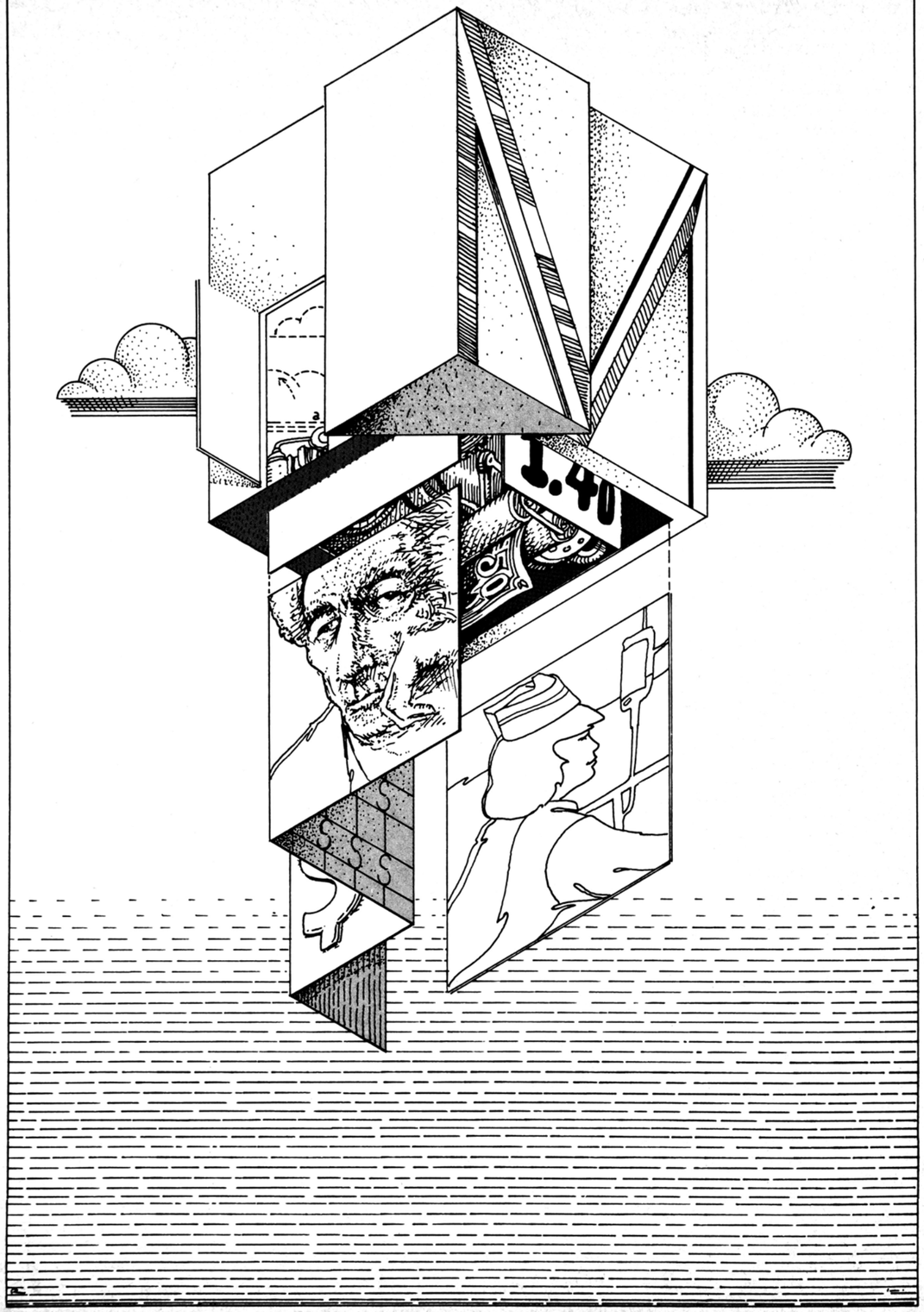

RICHARD LAURENT

DISSECTING MARYLAND'S MEDICAID SYSTEM

BY ROGER C. LIPITZ and HERBERT P. WEISS

This detailed breakdown explains why this system works, and how it works to keep all concerned happy.

Editor's Note: *This is the second installment in a two-part article on Maryland's innovative and highly successful new Medicaid reimbursement system. The first article appeared in the November 1984 issue on page 32, and explained how the powers-that-be came together to create the system. In this article, the authors explain in great detail the mechanics of Maryland's program, in order to give the reader a better understanding of why and how this system ranks so highly among modern long-term care experts. Roger C. Liptz is a principle in Meridian Healthcare, a growing long-term care corporation based in Towson, Maryland. He is a past president of the American Health Care Association, the Health Facilities Association of Maryland, and the National Council of Health Centers (now merged with AHCA). Herbert P. Weiss, MA, NHA, is director for education and research for the Health Facilities Association of Maryland. He is a licensed nursing home administrator in Washington, D.C., and a member of this magazine's Editorial Advisory Board. The authors wish to thank Linda Thicken and Debbie Van Baalen for their contributions toward the completion of this article.*

In the summer of 1980, the Maryland Department of Health and Mental Hygiene (DHMH) issued a request for proposals to select an economic consultant to develop a new Medicaid Reimbursement System. By design, this system would have to be sensitive to the distinct needs of the consumer, the provider and the state.

