middle class. The President warned the crowd that more seniors will lose coverage as a growing number of private insurers drop drug coverage altogether because of the expense.

The Clinton prescription plan would cost $118 billion over ten years. Over 60 percent of the costs would be offset by the proposal's savings resulting from making Medicare more competitive and efficient, aggressive federal anti-fraud and abuse enforcement efforts, Medigap reforms, along with slashing Medicare spending by $72 billion over a 10 year period. About 15 percent of the projected federal budget surplus, translated to $45.5 billion, would come from the Medicare allocation of the surplus.

Currently the Medicare program does not cover the cost of outpatient prescription drugs. Once approved by Congress, the Clinton proposal would create a new and voluntary outpatient Medicare prescription drug benefit (a "Part D of the program") that begins for all beneficiaries beginning 2002. Under the proposal, beneficiaries would pay a $24 per month premium, for Medicare to cover half of their first

BBA HAS UNINTENDED IMPACT ON QUALITY OF CARE

Since the Health Care Financing Administration began to implement the changes mandated by the Balanced Budget Act (BBA), access to critical nursing home services has been limited to frail nursing home residents. Here are some examples:

- A nursing home in rural Wisconsin had to close down its ventilator care unit because Medicare reimbursement fell to half of the actual cost of providing the services. Now those patients it served must travel nearly 100 miles for care.
- In Michigan, a skilled nursing facility provided over $80,000 in intravenous medications to a resident with cancer who was in the facility for 27 days. Of that amount, Medicare paid less than $10,000.
- Some nursing home residents are denying themselves needed therapies in order not to exceed the therapies cap. ◆

Source: American Association of Homes and Services for the Aging, July 1999.

$2,000 in drug costs, or up to $1,000 annually.

Once fully implemented by 2008, the premium increases to $44 a month, with Medicare covering half of their first $5,000 in drug purchases or up to $2,500 annually. For low income beneficiaries with income below 135 percent of poverty, would not pay premiums or share prescription costs.

Besides the new prescription drug benefit, beneficiaries will receive improved access to preventive care with the elimination of cost-sharing requirements. Finally, the president estimates that his Medicare fix will extend the solvency of Medicare to 2027.

THE DEBATE BEGINS

"No one should have to choose between food and medicine," quipped Chairman Chuck Grassley (R-Iowa) of the Senate Special Committee on Aging, in a statement responding to President Clinton's call for a new prescription drug benefit. "The challenge is to create a prescription drug benefit that has all the right elements," he added.

Many questions must be answered before Congress can approve the benefit, Grassley said, like: "Will the benefit target those who need the most help? Can the nation afford it, now and when baby boomers will retire? Will the government benefit be less generous than what many retirees receive from their former employees? Will we save Medicare in the process?"

Meanwhile, Michael Rodgers, senior vice president of the American Association of Homes and Services for the Aging (AAHSA), states that his group supports the new Medicare benefit because many low-income elderly will gain access and benefit from prescription drugs they need.

Adds, President James Firman, of the National Council on Aging (NCOA), the "bold Medicare reform plan will move the upcoming debate in a positive direction. NCOA supports prescription drug coverage because it is available to all beneficiaries, not just limited to the poor elderly."

OTHER GLITCHES TO IRON OUT IN MEDICARE

Although AAHSA applauds the President's proposal to provide prescription drug coverage to Medicare beneficiaries, Rodgers believes that the provider set-aside of $7.5 billion over the next ten years to help fix gaps in Medicare coverage resulting from the passage of the Balanced Budget Act (BBA) is not enough.

"Many of the BBA provisions affecting nursing home residents make it harder for the frailest and most vulnerable residents to access the care that they need," Rodgers says. However, he points out that the key decisions will be on how to spend the limited new funds, as Medicare beneficiaries continue to find their access to nursing home care, home health, hospitals and Medicare health maintenance organization plans by funds cuts in the BBA agreement.

According to Rodgers, AAHSA still has serious concerns about the course Medicare has taken to separate payment rates from the cost of providing the high quality of care. "We hope that once Congress and the Administration further explore the budget act's many unintended consequences for Medicare beneficiaries, they will appropriate adequate resources to address these concerns," he adds. ◆

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New Reports Spotlight Inadequacies of PPS

By Herbert P. Weiss

For skilled nursing facility (SNF) providers participating in the Medicare program, the writing is clearly on the wall. Unless the new prospective payment system (PPS) is fixed by Congress, the unintended consequences will devastate the financial stability of thousands of facilities. With all of the SNFs participating in Medicare now being reimbursed by PPS, industry and government reports are now documenting the new payment system's shortcomings.

Vencor, the operator of 293 nursing facilities and 56 hospitals in 46 states, has become the first victim of the severe Medicare cuts and has filed for bankruptcy protection. Regional chain operators such as Frontier, Newcare, and Iatros, along with a growing number of independent facility providers have also declared bankruptcy this year, because of the of the new PPS reimbursement policy. According to the *Turnaround Letter*, a newsletter that covers the financing issues in health care industry, "stocks of Mariner Post-Acute Network, Sun Healthcare Group and Vencor will probably end up worthless."

MEDICARE CUTS NEARLY DOUBLE PROJECTIONS

According to one recent study, sponsored by the American Health Care Association (AHCA), Medicare cuts to SNFs resulting from the 1997 Balanced Budget Act will exceed $2 billion per year, nearly twice the $1.3 billion originally predicted by the Congressional Budget Office. The study detailing a survey of AHCA members found that facilities have had payments per day reduced by $50 and have also had a 10.5 percent reduction in Medicare days. AHCA charges that the findings suggest that total cuts to SNFs have now reached 24 percent.

"The new independent analysis confirms what we've already learned anecdotally from SNFs across the nation," stated AHCA Vice President Linda Keegan. "The cuts are much deeper than envisioned, and the impact on access to health care for our nation's elderly and disabled is potentially devastating. Indications are that it is the sickest patients who are hardest hit."

"The bottom line is that the cuts to our SNFs present a clear and present danger to the well-being of our nation's seniors," added Keegan. "We simply cannot afford to watch real people with real problems continuing to bear the brunt of legislation in urgent need of change."

Additionally, a recently released federal government report charged that medically-complex patients are most likely to have difficulty accessing nursing home care under the new PPS system.

To assess PPS's impact on Medicare beneficiary access to SNF care, the Department of Health and Human Services' Office of the Inspector General randomly surveyed 180 hospital discharge planers and analyzed Medicare data. In an August 30 report, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, it was found that 58 percent of the respondents stated that Medicare patients requiring extensive services such as intravenous feedings, intravenous medications, or ventilator/respirator care were becoming more difficult to place in facilities in the past year.

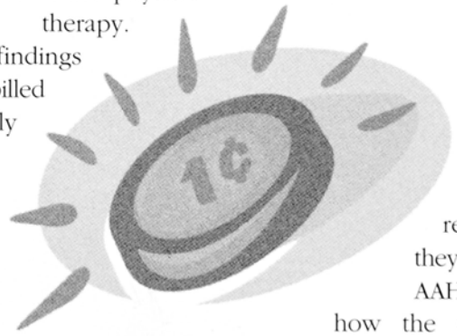
Nursing facility administrators are also changing the ways they have traditionally done business, the IOG study found. About

half of all those surveyed noted that facilities have changed their admissions practices as a result of the new payment system. Now facilities are requesting more detailed clinical information about patients, looking more closely at the cost of care, and conducting more in-person assessments of patients before making admission decisions.

On the other hand, the study noted that 69 percent of the discharge planners reported that Medicare patients who required special rehabilitation, which is reimbursed at the highest rate under PPS, had become easier to place in facilities in the past year.

Two other reports, on the impact of PPS on rehabilitation services, were also released by the OIG. One report, *Physical and Occupational Therapy in Nursing Homes: Quality of Care and Medical Necessity for Medicare Patients*, found that most Medicare patients received appropriate therapy for their initial medical conditions and benefited from therapy. However, the investigators also found that almost 13 percent of therapy was billed improperly to Medicare because the therapy was not deemed medically necessary or was provided by inappropriate staff. Also, about 4 percent of therapy was not properly documented in the patient' medical records.

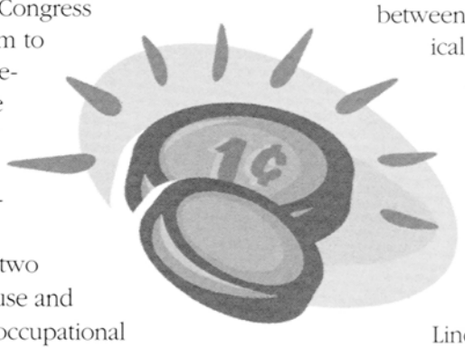
The last report, *Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare*, estimated that for the 12-month period ending June 30, 1998, Medicare paid SNFs almost $1 billion for improperly billed physical and occupational therapy and $331 million for improperly documented physical and occupational therapy. Additionally, the findings showed that SNFs billed Medicare significantly more for contract occupational therapists than the nursing facilities themselves paid for these services. It was estimated that the markups added an estimated $342 million a year to Medicare's costs for occupational therapy.