The reimbursement system in effect at that time was a retrospective payment system with a prospectively determined maximum payment. Costs under this system were reimbursed using Medicare principals of reimbursement. An efficiency payment of up to $1.40 was paid to providers if their costs and the efficiency payment did not exceed the maximum payment. There was no payment for return on equity. The maximum payment was set at the 75th percentile of facilities' costs, which were weighed by Medicaid patient days. The Maryland consumer price index was used to index facilities' costs forward to the midpoint of the rate year in which the maximum payment was being set.

The deficiencies of such a system were fairly obvious to the nursing home industry. Providers were encouraged to keep costs low to ensure the earning of the efficiency payment of $1.40. Providers would attempt to accomplish this by taking easy-to-care-for patients. If costs were below the ceiling, there was no incentive on the part of the nursing home to admit Medicaid patients because the nature of cost reimbursement reduced everyone's payments as costs decreased. To overcome these deficiencies as well as others, the state established specific objectives in its "Request for Proposal." These objectives stated that the system must:

- be cost-related;
- meet both federal and state requirements;
- be administratively effective;
- recognize the fair value of assets used in the Provisions of Health Care;
- recognize factors which cause cost differentials;
- increase access for Medical Assistance Patients, particularly those who need intensive nursing care;
- include incentives to contain health care costs; and
- provide a mechanism to influence the bed supply.

The consulting firm of Applied Management Sciences Inc. (AMS) of Silver Spring, Maryland, was awarded the contract to design a reimbursement methodology consistent with these objectives.

On January 1, 1983, the new and innovative Maryland Medicaid Reimbursement System became a reality and was implemented by DHMH.

The Make-Up

The new system combines the components of both a prospective and retrospective reimbursement methodology. There are four cost centers:

- Routine and Administrative Cost Center
- Other Patient Care Cost Center
- Nursing Cost Center
- Capital Cost Center

During the developmental stages, the consultant recommended an additional cost center and an additional nursing classification. The Health Facilities Association of Maryland (HFAM) negotiated successfully for consolidation to keep the system from being too complex.

The reimbursement methodology is sensitive to regional variations of cost, levels of patient care and incentive payments for efficiency. Cost containment measures are built into the system both in the form of ceilings and fixed payments. For each cost center except the Capital Cost Center,

the reimbursement methodology divides Maryland into three distinct geographic regions — the Baltimore area, the Washington area and the Non-Metropolitan area. In addition, the Administrative and Routine Cost Center established a separate center for small facilities (less than 70 beds).

The reimbursement for the Nursing Cost Center is a fixed rate for each region of the state based on different reimbursement levels for each of four patient classifications (light care, moderate care, heavy care and heavy special) plus payment for a number of special services. Efficiency payments, up to a maximum, are paid in the Administrative and Routine and Other Patient Care centers based on a sharing of the savings. Minimum and fixed occupancies play a significant role in the system. Exhibit A provides a general overview of the methodology.

The success of this complicated reimbursement methodology relies on the interdependence of the distinct features of the entire methodology. The whole is truly greater than any of its individual parts.

The Cost Centers

Administrative and Routine Cost Center — Reimbursement under the Administrative and Routine Cost Center is calculated on the basis of actual costs reported by the provider on their annual Medicaid cost report. Costs included in this cost center:

- Administrative expenses
- Medical records expenses
- Training expenses
- Dietary
- Laundry
- Housekeeping
- Operation and maintenance
- Capitalized organization and start-up costs

Exhibit B provides a more detailed list of costs allocated under the Administrative and Routine Cost Center.

The actual ceiling for this cost center is determined by calculating the median cost of all providers in the three separate geographic regions. Also, in this cost center, the median cost of all facilities containing 70 beds or less is calculated to determine the ceiling for small facilities on a statewide basis. This adjustment for small facilities is the result of the state's recognition, after reviewing HFAM analyses, that these facilities encounter higher costs due to their small size and the fixed nature of some costs in this cost center. This special category for small facilities is only found in this cost center.

After facilities are grouped together in geographic and size categories, their costs are weighed by Medicaid patient days with the ceiling set at 108 percent of the median cost after being carried forward to the reimbursement year by use of a market-based indexing system.

The methodology used in establishing this ceiling as well as the other patient care ceilings is unique in that it allows all providers to be below the ceiling with an opportunity to earn the efficiency payment. By use of a median cost, providers can reduce their costs below the ceiling without affecting the median. In a percentile system of establishing payment, such is not the case. As high-cost providers reduce their costs, the ceiling generally will fall.

The new Medicaid reimbursement methodology encourages the provider to be more efficient, promoting the state's goal of cost containment. An efficiency payment, equal to 40 percent of the difference between the established ceiling and the facility's actual per diem cost, is paid to facilities with costs below the ceiling. Efficiency payments are limited to a maximum of 10 percent of the ceiling of the cost center.

A maximum efficiency payment has been incorporated into the methodology to reduce the incentive to providers to be overly efficient at the expense of patient care. Finally, payment under this cost center is made at a minimum occupancy rate of 95 percent, encouraging providers to admit all Medicaid patients.