Finally, the report noted that unnecessary and improperly documented therapy, as well as the occupational therapy markups, were not identified and eliminated before the move to the new PPS resulting in inflated base-year costs for the new payment system.

OIG REPORT SPOTLIGHTS PROVIDER CONCERNS

The OIG study supports the American Association of Homes and Service's for the Agings' (AAHSA) call for Congress to fix the broken payment system, said AAHSA President Len Fishman. "We have been pointing out this flaw in PPS to members of Congress and asking them to add more resources for the most medically complex nursing home residents."



As to the two reports on the use and payment for occupational and physical therapy in nursing facilities, Fishman noted that the data was collected before the implementation of PPS and does not address problems caused by the $1,500 a year therapy caps imposed by the Balanced Budget Act.

"Therapy caps place an unfair burden on nursing home residents in need of therapies," Fishman stated. "Other Medicare beneficiaries with the same therapy needs and who live outside a nursing home are not subject to caps. We believe Medicare should pay for therapies based on the medical needs of the beneficiary regardless of where they live."

AAHSA is also concerned how the OIG estimates the amount of "medically unnecessary" care that is being provided in facilities, added Fishman. While unnecessary treatments to increase profits should not be tolerated, he said, federal regulations require facilities to keep their residents functioning at the highest practicable level. "So therapies that may appear unwarranted after the fact, must be seen in the light of the good faith efforts care givers undertake to make the best decisions for their residents."

FIXING THE PROBLEM

One quick fix for the PPS may lie with the passage of the Hatch-Domenici-Daschle-Kerrey Bill that restores the unfair Medicare cuts, say provider groups. S. 1500, The Medicare Beneficiary Access to Quality Nursing Home Care Act of 1999, would identify where there are high-cost patients (e.g., cancer, hip fracture and stroke) in the PPS system and make payment add-ons to address the disparity between the cost of providing medically complex services and the funding Medicare currently provides.

"These Senators are literally throwing a lifesaver to Medicare beneficiaries who need nursing home care," states AHCA Vice President Linda Keegan. Adds AAHSA President Len Fishman, "This bill address urgent issues AAHSA has been raising about problems Medicare residents have had accessing medically complex nursing home services because of the unintended consequences of the Balanced Budget Act of 1997." ◆

Herbert P. Weiss, NHA, is a Pawtucket, Rhode Island-based writer covering aging and health care issues and a member of the ACHCA's Rhode Island Chapter.

OPINION OR VIEWPOINT?

Have an opinion or viewpoint to share with other ACHCA members? Send your letters to *Balance*, c/o ACHCA, 1800 Diagonal Road, Suite 355, Alexandria, VA 22314, fax—(703) 739-7901, or e-mail info@achca.org. ◆

Budget Bill Provides Fixes for PPS

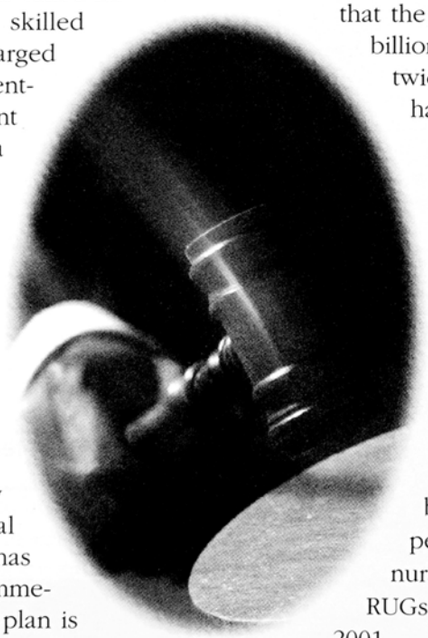
By Herbert P. Weiss

With passage in the House and after days of intense negotiation between House and Senate leadership to hammer out differences before Senate consideration, on Nov. 19 the Senate moved quickly without debate to pass a final budget bill of this century with a 74-24 vote and sent the measure to President Clinton to sign into law.

Signed just one month before the end of the century, the $390 billion spending plan, a package of five spending bills, provided a Congressional fix for the unintended adverse consequences of the Balanced Budget Act (BBA) of 1997.

PROVIDERS CALL FOR BBA-RELIEF

Weeks before the Senate budget vote, an open letter distributed to Congress from 12 national organizations called for restored funding for skilled nursing care and charged that the newly implemented prospective payment system has resulted in a growing trend of nursing facility chain and provider bankruptcies.



At that time, Linda Keegan, Vice President of the American Health Care Association, stated "the situation is urgent." She added: "This is a very real crisis facing real people, and Congress has the power to provide immediate relief. The Senate plan is the one plan on Capitol Hill that will protect America's seniors by ensuring access to needed skilled nursing care. It throws a life saver to seniors, their families and to providers who are struggling to deliver quality care."

At the signing ceremony in the chilly White House Rose Garden, President Clinton told the crowd that "This budget is a hard-won victory for the American people. Simply put, it's a budget that meets our priorities, supports our values, and invests in our future.." Nursing home groups knew that the fiscal year 2000 budget measure, that would ultimately incorporate the Senate's prescription for overhauling the prospective payment system (PPS), was their personal victory too, one result in their year-long intense grass-roots lobbying efforts.

NEW FEDERAL BUDGET FIXES PPS

For skilled nursing facilities, the final budget restores $2.7 billion in Medicare funding over the next three years. A Congressional Budget Office study released earlier this year had found that the BBA had slashed $208 billion from Medicare, nearly twice as much as Congress had originally intended.

Specifically, the final budget package raises the reimbursement rate for 15 RUGs for care provided to the most medically-complex residents and for residents requiring some rehabilitation therapies. It also gives an across-the-board increase of four percent in payments to nursing facilities for all 44 RUGs in fiscal years 2000 and 2001.

Identifying the key RUG categories that needed to be addressed was essential to influencing Congress to pass this much needed legislation. It reassured them that the additional funds that they were allocat-

SPECIFICALLY, THE FINAL BUDGET PACKAGE RAISES THE REIMBURSEMENT RATE FOR 15 RUGS FOR CARE PROVIDED TO THE MOST MEDICALLY COMPLEX RESIDENTS AND FOR RESIDENTS REQUIRING SOME REHABILITATION THERAPIES.

ing were going to providing care for vulnerable Medicare-eligible nursing home residents.

Additionally, the budget measure allows costs for prosthetics, chemotherapy drugs, and ambulance services to and from dialysis to be "carved out" of the Medicare prospective payment system and they can now be billed to Medicare directly.

Providers will also see three other fixes. Congress gave an option to facilities to move immediately to payment at the full federal rate, which would help facilities that have significantly changed their operations since 1995, the BBA base year. This takes effect 30 days after the final budget bill becomes law. In addition, there is a two-year suspension in implementing the $1,500 a year cap on physical therapy (including speech) and occupational therapy. Finally, the new law corrects a BBA technical error that denied payment of Part B services to SNFs participating in PPS demonstration projects.

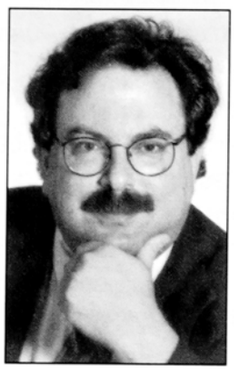
Home care providers also found regulatory relief in major provisions of the year 2000 budget. Congress called for a one-year delay in the 15 percent cut in reimbursement rates scheduled to take effect on October 1, 2000. Additionally, costs for durable medical equipment were "carved out" of the Medicare PPS system and can now be billed to Medicare directly. Finally, surety bonds will be required for either $50,000 or 10 percent of program revenues, whichever is lower.

"Congress bent over backwards to get this budget legislation passed this year," Robert Greenwood, the Associate Director of Public Affairs at American Association of Homes and Services for the Aging (AAHSA). Congressional action came about because of a tremendous effort of provider groups and consumers who educated Congress about how the reduced access and the quality of care provided to residents, Greenwood told *Balance*.