An example of how the reimbursement level is calculated for the Routine and Administrative Cost Center:

State Ceiling $15.00
Maximum Efficiency Payment (10 percent of ceiling) $ 1.50
Provider's Actual Cost $13.00
Efficiency Payment Calculation - $15.00 – $13.00 × 40 percent = $.80 (amount not in excess of maximum of $1.50)
Total Payment Allowed to Provider for Administrative and Routine Costs - $13.00 + $.80 = $13.80 (amount not in excess of ceiling of $15.00)

Other Patient Care Cost Center — The reimbursement level for the Other Patient Cost Care Center is calculated in the same way as those for the Administrative and Routine Cost Center. The cost ceiling, however, is set at 120 percent of the median rather than 108 percent. This higher percentage is a result of the state's desire to assure payment of these costs since they are more directly related to patient care than those found in the Administrative and Routine Cost Center. Costs that are included in this cost center:

- Medical Director administrative expense
- Physical therapy expense
- Pharmacy expense
- Oxygen
- Recreational activities expense
- Patient care consultant service
- Occupational therapy
- Food cost - raw food
- Social services
- Religious

An example of the reimbursement level calculation for the Other Patient Care Cost Center:

State Ceiling $6.00
Maximum Efficiency Payment .60
Provider's Actual Cost 4.25
Efficiency Payment - $6.00 – $4.25 × 40 percent = $.70 (in excess of maximum payment of $.60)
Total Payment Allowed to Provider for Other Patient Care Cost Center - $4.25 + $.60 = $4.85 (below maximum payment of $6.00)

Nursing Care Cost Center — The methodology for establishing the reimbursement level in the Nursing Cost Center is different and more complex than that of the other cost centers. This patient-specific methodology attempts to reimburse the actual cost of patient care, while taking into account different patient conditions and the current staff wage rate in each of the three geographic regions.

Three criteria are used by the state to determine the reimbursement level in the Nursing Care Cost Center:

- Patient Classification
- Work Measurement Study on Nursing Procedures and Staffing Patterns
- Salary Survey

In addition, estimates of any additional services and the associated cost is determined and incorporated in the reimbursement level.

In order to understand the dynamics of the Nursing Care Cost Center, one must review the background calculations that the state performs.

Patient Classification, which depends upon the patient's level of care, is determined by the number of activities of daily living with which each patient requires assistance. The activities of daily living and their definitions, as shown in Exhibit C, are bathing, dressing, mobility, continence toileting and eating. The four categories of patient classification and additional services that may be required are detailed in Exhibit D.

Finally, special reimbursement will be made for patients requiring the following services, according to the type and number (frequency) required:

- Single injections daily
- Multiple injections daily
- Oxygen/aerosol therapy
- I.V. care
- Restraints or protective devices
- Ostomy care
- Suctioning or tracheostomy care

Facility staff assign patients to the patient classifications through the utilization of a patient assessment form, which is then verified by the

EXHIBIT A

Summary of Methodology Utilized to Determine Reimbursement Level in Cost Centers

Cost Center	Reimbursement Methodology	Minimum Occupancy	Ceiling	Efficiency Payments	Efficiency Ceiling	Data Source
Routine & Administrative Costs	Cost Plus Efficiency Payments	95%	108% of the median[1]	40% of the difference between costs & the ceiling[1]	10% of Ceiling	Cost Reports
Nursing Care Costs	Flat Rate for each of four patient classifications plus 6 additional services	None	None	2%, 3% and 4% for Moderate, Heavy and Heavy Special Care Patients Respectively	None	Patient Assessment Wage Survey Time for Service
Other Patient Care Costs	Cost Plus Efficiency Payments	95%	120% of the median	40% of the difference between costs & the ceiling[1]	10% of Ceiling	Cost Reports
Property-Capital Capital Costs	Full cost for property tax, interest and insurance. 4.8% after tax rental on owner's equity[1]	95% Fixed Occupancy	About 95th Percentile	None	N/A	Cost Reports Facility Appraisal

Source: Health Care Analysis Group — MTSC Inc. Seminar Handout, "Seminar II: Operating Under the New System," November, 1982 . . . Developed for the Health Facilities Association of Maryland.

[1]These percentages were originally higher, but due to Medicaid budget problems, principally in the areas other than nursing home reimbursement, they have been reduced to these levels for a three-year period.

EXHIBIT B

Routine & Administrative Cost Center

General and Administrative Services:

Administrative Expenses
- Salaries - Administrators
- Salaries and Wages - Office Staff
- Supplies
- Management Services
- Central Office Overhead
- Insurance - Non-Property
- Business Taxes and Licenses
- Auto Expenses
- Legal and Accounting
- Dues and Subscriptions
- Travel
- Communications (Telephone, Postage)
- Corporate Administrative Expense
- Data Processing
- Advertising
- Other

Medical Records Expenses
- Salaries and Wages
- Supplies
- Contracted Services
- Other

Interest Expenses
- Working Capital/Other
- Auto Loans

Employee Benefits
- Employees in above categories

Routine Service:

Dietary Expenses
- Salaries and Wages
- Supplies
- Contracted Services
- Other

Laundry Expenses
- Salaries and Wages
- Supplies
- Contracted Services
- Linen Replacement
- Other

Housekeeping Expenses
- Salaries and Wages
- Supplies
- Contracted Services
- Other

Operation and Maintenance Plant
- Salaries and Wages
- Supplies
- Repairs and Maintenance
- Contracted Services
- Utilities
- Minor Equipment Expense
- Other

Source: Health Care Analysis Group - MTSC Inc. Seminar Handout, "Seminar II: Operating Under the New System," November, 1982 . . . Developed for the Health Facilities Association of Maryland.

EXHIBIT C

Activities of Daily Living

Activities of Daily Living:	Definition of Dependent:
Bathing	Needs assistance Needs water brought Helped in/out of tub at least once per week
Dressing	Receives assistance (except tying shoes) Requires supervision Requires instruction Bedfast patients
Mobility	Needs assistance getting in or out of bed or chair Unable to ambulate without assistance Bed/chair confined
Continence Toileting	Accidents 3 or more times per week Accidents at night only Needs daily continence care Continence retained through regular toileting (must be documented) Indwelling catheter, Texas catheter
Eating	Receives assistance/supervision in order to achieve adequate nutrition or guard against life-threatening incidents *Not included:* Assistance in cutting, opening containers, cleaning up after accidents

Source: Health Care Analysis Group - MTSC Inc. Seminar Handout, "Seminar II: Operating Under the New System," November, 1982 . . . Developed for the Health Facilities Association of Maryland.

EXHIBIT D

Definitions of Patient Classification Categories and Additional Services Required

1. **Light Care** (0-2 ADL dependencies)
   - Resident can provide most or all of the basic ADL needs for him or herself.
   - Typically, resident will be totally independent in 5 ADLs *or* will need help or supervision* in 1 to 2 activities, most commonly *bathing* and *dressing*. Resident can ambulate self, has control over bowel and bladder functions (or is ostomy/catheter self-care), and can feed self.
2. **Moderate Care** (3-4 ADL dependencies)
   - Residents need help or supervision in 3-4 ADLs.
   - Typically, resident needs help or supervision in *bathing, dressing, transferring*, is occasionally *incontinent* **but** is ambulatory (can walk or wheel without help), can feed self, has control over bowel and bladder function or ostomy self-care.
3. **Heavy Care** (5 ADL dependencies)
   - Resident needs help in all 5 ADL functions.
   - Resident needs help or supervision in *bathing, dressing, transferring, continence* (occasionally or always), and *feeding*.
4. **Heavy Special Care Patients**
   - A group of patient care types has been identified which, by virtue of their needs, present an additional care burden to the admitting facility. These residents may have one or more of the following predisposing conditions:
     a. nasogastric-tube feeding that requires round-the-clock feedings,
     b. Stage III/IV necrotic ulcers with patient at risk of further breakdown and deterioration, and/or
     c. totally bed/chair confined and unable to reposition self so that resident requires round-the-clock turning and positioning and *probably* total assistance in all 5 ADL functions.

The six types of "additional services" for which reimbursements are to be generated (and which could apply to residents of all four patient classifications) include:

*Help or supervision can mean activity is done totally by the staff with no patient input, or staff assists patient by doing some part of the activity.

1. **Ostomy Care**
   - Fifteen days of care or less (self-care patient and/or temporary condition); pay for 15 days of care, and
   - more than 15 days of care (permanent condition); pay for 30 days of care.
2. **Aerosol/Oxygen Therapy**
   - Less than 15 days oxygen therapy, pay for 45 treatments per month, and
   - fifteen days or more of oxygen therapy or any level of aerosol treatments, pay for 90 treatments per month.
3. **Suctioning Care**
   - Self-suctioning (patient is being instructed in self-care, or needs only minimum assistance, or is receiving maintenance of airway passage by licensed nurse); pay for 15 days per months, and
   - continuous suctioning care; pay for 30 days per month.
4. **IV/Subcutaneous Fluid Care**
   - One to 48 hours continuous IV care; pay for average hours of care in this category,
   - forty-eight to 96 hours of continuous IV care; pay for average hours of care in this category, and
   - more than 96 hours of continuous IV care; pay for average hours of care in this category.
5. **Behavioral/Mental Preventive Measures**
   - Requires ongoing and continuous* preventive restraints so that patient needs to be restrained/unrestrained every 2 hours; pay for minutes of care required on average.
6. **Injections**
   - One injection or less per day, and
   - Two or more injections per day.

*Intermittent care of this type is included in the base ADL reimbursement levels.

Source: Health Care Analysis Group - MTSC Inc. Seminar Handout, "Seminar II: Operating Under the New System," November, 1982 . . . Developed for the Health Facilities Association of Maryland.

state through a contract with a Professional Review Organization.

The state has incorporated an incentive payment into the reimbursement methodology to encourage admission of patients requiring high levels of care. The reimbursement levels are increased for Heavy Special Care, Heavy Care and Light/Moderate Care by four percent, three percent and two percent, respectively, over the calculated daily rate. Finally, the state promotes high-quality care by paying at the higher level for two months after a patient's condition has improved, as measured by a change in the patient's classification.

The classification of patients to the four levels of care is the cornerstone of the new Medicaid Reimbursement System. Reimbursement levels influence the facility to admit sicker patients and promotes restorative nursing. It is important to realize that the correct amount of reimbursement paid to the facility is clearly intertwined with the detail and accuracy of the patient's chart. The documentation from the patient's chart will determine the patient category and ultimately the reimbursement level.

In order to assure an orderly transition to the new system, the state, at the suggestion of HFAM, adopted a "Hold Harmless" provision for the first six months of the new system. Facilities were paid actual cost or the nursing rate, whichever was greater. This gave the industry time to adjust patient mix if necessary without disruption to the patients currently in the facilities.