According to Greenwood, Senate Minority Leader Thomas Daschle (D-SD) included many key budget provisions that nursing home groups had advocated for this year in the bill he introduced. Sen. William Roth (R-DE) was instrumental in raising many PPS-related issues in the final budget bill in legislation he introduced this summer. Rep. Bill Thomas (R-CA) pushed for Congress to act on nursing home provider concerns before it adjourned in November. Finally, Rep. Nancy Johnson (R-CT) was instrumental in providing carve-outs for certain high-cost, nontherapy ancillary services whose costs were not adequately reflected in the new Medicare prospective payment system. ◆

Herbert Weiss, NHA, is a Pawtucket, Rhode Island-based writer covering aging and health care issues and a member of the ACHCA's Rhode Island Chapter.

Election Year May Stall Many Clinton Proposals



By Herbert P. Weiss

Calling for bipartisan efforts, President Clinton, in his last State of the Union address of his presidency, outlined a jam-packed policy agenda in a speech lasting 89 minutes interrupted by more than one hundred times by applause (mostly from Democrats).

Citing a booming economy, Clinton offered to the packed Chamber dozens of proposals for modest tax cuts and increases in domestic spending. The President urged fellow Democrats and the Republican-controlled Congress to support his whopping $350 billion package to be phased in over 10 years. The package of initiatives would promote educational opportunities, expanded access to health care and to child care for lower-and middle-income working Americans. It would also include an issue seized from Republicans—reducing the impact of the "marriage penalty" for two-wage earner couples.

Other major Clinton proposals included state licenses for hand gun purchase and increased federal funding of smart gun technologies and biomedical research, campaign finance reform and increasing the nation's minimum wage.

In his speech, Clinton again called for lawmakers to revisit the patients' rights legislation. Last year, the President supported passage of the Democratic version that would guarantee a patient's access to specialists and emergency rooms and the right to challenge care decisions.

Clinton asked Congress to pump $400 billion into the ailing Medicare program to ensure the solvency of the program and to offer coverage for prescription drugs. This "Buy-In" program would enable people ages 55 to 65 to pay monthly premiums and be covered by Medicare. A tax credit would help offset a portion of the premium cost.

Additionally, the President asks for a $3,000 tax credit for caregivers, tripling the credit over last year's proposal and increasing the total investment in the long-term care tax credit to $28 billion over 10 years.

As last year, the President proposed allocating an additional $125 million annually to help caregivers provide care to frail or disabled elderly who require long-term care services. This additional funding would pay for respite care, counseling and other support for family caregivers.

Meanwhile, Clinton proposes funding for long-term care be also made available to convert low-income elderly housing projects into assisted living and to give states the flexibility of offering community-based services to nursing home qualified Medicaid beneficiaries.

BELTWAY PUNDITS MAKE PREDICTIONS

Clinton faces an up hill battle getting his proposals passed in a Congress with a Republican majority in an election year, stated Ed Howard, Executive Vice President, of the Washington, DC-based Alliance for Health Care Reform.

"In this town you can get 95 percent accuracy in your predictions by saying nothing is going to happen," Howard told *Balance*. Congress won't have much time to legislate with fewer than 100 legislative days between now and the November election, he said.

Bill Benson, former AOA Assistant Secretary for Aging and now President of The Benson Consulting Group, agrees, noting that during the upcoming session of Congress there will be "a lot of noise about senior citizen issues to get attention in an election year." That may be about it, he predicts.

According to Benson, many of Clinton's big ticket items, like his Medicare reform proposals, will be tough to pass because of strong ideological feelings on both sides of the aisle. For example, he says Republicans push for raising the age of eligibility and cost sharing of the Medicare program while the Democrats push for expanding benefits like prescription drugs.

"Last year's proposed $1,000 tax credit for caregivers was deservedly criticized because it was so tiny," Benson noted, stating Clinton's proposal for increasing the tax credit to $3,000 will mostly force Congress to take a serious look at it.

"Hopefully, the one thing I think Congress may get done is pass patient protection legislation," Benson added, even though he believes a watered-down version will be enacted.

According to Michael Rodgers, the American Association of Homes and Services for the Aging's (AAHSA) Senior Vice President for Government Affairs, the nonprofit group gives thumbs up to the President's $3,000 tax credit for seniors. As to the prescription drug benefit for seniors, AAHSA supports the concept, he says, but is closely examining the differing specifics being considered. While this new Medicare benefit does not directly impact the providers themselves it is an especially big issue for CCRC, assisted living and federally subsidized housing residents who have high medication costs.

Rodgers adds, although AAHSA supports the concepts in Clinton's speech, "we want to see the details in the President's FY 2001 Budget." For legislative proposals, he notes that the "devil's in the details." ◆

Herbert P. Weiss is a Pawtucket, Rhode Island-based writer covering aging and health care issues. He serves as editor of the Rhode Island Report, the award winning membership newsletter of the Rhode Island Chapter of ACHCA.

CONGRESS RECONVENES, AAHSA TARGETS LTC ISSUES FOR LAWMAKERS

Here is a sampling of listing of AAHSA legislative priorities for the second session of the 106th Congress:

Return-to-home legislation. Although not mentioned in the President's State of the Union Address, this proposal will return this year. Initially introduced during the 105th session, "Return-to-home" legislation was not enacted because it was linked to the "patient's rights" legislation.

Section 202 funding. AAHSA pushes to maintain funding for Section 202 new developments to at least $660 million. The nonprofit group urges Congress to: allow for flexibility of mixed financing; using Section 202 funding with tax credits, allowing the development and operation of commercial facilities in Section 202 properties; and allowing for the development and operation of Section 202 units on the same premises as, and integrated with, private financed units.

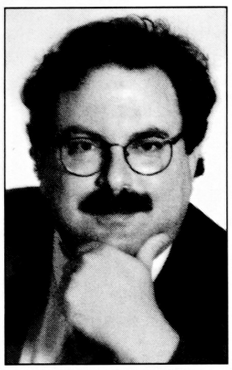
Affordable Assisted Living. AAHSA asks Congress and the administration to expand funds for new development, to retrofit, rehabilitate and/or convert other federally assisted elderly housing to assisted living. The group continues to make the argument that assisted living has its place in the continuum of care and is a cheaper alternative to nursing home care, especially for those who do not require 24-hour skilled nursing home care.

Nursing Home Staffing. AAHSA will continue to educate Congress about the drawbacks to mandatory federal staffing ratios and provide them with alternative approaches to ensuring high quality of care in facilities. One such approach is to permit non-nursing staff with special training to assist residents with specific tasks, such as eating.

Older Americans Act Reauthorization. Congress will reconsider reauthorizing the Older Americans Act. Efforts to reauthorize the Act stalled last year and it is being funded under a continuing resolution. Republicans and Democrats could not agree as to how to modernize the program. This upcoming session, AAHSA along with a large number of aging advocacy groups will again push Congress to reauthorize the highly popular program. ◆

Source: American Association of Homes and Services for the Aging, Currents, January 2000.

Debate Over a Medicare Prescription Benefit Gains Momentum on Capitol Hill



By Herbert P. Weiss

As the November election looms, Congress is working at a furious pace to finish up legislative business. Between now and October 6 recess, lawmakers will attempt to pass a federal budget along with 13 appropriation bills, as well as seek passage of some popular election issues such as tax cuts, education, patient's bill of rights, and gun control. Meanwhile, bipartisan support in the 106th Congress for a Medicare benefit to cover costly prescription drugs is gaining momentum on Capitol Hill.

Costly prescription drugs are becoming a major issue in this year's election campaign for the nation's elderly. With the average senior filling about 18 prescriptions per year, prescription drugs are now the largest out-of-pocket health care costs for seniors.

THE DEBATE ON PRESCRIPTION DRUGS BEGINS

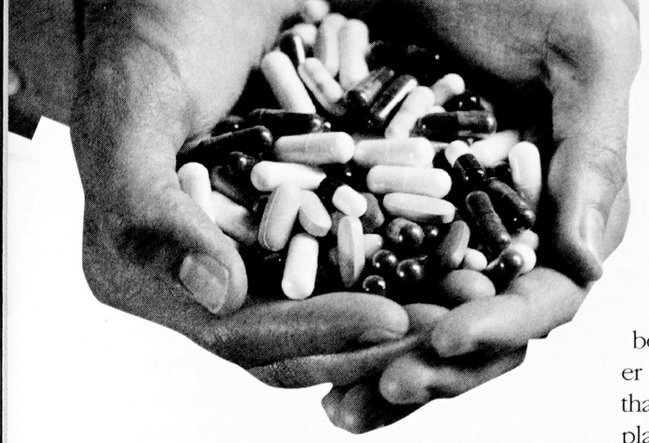
In his January State of the Union Address, President Clinton called for a new voluntary Medicare prescription drug benefit. Later this proposal would be incorporated into the President's FY 2000 Budget. The administration's plan would simply give elderly and disabled beneficiaries the option to purchase a prescription drug benefit that covers half of all drug costs up to $5,000 when fully phased in. It also includes a stop-loss provision to protect seniors against catastrophic drug costs.

Before Easter recess, House Republican leadership hoping to keep the Democrats from seizing a popular election issue in their districts have released their own proposal to cut pharmaceutical costs for the nation's elderly. Democrats were quick to call the GOP's new effort as election posturing.

COSTLY PRESCRIPTION DRUGS ARE BECOMING A MAJOR ISSUE IN THIS YEAR'S ELECTION CAMPAIGN FOR THE NATION'S ELDERLY.

At least 85 percent of 39 million Medicare beneficiaries take at least one prescription medication per day. The average spending last year per Medicare beneficiary for drugs was $942 annually, or about $79 per month. As a result, many beneficiaries who cannot afford drug coverage often do not take the drugs that their physicians prescribe, and one in eight is sometimes forced to chose between buying food and their medications.

While still sketchy, the $40 billion dollar plan, to be phased in over a five year period, would give Medicare beneficiaries and disabled persons increased bargaining power through private health plans to purchase prescription drugs at discounted rates. Health insurance policies covering the purchase of prescrip-



tion drugs would remain affordable because the federal government would subsidize the poor and share risks with the insurers. House Speaker Dennis Hastert (R-Ill) is expected to introduce legislation on the House floor early this summer.

Both President Clinton's and the House Leadership's proposals have similarities in that each offers a voluntary drug benefit open to all Medicare beneficiaries. Additionally, both the Democratic and Republican proposals would provide financial assistance to low-income beneficiaries.

According to Ed Howard, Executive Vice President of the Washington, DC-based Alliance for Health Reform, the changes for enactment of a prescription drug benefit have been enhanced this year with the release of the Medicare trustees report that indicated that the life of the trust fund has been extended for another eight years.

However, Howard predicts a more difficult passage because of this year's elections.

Everybody wants to see a Medicare drug benefit happen if you judge by their outward actions or statements but they want it to happen in a way that they like, he notes.

"The Republicans have proposed more targeted prescription drug benefits to get the Democrats off their back. They are very likely to stall any action on the broader benefits [offered by the Democrats] just because they don't want to see either President Clinton or the Democrats get what they want," Howard adds.

Others are more optimistic for the chances of a prescription drug benefit to pass.

There is a good chance that the Medicare drug plan will get passed by Congress this year, Robert Greenwood, Associate Director of Public Affairs for the American Association of Homes and Services for the Aging, tells *Balance*. "Incumbent Republications and Democrats who are looking to keep control of the House both want to show that they can deliver for seniors," Greenwood says. "Now that the GOP has come out with its own plan, it is more likely that some version of the bill will pass," he adds.

Although Medicaid pays for the majority of prescriptions for nursing home residents, seniors residing in subsidized housing, assisted living facilities and CCRCs must pay for their own medications, Greenwood noted. "Coverage of prescription drugs by Medicare would be a good thing for those persons on fixed incomes in these facilities," he says.

A budget Omnibus Reconciliation Act will be the likely vehicle to attach the prescription drug benefit proposal, Greenwood states. ◆

Herbert Weiss, NHA, is a Pawtucket, Rhode Island-based writer covering aging and health care issues and a member of the ACHCA's Rhode Island Chapter.

BUILDING A CASE FOR A NEW MEDICARE PRESCRIPTION BENEFIT

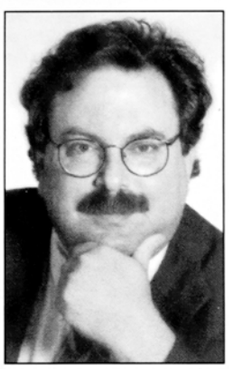
A new Department of Health and Human Services study, released on April 10, 2000, underscores the need for a voluntary Medicare prescription drug benefit. Here are some of the HHS study's findings:

- Seniors without drug coverage not only lack insurance against high costs, but do not have access to the discounts and rebates that insured people receive.
- Older Americans and people with disabilities without drug coverage typically pay 15 percent more than insurers who negotiate price discounts for the same prescription drug.
- The gap between drug prices for people with and without insurance discounts nearly doubled, from 8 to 15 percent, between 1996 and 1999. These differences do not take into account manufacturers' rebates, which could widen this gap by an additional 2 to 35 percent.
- Prescription drug spending and utilization is growing rapidly—more than twice the growth in other health spending.
- The percent of Medicare beneficiaries without drug coverage who report not being able to afford a needed drug is about five times higher than those with coverage.
- Uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.
- Chronically ill, uninsured Medicare beneficiaries spent over $500 more out-of-pocket than those with coverage.
- Nearly half of Medicare beneficiaries do not have coverage for prescription drugs for the entire year.
- One out of four Medicare beneficiaries with higher income (about $45,000 per couple) has no coverage for prescription drugs throughout the year.

Because of limited information about price discounts, HHS will host a conference on prescription drug pricing practices this summer. The HHS study, available in its entirety at http://aspe.hhs.gov/health/reports/drugstudy. ◆

Source: White House, April 10, 2000

Attorney General Reno Calls for Crack Down of Facilities Providing Poor Care



By Herbert P. Weiss

From more than 40 states, federal, state and local officials traveled to Washington, DC to discuss better ways to coordinate their enforcement efforts to more effectively deter abuse and neglect at the grass roots levels in the nation's 17,000 nursing homes and to discuss strategies for enhancing the quality of care in these facilities.

Efforts to coordinate federal, state and local agency efforts to crack down on poor nursing home care began at an October 1998 meeting hosted by the Department of Justice. At this meeting, the Department of Health and Human Services along with state and local officials launched the Nursing Home Initiative (see box) to coordinate their efforts to protect vulnerable residents in nursing homes and other residential facilities against fraud, abuse and neglect. From these efforts, including the recommendation of a focus group convened by the Office of Victims of Crime, a strategy for stepped-up enforcement, coordination, and training of regulators, investigators, prosecutors and patient advocates was developed.

EFFORTS TO COORDINATE FEDERAL, STATE AND LOCAL AGENCY EFFORTS TO CRACK DOWN ON POOR NURSING HOME CARE BEGAN AT AN OCTOBER 1998 MEETING HOSTED BY THE DEPARTMENT OF JUSTICE.

The June 12th meeting held in Washington, D.C., sponsored by the Department of Justice, comes on the heels of four regional conferences, scheduled between July 1999 and February 2000, that provided training to more than 1,000 federal, state and local officials. These four conferences were held to create or enhance the efforts of inter-governmental and multi-disciplinary State Working Groups at the grass-roots level to prevent abuse and neglect. Such efforts are now underway in at least 30 states.

In her keynote address, Attorney General Janet Reno charged that "despite some improvements seriously inadequate care persists at far too many nursing facilities." Successful regulatory efforts require a multidisciplinary response, she told the participants, noting that in some jurisdictions as many as 25 different law enforcement, regulatory, oversight, advocacy and emergency entities have responsibilities over nursing homes. "Historically, there has been too little information sharing and cooperation among these agencies," she added.

Reno stated that the newly created State Working groups are cracking down on poor care in nursing homes. For instance, new federal cases have been opened based on information provided by surveyors, ombudsman and others to federal prosecutors. Additionally, Florida's "Operation Spot Check" initiative has brought unannounced visits at nursing homes. Finally, some states have even reached out to policy, emergency room staff, firefighters, EMTs, medical examiners, investigators, surveyors, ombudsman, to meet with federal and state and local law enforcement officials and nursing home regulators, she said.

According to Reno, the first line of defense against poor care relies with the providers themselves. Law enforcement

only becomes a necessity when other systems have broken down, she said. If unscrupulous nursing home providers are aware of the coordinated efforts of agencies to "identify and pursue the worst actors," then the presence of law enforcement can "have a strong preventative impact."

Reno added that it's a difficult time for nursing homes, telling the audience that already four of the ten largest chains have filed for bankruptcy. She urged the nursing home industry to "root out the wrongdoers for the good of the rest."

Consumers, Provider Groups Agree

"Nursing homes pretty much deny that poor care is a problem of any magnitude," stated participant Sara Burger, who serves as Director for Special Projects at the National Citizens Coalition for Nursing Home Reform. Attorney General Reno put a very different light on that belief, she added, noting that her speech sends a message to the nation that "Poor care is still a widespread problem and not just found in a few nursing homes."

Referring to nursing homes that provide poor care, Senior Vice President Michael Rodgers, of the American Association of Homes and Services for the Aging (AAHSA), stated in a written statement that "The attorney general is right when she points out that these homes give a 'black eye' to the entire field."

AAHSA supports the federal government's efforts to strengthen procedures to prevent fraud, abuse and neglect among the nation's vulnerable nursing home population, Rodgers said. The nonprofit provider group called on the Justice Department to work closely with the Health Care Financing Administration, to effectively target enforcement resources to homes that are chronically out of compliance.