EXHIBIT E

Summary of Results of Work Measurement Study

Activity/Procedure	Average Time for Activity Only (Minutes)	Average Time Per Day Including Preparation Clean-up, Etc. (Minutes)	Average Time Per Day Including Nursing Overhead (Minutes)	Staff Required Type	% of Time
1. Medications	0.85	9.68	14.70	RN:	41
				LPN:	44
				CMA:	15
2. Personal Hygiene	N/A	8.16	11.59	NA:	100
3. Dressing	4.01	11.28	16.03	NA:	100
4. Mobility Assistance	N/A	18.65	26.75	RN:	7
				LPN:	7
				NA:	86
5. Feeding Assistance					
Pass Meals/Preparation	2.71	6.17	8.89	RN:	10
				LPN:	7
				NA:	79
Feeding	12.05	22.61	33.12	RN:	21
				LPN:	11
				NA:	79
6. Tube Feeding	3.51	38.14	57.96	RN:	48
				LPN:	52
7. Incontinent Care					
Occasional	N/A	3.44	4.89	NA:	100
Daily	N/A	22.07	31.36	NA:	100
8. Turn and Position	1.38	18.46	26.23	NA:	100
9. Necrotic Ulcer Care	6.98	34.12	51.85	RN:	48
10. Stage I/II Ulcer Care	3.71	13.43	20.41	RN:	48
				LPN:	42
11. Lacerations/Skin Care	3.08	10.13	15.40	RN:	48
				LPN:	52
12. Vital Signs	2.00	0.10	0.14	NA:	100
13. Suction/Trach.*	2.43	9.75	14.82	RN:	48
				LPN:	52
14. O_2/Aerosol Therapy*	1.20	4.11	6.25	RN:	48
				LPN:	52
15. IV/Subcutaneous**	1.60	—	20.00	RN:	100
16. Injections	1.03	3.16	4.80	RN:	48
				LPN:	52
17. Sitz Bath/Douche/Enema*	3.94	5.75	8.17	NA:	100
18. Behavioral/Mental	2.09	14.90	21.60	RN:	14
				LPN:	15
				NA:	71
19. Ostomy Care	3.00	4.63	7.04	RN:	48
				LPN:	52

*Ohio estimates used due to lack of data for Maryland.
**West Virginia estimates used due to lack of data for Maryland.
Source: Health Care Analysis Group - MTSC Inc. Seminar Handout, "Seminar II: Operating Under the New System," November, 1982 . . . Developed for the Health Facilities Association of Maryland.

EXHIBIT F

ADL Classification and Procedure Types	Daily Hours Required	Personnel Categories	Weights
Light Care	1.4398	Director of Nursing	0.0486
		Registered Nurse	0.1236
		Licensed Practical Nurse	0.1344
		Nurse Aide	0.6610
		Certified Medication Aide	0.0324
Moderate Care	1.9273	Director of Nursing	0.0363
		Registered Nurse	0.1077
		Licensed Practical Nurse	0.1171
		Nurse Aide	0.7147
		Certified Medication Aide	0.0242
Heavy Care	2.8545	Director of Nursing	0.0245
		Registered Nurse	0.1136
		Licensed Practical Nurse	0.1235
		Nurse Aide	0.7220
		Certified Medication Aide	0.0164
Heavy Special Care	2.8545	Director of Nursing	0.0245
		Registered Nurse	0.1136
		Licensed Practical Nurse	0.1235
		Nurse Aide	0.7220
		Certified Medication Aide	0.0164
Decubitus Ulcer Care	0.8642	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Tube Feeding	0.9660	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Turning and Positioning	0.4372	Nurse Aide	1.0000
Ostomy Care	0.1173	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Oxygen/Aerosol Therapy	0.1042	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Suction/Tracheostomy	0.2470	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
IV/Subcutaneous	0.3330	Registered Nurse	1.0000
Physical Restraints	0.3600	Registered Nurse	0.1359
		Licensed Practical Nurse	0.1479
		Nurse Aide	0.7162
Injections - single	0.0800	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Injections - multiple	0.1600	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210

Source: Health Care Analysis Group - MTSC Inc. Seminar Handout, "Seminar II: Operating Under the New System," November, 1982 . . . Developed for the Health Facilities Association of Maryland.

Determining the Nursing Rate

A work measurement study was conducted in 23 randomly selected facilities in Maryland. The purpose was to calculate the average time required to perform nursing tasks in relation to the five ADLs, the preparation and clean-up time, and finally, nursing overhead (education, indirect patient care, administration and personal activities). Exhibit E is a summary of the results of the work measurement study.

The minutes calculated for preparation and clean-up time and nursing overhead form the base number of minutes that are used in calculating all patients' reimbursement. The number of minutes to provide nursing care for one to two ADLs, three to four ADLs, and five ADLs, when added to the base number, will determine the total number of minutes that will be incorporated into the formula to calculate the reimbursement level for each of the four patient classifications.

The work measurement study also provided the percentage of Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Nursing Assistants (NAs) time required to perform each specified nursing task.

The amount of time utilized and the percentage of each type of nursing staff which determines the reimbursement level for the four patient classification categories are listed in Exhibit F (page 44). In order to be sensitive to changes in patterns of delivery of nursing care, work measurement studies will be conducted by the state every three years.

The Salary Survey

Annually, in the midpoint of the rate year, the state surveys all the facilities that participate in the Medical Assistance program to determine the wages of nursing personnel (Directors of Nursing (DONs), RNs, LPNs, Certified Medicine Aides and NAs).