The enforcement system should be based on collaboration, Rodgers added, suggesting that states might develop programs to recognize and reward high quality nursing home care. "We must break the cycle of only investigating, accusing and punishing if we are to achieve the type of nursing home care our seniors deserve," he says. ◆

Herbert P. Weiss is a freelance writer based in Pawtucket, Rhode Island and a member of ACHCA's Rhode Island Chapter.

ROOTING OUT ABUSE AND NEGLECT IN NURSING HOMES

The Department of Justice's Nursing Home Initiative calls for stepped-up enforcement, coordination and training to root out neglect and abuse in the nation's nursing homes. Here are seven key areas:

- Stepped up investigations and prosecutions at the federal, state and local levels.
- Improved coordination and information sharing between the Department of Justice, Department of Health and Human Services, and other federal, state and local partners.
- New legislation to address gaps in current federal civil and criminal laws.
- Renewed efforts to work with industry to boost compliance efforts.
- Dissemination of a soon-to-be-released focus group report containing broad recommendations that can serve as a helpful blue print for additional action.
- New efforts to train regulators, investigators, prosecutors, patient advocates and others in how to identify and respond to fraud, abuse, and neglect.
- Establishment of interagency working groups at the state and local level to bolster enforcement, prevention, training and coordination.

Source: Speech of Attorney General Janet Reno, June 12, 2000, Conference of State Nursing Home Fraud and Abuse Working Groups.

Getting the True Story Behind the Headline

By Herbert P. Weiss

With the nation's population growing older we can expect an epidemic of Alzheimer's disease, says an analysis released last March by the Chicago-based Alzheimer's Association. Using current growth rates, the report's findings suggest that the number of Americans with the disease is expected to grow by 350 percent by mid-century. Gearing up to confront this looming health care crisis, in July President Clinton announced that he has committed an additional $50 million for Alzheimer's research at the National Institutes on Aging, above the funds already appropriated by Congress.

More funding for research to discover a cure or vaccine against the deadly, debilitating disorder will produce a plethora of research findings being funded by new research monies, that will be picked up by both print and electronic media.

Yes, everyday millions of caregivers and nursing home providers scan their daily and weekly newspapers, senior papers, nursing home trade publications, *Time, Newsweek, Modern Maturity* or even the *National Enquirer* in hopes of learning a little more about new effective treatments for Alzheimer's Disease.

Oftentimes it is confusing to determine which treatments are promising and which ones are not, this being caused by the diverse opinion in the research community. For instance, one article might report on the effectiveness of taking Vitamin E; others might state how Ginko really improves your memory and is good for Alzheimer's patients to take. Others might describe studies that indicate that estrogen replacement therapy is not really an effective treatment for Alzheimer's Disease for some women. Or, some might even worn the reader "Don't eat off of aluminum plates" because research seems to indicate that an accumulation of heavy metals, such as aluminum in the brain, may surely cause Alzheimer's.

Here are some tips for unraveling the mysteries of Alzheimer's Disease as reported by newspapers.

- Look for Expertise. Most newspaper reporters may not have the medical or a scientific background to accurately report on an Alzheimer's study or treatment. Lack of familiarity of the issue may become an obstacle in tracking down the appropriate quotes or to thoroughly researching the topic on a tight deadline.
- Beware of Glitzy Headlines. Time limitations keep people from reading every article in their daily, weekly, or monthly newspapers. As a result, many readers just quickly scan the headlines for information. Don't judge an article by its glitzy title. The content of an article is much more balanced than the headline that is catchy and written to draw the reader in.
- Understand Relationships. Sometimes an article reads like a press release, especially when it only quotes the study's researcher. Surprise, it probably came straight out of a University's public affairs department or public relations firm. In some cases, the press release is reported "word for word" without noting the financial interest between the researcher and pharmaceutical company, totally ignoring the potential conflict of interest. The smaller newspapers and some trade publications do not have the time nor the manpower to thoroughly cover the issue.
- Look for Authoritative Commentary. You can consider an article more credible when it provides multiple quotes

Continued on page 29.

GETTING THE TRUE STORY BEHIND THE HEADLINE

Continued from page 4.

on the indications of an Alzheimer's treatment. The reporter has done a good job in reporting if there is an authoritative commentary on the significance of the study. Two likely sources might be staffers from either the National Alzheimer's Association or the National Institutes of Health, a major funder of Alzheimer's research studies. Remember that the National Alzheimer Association's point of view tends to be less biased and a more reliable opinion than those researchers who have ties to a pharmaceutical company that issued the press release.

- Disputes on Findings. Keep in mind that even if a research study is reported there might be those persons who believe that the study is not well-designed or has major research flaws. On the other hand the study might just be accepted by the scientific community as a solid study. However, there might still be serious disagreements about how to interpret the results or how to classify it. Some researchers might consider it a major study while others a minor study. A well-researched article will include the quotes of those who oppose the findings.

Are you still confused by how to cull newspaper and trade publication articles for tips on safe and effective treatments for Alzheimer's? Where do we go from here? Providers and caregivers should view any article written about new Alzheimer's treatments as informational in nature. The article can open the door to the research community and it now becomes your responsibility to do homework and find out more details what the research findings indicate. First, if the article describes the results of an actual published research study, obtain the scientific journal with the published study and carefully read it. If the findings are reported from a presentation at a conference, attempt to track the researcher down for more information. Finally, cruise the internet and check out the official web sites of the Alzheimer's Association or the National Institute of Aging to determine if they can provide information about a reported new treatment.

Finally, don't hesitate to call your local chapter or National Alzheimer's Association to solicit their comments. They will gladly share all the information they have. Remember these groups closely monitor research studies and their implications for treatment. ◆

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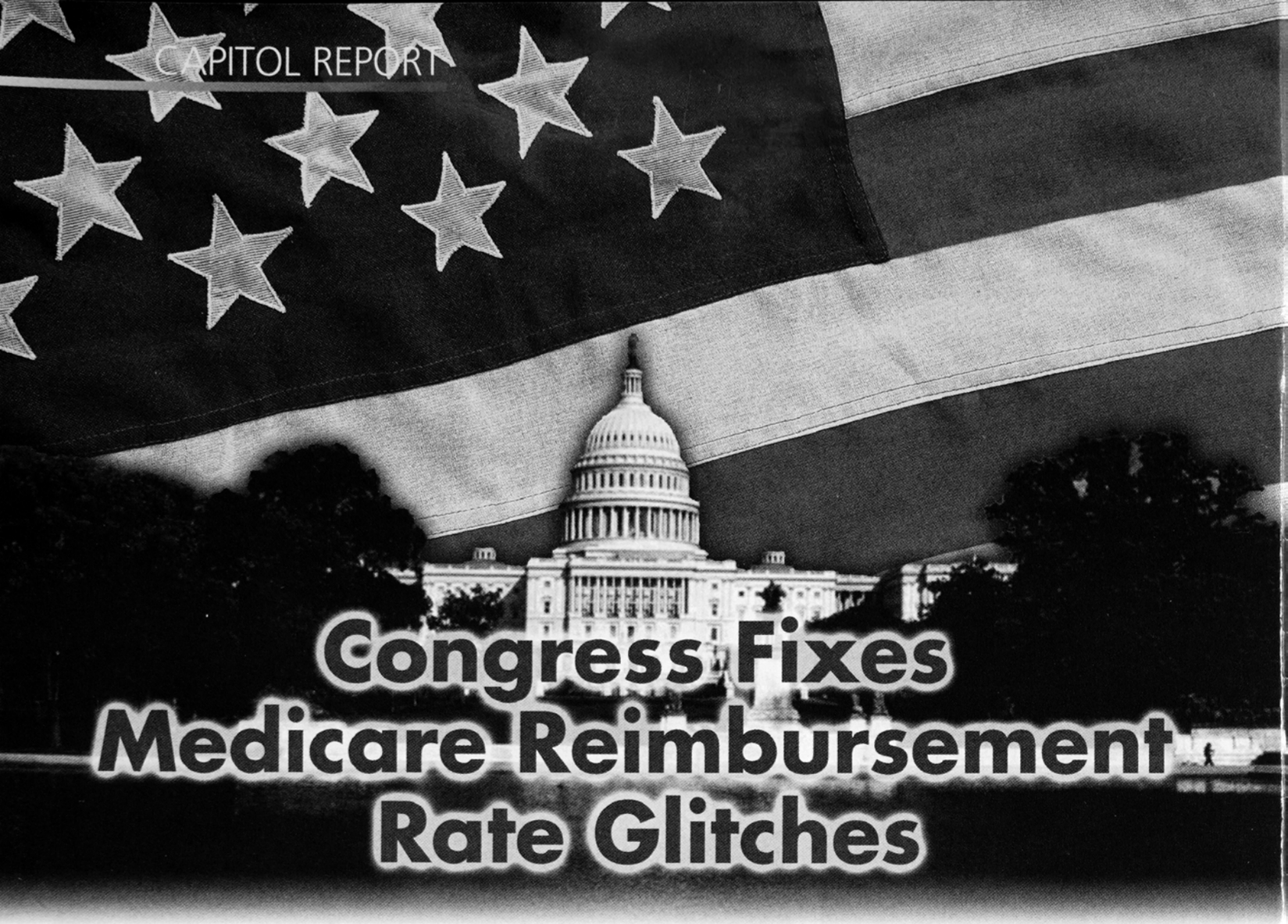

Congress Fixes Medicare Reimbursement Rate Glitches

Nursing facility operators struggling to provide good quality skilled nursing care while not being adequately reimbursed by Medicare will now see some increased funding from passage of the Medicare and Medicaid provider relief package in the omnibus budget bill.

Nursing facility groups pushing for Medicare relief for skilled nursing facilities got an early Christmas present from Congress, at the end of the 106th Congress. On December 15, the omnibus budget bill (H.R. 4577) approved by 292 to 60 in the House and adopted later by a voice vote in the Senate provided $450 billion to fund all federal departments and agencies through next September.

At press time, with the "lame duck" session of Congress ending, the passed omnibus measure still awaits President Clinton's signature to become law. Before the November 7th Presidential election, Congress was able to pass 10 out of the 13 appropriation bills, which were signed by President Clinton into law. However, an impasse and bipartisan bickering over three appropriation bills forced Congress to sit down and negotiate in order to iron out their differences. By the time the huge budget package was passed, hundreds of pet projects from members were attached.

But for health care providers, including skilled nursing facility (SNF) providers, the massive budget bill, printed on hundreds of pages, pumps $35 billion over the next 5 years into the Medicare program, restoring the deep funding cuts that occurred with the passage of the 1997 Balanced Budget Act (BBA). A provision in the omnibus budget bill increased Medicare nursing facility rates by making a full market basket adjustment in 2001 for both nursing facility and home care providers. An increase of 16.6 percent was also made in the nursing component of nursing facility reimbursement for 18 months.

Other long-term care related provisions in the budget bill included an extension of the moratorium on the Part B therapy caps through 2002, along with a repeal of the impending SNF consolidated billing requirement except for Medicare Part A covered stays and Medicare Part B therapy services. Return-to-home protection, long sought by the American As-

sociation of Homes and Services for the Aging (AAHSA), for long-term care residents who are hospitalized was included in the finally passed omnibus budget.

Meanwhile, one of the most controversial provisions in the omnibus bill required skilled nursing facilities that participate in the Medicare or Medicaid programs to post nurse staffing information in their lobbies by 2003.

Additionally, nursing home regulators will see more funding, too, for their regulatory oversight activities. The omnibus budget includes $32 million (about a 68 percent increase) for the Nursing Home Initiative, which ensures more rigorous inspections of nursing facilities and improves federal oversight of nursing home quality.

The massive budget bill also creates the Family Caregivers Program by providing $125 million for states to provide respite and other support services to families who care for elderly relatives with long-term care needs. It even invests $20.3 billion in cutting-edge biomedical research at the National Institutes of Health, a 14 percent increase since the last year and nearly double the $10.3 billion spent in 1993.

PROVIDERS APPLAUD BBA RELIEF

Nursing facility operators struggling to provide good quality skilled nursing care while not being adequately reimbursed by Medicare will now see some increased funding from passage of the Medicare and Medicaid provider relief package in the omnibus budget bill.

"The unexpectedly large reductions in Medicare funding caused by the 1997 BBA clearly hurt patients and the providers who serve them," stated Charles H. Roadman, M.D., President and CEO of the American Health Care Association. "The restorations made in the final legislative agreement were not just necessary, but absolutely essential to maintaining the economic viability of American's skilled nursing care provider base."

According to Dr. Roadman, in his December 20th President's Memorandum to AHCA membership, the infusion of Medicare monies "will provide benefits to virtually all facilities." He added that an in-house analysis indicates "that the revisions to the Balance Budget Amendment will, in combination with the revisions enacted in earlier legislation, provide nursing facilities an additional, on average, $44.43 per Medicare patient day in 2001. These additional dollars represent an estimated $2.1 billion influx of much-needed new monies during 2001 for patient care."

"Even with a very partisan-charged environment, a lot was accomplished in this omnibus budget bill," agreed Robert Greenwood, AAHSA's Associate Director of Public Affairs. "We were glad to see Congress roll up their sleeves and get the work done rather see it left to a future Congress."

However, there are still many policy issues remaining in how the federal government pays for nursing facility care, he said. "Many of the proposed Medicare cuts are still on the table, only delayed by this legislation. We will be hard working to get them repealed," he stated.

"Congress must devise a way to make state-set Medicaid rates fair," Greenwood added, referring that the legislation language must include "Boren-Plus" language. He referred to the repealed Boren Amendment that allowed providers to challenge state-set Medicaid rates in federal court.

One of the most significant provisions in the omnibus budget bill, according to Greenwood, is the repeal of the Part B Consolidated Billing requirement. "This requirement would have been an administrative nightmare for administrators," he warned.

Greenwood also called the required posting of a list detailing the number of nursing staff per shift in a facility lobby "unnecessary," adding, that "This does not provide any

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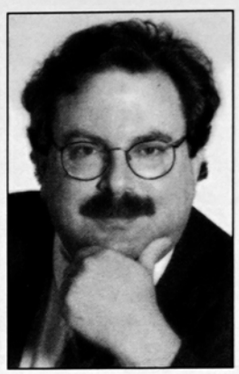
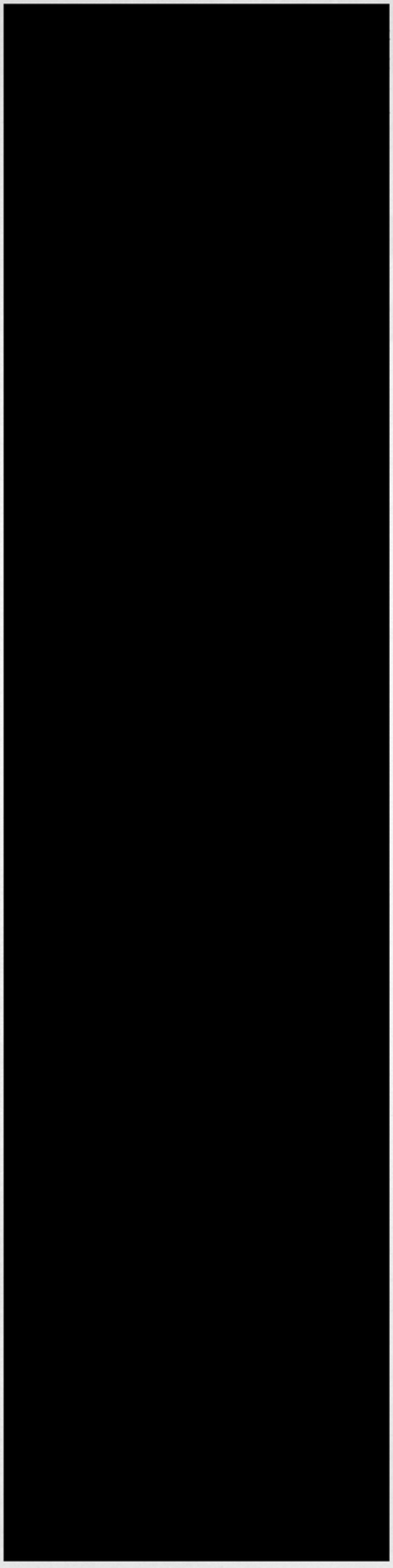
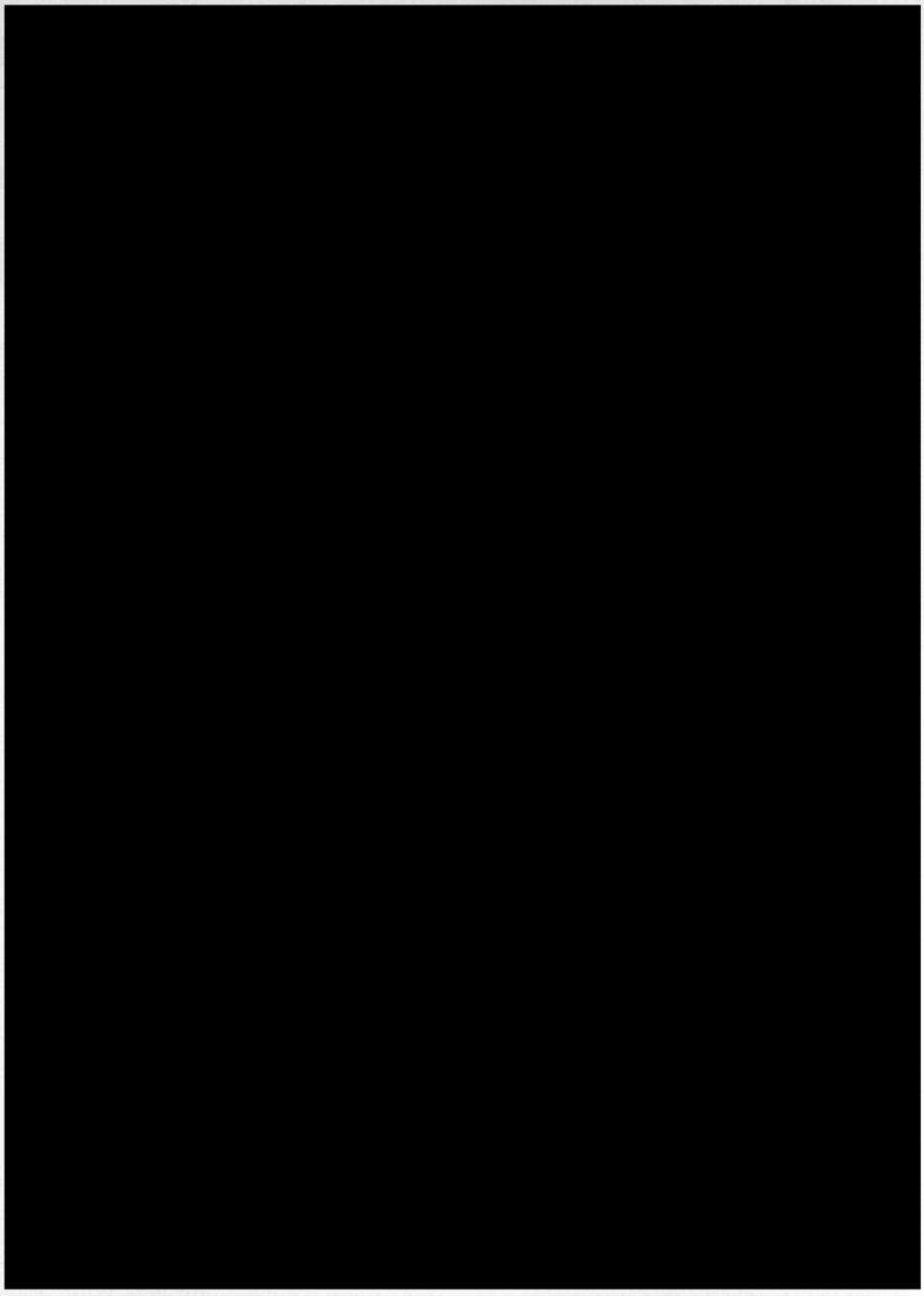