The survey is used to determine the 75th percentile of wages paid each employee category and is calculated separately for the three geographic regions. This standard wage is indexed forward to the midpoint of the year in which the nursing rate is set.

The percentile wages are determined on an employee-by-employee basis. Therefore it is possible that all facilities' average wages might be less than the 75th percentile even though some of a facility's employees' wages were above the 75th percentile. All facilities have the potential to have an actual wage rate at or below the standard wage used in the determination of the nursing rate.

It is important to note that occupancy plays a critical role in the nursing cost center. Under prospective flat rate reimbursement there is no payment for empty beds, or any reduction of payment as occupancy increases. This significantly encourages facilities to admit Medicaid patients even if they are classified light care.

A fringe-benefit percentage including paid days off is obtained from the providers' cost report and is added to each standard wage. Correct reporting of fringe-benefits on the cost report is essential to the accurate reimbursement of the standard wage to the nursing home industry, as it represents in excess of 20 percent of direct wages (many facilities still do not report fringe benefits accurately in this cost center), and affects everyone's payment, since the rate is the same for all providers. The standard wage, including fringe benefits for each category of nursing personnel, is multiplied by the number of minutes shown in Exhibit F to form the base nursing rate to be paid.

A standard nursing supply cost is

EXHIBIT G

Current Rates for Nursing Centers and Ceiling in Other Cost Centers

	Baltimore Region	Washington Region	Non-Metro Region
Light Care	35.88	40.18	33.79
Moderate Care	39.55	43.67	37.22
Heavy Care	46.93	50.85	44.03
Heavy Special Care	47.15	51.06	44.23
Decubitus Ulcer Care	11.29	11.70	9.98
Tube Feeding	16.33	16.80	14.87
T&P	2.75	2.55	2.63
Ostomy Care	1.31	1.36	1.14
Oxygen/Aerosol Therapy	1.16	1.21	1.01
Suctioning or Tracheostomy Care	2.76	2.87	2.40
IV Care	4.15	4.33	3.69
Physical Restraints	2.76	2.69	2.54
Injection - Single	.89	.93	.78
Injection - Multiple	1.79	1.86	1.55

added to the rate for supplies not specifically included in a procedure payment. The current rates (effective July 1, 1984) for the nursing care cost center are shown in Exhibit G.

A significant amount of information culled from the reimbursement system has proved valuable in the area of quality assurance. With this information the state is in a position to compare the amount of patient hours being billed against a facility's actual staffing patterns.

If there is a significant discrepancy, the Division of Licensing and Certification visits the facility to assure that patients are receiving appropriate care. Based on a sample of nursing homes by the state, it appears that nursing homes are now staffing above the predicted hours of care based on the patients' classification.

The Capital Cost Center

The Capital Cost Center utilizes a capital rental system to determine the reimbursement level for property costs. The fair rental payment system is based on an appraisal of each nursing home. The problems associated with the rebasing of assets upon the sale or lease of a facility are absent in the Maryland system, since the appraisal is used in property payments and not the cost of the facility.

Reasonable property taxes, interest on mortgages and property insurance are reimbursed in full. An owner's equity payment is made based on the appraisal of the facility. This payment is in lieu of depreciation and a Medicare-type equity payment. A 95 percent fixed occupancy level will calculate the overall property capital per diem reimbursement level. This

(continued on page 54)

EXHIBIT H

Capital/Property Services

Index Category	Associated Price Index
1. Real Property Tax	CPI-U, Property Tax Component. Source: *CPI Detailed Report*, Table 6.
2. Insurance - Property	CPI-U, Property Insurance component. Source: See 1.
3. Land Value	Maryland land value statistics from the Bureau of Appraisal Review, Office of Real Estate, Department of Highways.
4. Building Value	Marshall Valuation Service, Quarterly Index for Construction in Baltimore City - Reinforced Concrete and Masonry Bearing Walls.
5. Equipment Allowance	Marshall Valuation Service, Quarterly Index for Hospital Equipment - National Average.

Dissecting Maryland's Medicaid System

(continued from page 46)

fixed occupancy level also encourages the provider to keep nursing home beds full.

The determination of a facility's fair value is based upon a three-step method. Facility appraisal is the first step. Every three years, the value of the facility's building and land is determined by a cost-based appraisal. During years in which the appraisal survey is not undertaken, the value determined at the last appraisal will be moved forward by a market index to obtain a new value (See Exhibit H).

The second step involves equipment allowance. During the first year of the system's operation, it was determined that an equipment allowance of $2,500 would be added for each bed in the facility. Annually, a new value is determined by indexing.

Then a facility appraisal ceiling is set. This ceiling was determined by a review of recently built nursing homes. This ceiling is the maximum that is used in calculating the equity payment regardless of the facility's appraisal. The amount is revised annually by the use of an inflation index.

The owners' equity payment is calculated by a formula: Owners' Equity = Appraisal Value + Equipment Allowance – Outstanding Mortgages × the Rate of Return (8.88 percent for for-profit facilities and 7.88 percent for nonprofit facilities). The difference in rates is a recognition of income taxes paid by for-profit facilities. The rates were reduced as part of the Medicaid reduction for a three-year period by one percent. This net rental amount is added on to the "pass through" property cost to produce a total allowable cost figure for this cost center. A per diem figure is obtained by dividing 95 percent of the total bed days available during the year.