By Herbert P. Weiss

NURSING HOME REGULATORS WILL SEE MORE FUNDING, TOO, FOR THEIR REGULATORY OVERSIGHT ACTIVITIES. THE OMNIBUS BUDGET INCLUDES $32 MILLION (ABOUT A 68 PERCENT INCREASE) FOR THE NURSING HOME INITIATIVE, WHICH ENSURES MORE RIGOROUS INSPECTIONS OF NURSING FACILITIES AND IMPROVES FEDERAL OVERSIGHT OF NURSING HOME QUALITY.





CONGRESS FIXES MEDICARE REIMBURSEMENT RATE GLITCHES

Continued from page 5.

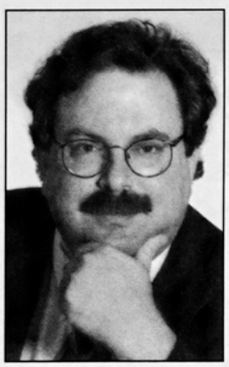
meaningful information to residents or families. Staffing numbers have to be viewed in the context of case-mix and management practices."

"We were disappointed that the budget bill did not include a provision that allowed nursing facilities to train non-nursing home staff to help residents eat," added Greenwood. "This legislation will be a top priority for us in the next Congress."

"Even with the work that remains to be done with passage of this omnibus budget bill, this turned out to be a very productive Congress for nursing facility providers," said Greenwood. ◆

Herbert P. Weiss is a Rhode Island freelance writer covering aging and health care issues.

Bipartisan Support Key To Congressional Success, Experts Say



By Herbert P. Weiss

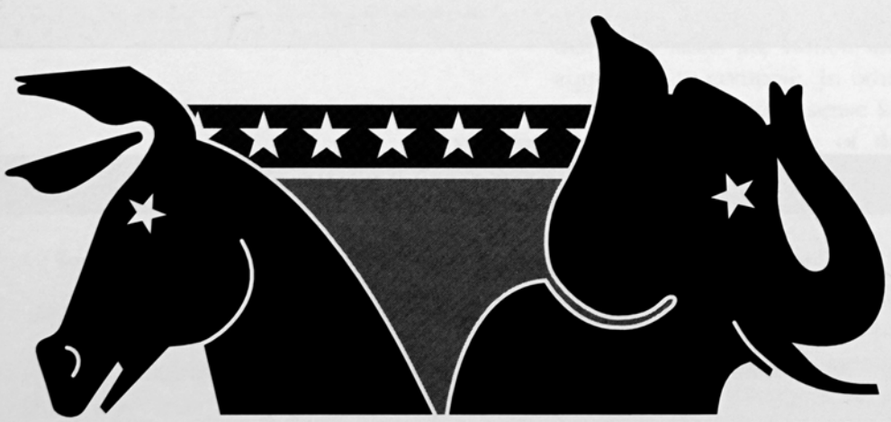
The operative word in national legislative circles these days is bipartisanship. Both sides of the politcal aisle working together will have to be part of the picture if the long-term care field is going to see any significant legislative changes, policy sources indicate.

Why is that so? In the Senate, "there's a 50-50 split between the two major political parties," notes Bill Benson, President of Benson Consulting Group, a Maryland-based organization.

What's more, the division "has resulted in an unprecedented agreement between Senate Democrats and Republicans to share power," according to Benson, formerly a top official with the U.S. Administration On Aging.

"A long-term care agenda has not emerged yet."

At press time, Democrats and Republicans alike were following the failing health of ninety-eight-year-old Senator Strom Thurmond. If the South Carolina Republican retires or dies before the end of his term in 2002, it's likely that his state's Democratic governor would appoint a Democrat, a move that would shift the majority in the Senate to the Democratic Party.



Yet, Benson tells *Balance* that any legislative proposal would still need bipartisan support for Senate passage. "To get a Republican proposal enacted, you will either have to get lots of Democrats to cross party lines, or bring in Vice President Cheney to act as a tie breaker," he noted. Meanwhile, in the House, the Republican majority holds but a razor thin margin. "Like in the Senate, if both parties don't work together in the House, you're looking at legislative gridlock."

Benson notes that the Bush Administration is also moving to stall the lengthy regulatory and administrative actions taken by President Clinton at the end of his administration. One such item that is temporarily halted is Clinton's guidelines for managed care organizations that serve Medicare beneficiaries.

President Bush campaigned on Medicare reform and wants to bring his proposal to Congress. His measure provides a private sector alternative to traditional fee-for-service Medicare by offering block grants to states to help seniors pay for prescription drugs. This approach may be derailed by the Democratic Party, which added to its Congressional seats during the recent election, Benson explains. He notes that Republican Charles Grassley of Iowa, Chairman of the Senate Finance Committee, has declared that he will not push Bush's Medicare or prescription drug plans because they lack votes for passage.

Yet, Benson also predicts that the fact that Congress is closely divided

WHAT AAHSA WILL LOBBY CONGRESS FOR IN 2001

Some of the issues that the American Association for Homes and Services for the Aging will lobby Congress for this year:

STAFFING.
AAHSA calls on Congress to permit nursing facilities to use specially trained, non-certified workers to assist residents with specific tasks such as eating.

PAYMENT ISSUES.
AAHSA believes there is still a need for a Medicare outlier provision that would apply to a small number of patients with costly care needs that cannot be adequately covered by the prospective payment system.

SURVEY & CERTIFICATION.
AAHSA will push for a survey and certification system that is less punitive, more focused on patient outcomes, and provides recognition and incentives for the highest quality care.

SENIOR SERVICES.
AAHSA will lobby for maximum funding for the Older Americans Act and Title XX programs that serve seniors. ◆

"We're hopeful the Bush Administration will take seriously its responsibility to provide long-term care providers with the resources they need to provide quality care."

increases the chance that something will be done about providing prescription drug coverage to seniors through Medicare. Otherwise, Benson adds, Medicare reform will amount to nothing more than talk this year.

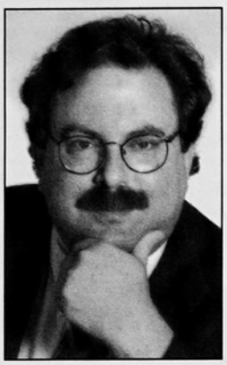
Meanwhile, Robert Greenwood, American Association for Homes and Services for the Aging's (AAHSA) Associate Director of Public Affairs, says that bold, revolutionary proposals won't be forthcoming from the nation's evenly split Congress. Instead, lawmakers will take an incremental approach toward program development.

"A long-term care agenda has not emerged yet," Greenwood observes. "We don't even have an administrator for the Health Care Financing Administration."

Greenwood says in the long run, "We're hopeful the Bush Administration will take seriously its responsibility to provide long-term care providers with the resources they need to provide quality care, and fund a regulatory system that allows providers to do their job while still protecting vulnerable residents." ◆

Herbert P. Weiss is a Rhode Island-based freelance writer who covers aging and health care issues.

President Bush Taps Washington Insider For HCFA Top Job



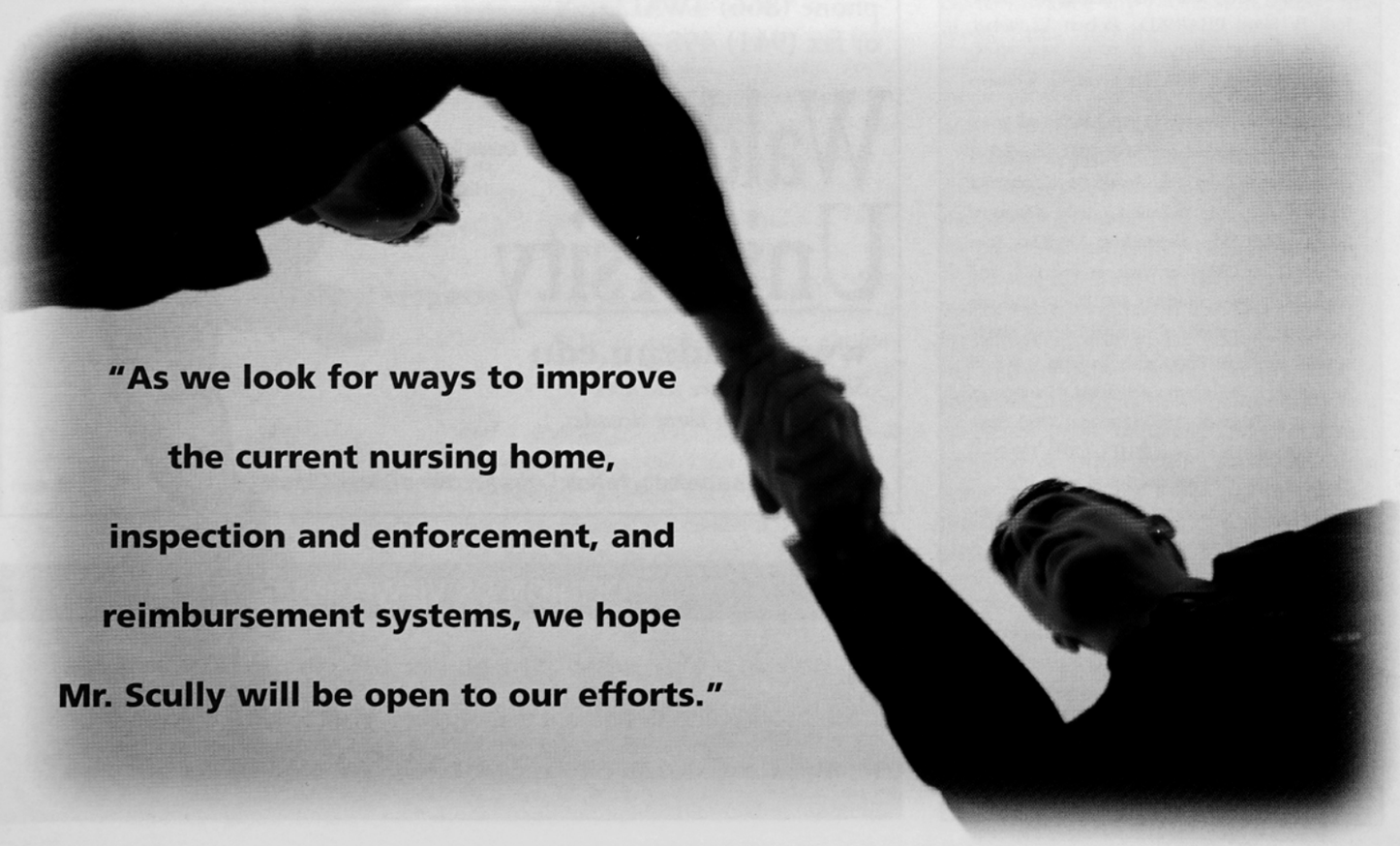
By Herbert P. Weiss

Editor's note: Shortly before press time, HCFA announced that for the first time ever, it plans to issue detailed ratings of the quality of care in nursing homes, among other health care providers. Balance will cover this development in later issues.

Washington insider Thomas A. Scully has been named by the new Bush White House to run the Health Care Financing Administration (HCFA). The federal agency provides health care to 74 million Americans via Medicare, Medicaid, and the State Children's Health Insurance Program.

Scully was President and CEO of the Federation of American Hospitals, a trade group that represents 1,700 for profit hospitals. Besides a potpourri of health policy experiences, the association executive has legal expertise gleaned from a legal practice which focused on regulatory and legislative work in health care. Scully's background also includes considerable government experience. He served as a staff assistant to U.S. Senator Slade Gorton (R-WA); as Associate Director of the White House Office of Management and Budget; and, as Deputy Assistant to the President and Counselor to the Director of the Office and Management and Budget under the administration of George Bush, Sr.

"Scully is smart, quotable, and politically savvy," Edward Howard, Executive Vice President of the Alliance for Health Care Reform tells *Balance*. "He's de-



"As we look for ways to improve the current nursing home, inspection and enforcement, and reimbursement systems, we hope Mr. Scully will be open to our efforts."

scribed as a problem-solver rather than an ideologue."

Howard expects Scully to turn his attention to fixing internal problems at HCFA because the agency has "substantial management problems." He notes that HCFA has lost a number of good people and Congress will most certainly give the agency new tasks.

At least Scully will not have to spend time learning "about the programs he supervises, because he knows them well" from his Washington experience, Howard adds.

William F., Benson, former Deputy Assistant Secretary for Aging at the U.S. Department of Health and Human Services, and President of the Maryland-based Benson Consulting Group, warns "don't look for Scully to be much of a consumer advocate." He indicates that Scully will be sympathetic to providers because of his ties to the hospital provider community.

"That does not mean Scully's going to be in any position to get hospitals any more money. But he will be more attuned to less regulation and more flexibility in rules and regulations for health care providers."

According to Benson, one of Scully's first tasks will be to carry out Health and Human Services Secretary Tommy Thompson's wish to reorganize HCFA.

Meanwhile, providers give the Scully appointment a thumbs up.

"Tom Scully has a unique combination of real-world perspective and public service experience," according to Rick Pollack, Executive Vice President of the American Hospital Association. "That makes him a great choice."

"From crafting Medicare regulation and budgets, to building strong relationships with lawmakers on both sides of the aisle, Tom has the right mix of knowledge for the job."

In a letter that was distributed this spring to U.S. Senators prior to the Scully confirmation vote, Dr. Charles H. Roadman II, M.D., President and CEO of the American Health Care Association and AHCA Legislative Counsel Bruce Yarwood wrote that "as HCFA administrator, Tom Scully will have the responsibility for leading dramatic change.

"The opportunity for HCFA reform is the brightest it's been in years," Roadman predicted in a public statement, expressing confidence that the controversial survey and enforcement apparatus that monitors quality of care in the nation's nursing facilities will be closely scrutinized by Scully and the Bush White House.

Meantime, Suzanne M. Weiss (no relation to this writer), Senior Vice President of the American Association of Homes and Services for the Aging, said in a public statement that her non-profit provider group looks forward to working with the new HCFA administrator.

"As we look for ways to improve the current nursing home, inspection and enforcement, and reimbursement systems, we hope Mr. Scully will be open to our efforts." ◆

Herbert P. Weiss is a Pawtucket Rhode Island-based writer who covers aging and health care.

One of Scully's first tasks will be to reorganize HCFA.