Facilities which were financially committed prior to the adoption of the new system are protected by a "Hold Harmless" provision which provides them a payment of the greater of the new system or historical cost.

EXHIBIT I

Calculation of Capital Rental Payment

Capital Value of Facility	= Appraised Value + (No. of Beds × 2,500)
Assumptions:	
# of Beds – 100	= 1,500,000 + (100 × 2,500)
Appraised Value of Building 1,500,000	
Property Service Cost with Interest	= $1,750,000 (or $17,500 per bed)
Insurance, RE Taxes - $136,000 (This is below the cost ceiling for the center)	
Owners' Equity = Capital Value	**– Outstanding Mortgage**
= $1,750,000	– $1,000,000
	= $750,000
Rental Rate	= 8.88%
Net Rental Payment	= 8.88% × $750,000
	= $66,600 per year
Total Property/Capital Cost	= Property Service Cost
	+ Net Rental
	= $66,600 + $136,000
	= $202,600
Per Diem Reimbursement	= $202,600/95% of Available Days
	= $202,600 / 36,500 × 0.95
	= $5.84

> A recent analysis of cost reports has shown that the industry's overall occupancy rate has increased from slightly over 96% to almost 98%.

A formula was also developed that converted leased facilities to an ownership model. The state is, therefore, indifferent as to whether facilities are owned or leased. The formula appears to be paying leased facilities more than comparable owned facilities, and some modifications to the formula to bring the payment in line with owned facilities are expected.

An example of the reimbursement level and its calculation for the Property Cost Center is shown in Exhibit I.

Dramatic Influences

The establishment of flat rate nursing, where payment for more difficult patients is substantially above less difficult-to-care-for patients, has influenced dramatically the admission patterns of nursing homes. In a survey conducted by HFAM, Maryland nursing homes were admitting patients with an average of 20 percent more needs than their existing patient population.

The occupancy impact of both the nursing and property cost centers, along with the disincentives of low occupancy in the other two cost centers, has made full occupancy a key ingredient to a nursing home's financial success. A recent analysis of cost reports has shown that the industry's overall occupancy rate has increased from slightly over 96 percent to almost 98 percent.

The payments of fair value for capital and the opportunity for efficiency payments have increased the Medicaid rate to a point where the industry is much more willing to accept Medicaid payments. The improved access to nursing homes for all Medicaid patients is significant. Considering that Maryland nursing homes operate at 98 percent occupancy and average about 35 percent self-pay (private pay), the system's ability to assure access for Medicaid patients is a tribute to the incentives built into the system. The impact of the efficiency payments and the flat rate nature of the nursing payments seems to have kept cost increases at or below the indexes used in forecasting these increases.

In spite of all these successes, the system is not without its shortcomings. The property cost system does not pay as much in the early years to a facility as the old historical property cost reimbursement system (assuming there was a significant amount of financing). What impact this will have on future nursing home development remains to be seen.

There have also been some problems in the administration of the system. The state has yet to reconcile the facilities' billed nursing levels with the professional review organization's final determinations. The computer system that does the reconciliation is not yet operational, though the reviews themselves have been completed. The computer system is expected to be operational shortly and should no longer be a negative factor once corrected.

In spite of these limitations and problems, the system is working. Providers are accepting more Medicaid patients with greater need for care and the state is willing to pay providers a fair rate for providing these services. There is little more that one should expect from a reimbursement system. **CLTC**

SHAPING YOUR IMAGE WITH THE SELF-AUDIT

BY HERBERT P. WEISS and P.J. CONDRAY

A self-audit program can ensure that the facility is in compliance with rules and regs and make the most of the situation.

When long-term care professionals talk in terms of public image building, conversation generally centers around the various programs which can be undertaken that will take the facility out to the community and those which bring the community into the facility. There are other methods, of course, that do not fit neatly into either of these categories.

One such public image building strategy that can prove invaluable in the long-term care setting is the review of ongoing operations through the self-audit. This strategy helps the administrator identify and subsequently resolve potential community relations problems, continuous staff turnover, poor community image, and patient and family dissatisfaction.

The good operational management that can result from the self-audit, interfaced with an effective community relations program, will promote a positive image in the community.

The administrator can obtain assistance from many sources when developing an internal audit procedure. Standard forms can be purchased to examine the quality of services provided in each department within a facility. Qualified consultants can be found in large numbers to develop quality assurance programs to fit the distinct needs of the facility. Many state nursing home associations affiliated with the American Health Care Association (AHCA) make available Peer Assistance Programs to members for evaluating their facility's services.

Whatever avenue is chosen, commitment to the continuous process of self-audit is a solid foundation for success in the provision of high-quality care. But you must follow up and make the public aware of your commitment to promoting good care by publicizing the Self-Audit Program through press releases to local newspapers, speaking engagements to senior citizen groups, and churches.

In developing a Self-Audit program, an administrator must examine perti-

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nent areas and quickly identify and correct potential problems that might create a bad reputation in the community.

Compliance with mandated licensure requirements. Compliance with both federal and state guidelines for participation in such programs as Medicare and Medicaid will promote and assure acceptable standards of patient care. The Texas Health Care Association and the Health Facilities Association of Maryland have taken the idea of AHCA's *The Quest for Quality Program* and developed a quality assurance program reflecting their distinct state licensure requirements. A valuable, easy-to-use resource guide available from AHCA entitled *HEW Interpretive Guidelines and Survey Procedures* can be used to determine if the facility is in compliance with the Conditions of Participation for Skilled Nursing Facilities 20CFR Part 405.

A thorough review of the annual or interim survey reports can quickly reveal potential community relations problems that may damage the facility's reputation in the community. For example, in some states, deficiency reports are placed in local libraries or can be easily obtained through the Freedom of Information Act. Therefore, it is important for the administrators to use the annual or interim survey reports to tell their side of the story. If you feel that the cited deficiency is not an actual deficiency or that the surveyor misinterpreted the regulation, clearly state in the plan of correction to the state that you do not accept the deficiency or the surveyor's interpretation of the regulation. Explain in full detail why there is a disagreement and attach appropriate documentation to strongly support your position. If the surveyor permits, tape record the exit interview. This will provide valuable information that can be used in writing the plan of correction supporting your position.

Why not publicize the results of a high survey score? Develop a press release to send to local newspapers, responsible parties of patients, hospital discharge planners and consumer advocates which describes the facility and the services it provides, the high score obtained on the state survey and finally, the good patient care that is provided by the staff of your facility.

Personnel policies and procedures. Personnel policies and procedures should be carefully reviewed and updated on a continuous basis. Poorly written and implemented personnel policies and procedures could result in poor staff morale and turnover, reducing the quality and continuity of patient care within the facility. Wages should be comparable to the current prevailing rate in the area in which the facility operates. Such information can be obtained from informal surveys among administrators or wage-fringe benefit survey reports available through state nursing home associations.

Upper management support for staff attending continuing education programs, upward and lateral career mobility within the facility and finally, an ongoing employee assessment, evaluation and promotion program are a few very important management tools which can be used by the administrator to forge a feeling of *esprit de corps* among the employees in all the departments of the facility.

> Once the program is established, the self audit should become an ongoing activity.

The Self-Audit Program may reveal ways in which the staff may use their talents and interests to promote a positive image of the facility to the community. For individuals with a strong interest in sports, an intramural sports team may be a way to foster employee bonds and provide an outing for the patients and their families who can cheer the facility staff on to victory. Why not challenge local politicians, state regulators, consumer advocacy groups and other local nursing homes to a game of baseball? Monies that are raised could be donated to local charities.

For the academically inclined staff, education programs could be conducted at the facility or in the community for family members, civic clubs, church groups or health care professionals, to explore topics in aging. Get the most out of these events. Publicize them in the facility newsletter. Send press releases to local newspapers, radio and television stations, or a specially developed VIP list.

Maintaining the physical plant through preventive maintenance and proper housekeeping procedures. An investor cannot build a nursing home for less than an average of $30,000 per bed. It therefore becomes very apparent that an ongoing preventive maintenance program supported by the administrator and facility staff will protect the physical plant and reduce potential capital expenditures, replacement equipment costs, and accidents within the facility. Good housekeeping techniques will promote a clean environment and reduce the spread of microorganisms within the facility. A clean, safe, odor-free, well-maintained environment will add to the quality of life of the patient within the facility. In the Self-Audit Program, the administrator can discover potential problems through routine walks throughout the building and surrounding grounds. It is a sure bet that the visitor or state surveyors will take notice of odors and dirty or poorly maintained facilities.

Making consultants and contractors part of your team. Use both legal and accounting counsel in the Self-Audit Program to closely examine provider contracts with third-party payors, patient admission agreements and service contracts with outside consultants and contractors. An annual review of contracts with physicians, psychiatrists, dentists, podiatrists, rehabilitation specialists, mobile X-ray services, laboratory services, pharmacists, pest control companies, etc., will determine if contractual agreements are in compliance with state and federal regulation. An ongoing audit will enable the administrator to determine if every consultant and contractor is providing their service to the facility in the most appropriate and economical manner.

Developing the Program

A Self-Audit Program can be implemented:

- when there is a change in owner-

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Public Image, Part Three

(continued from page 39)

ship, administration or key departmental leadership;

• when the facility is about to introduce a new service; and

• before the preparation of the annual budget.

Once the program is established, the self-audit should become an ongoing activity. Valuable information can be obtained which can save the facility thousands of dollars of unneeded and unanticipated expenditures. Licensure violations *can* be discovered and corrected. A well-managed facility will reap the positive benefit of an excellent reputation in the community.

The administrator should have the ultimate authority for development, monitoring and accountability to make sure that the discovered deficiencies are corrected in a timely fashion. The program should be developed with consideration to staff input, the size of the facility, and resources and manpower that are available. A simple process should be followed:

• Develop a list with the name and address of every consultant and contractor that does business with your facility. Send letters to these individuals stating that contracts are going to be reviewed by a self-audit to determine if they are providing the maximum potential benefit to the facility and patient. Ask that they become actively involved and committed to the facility's Self-Audit Program.

• Develop a monitoring instrument to measure quality of services in administration, nursing services, dietary services, resident services, environmental services, physician services, pharmacy services and rehabilitation services. Standard forms are easily available.

• Use department heads and consultants to perform auditing of their departmental areas and clinical specialties. Delegation and participation of facility staff are very important to the success of this program.

• Department heads and consultants write easy-to-read reports and submit them to the administrator for review and analysis. A strategic plan consisting of goals, objectives and schedules to correct items is developed to upgrade existing services and correct discovered deficiencies.

• The administrator monitors and evaluates each department's effort to accomplish the strategic plan. The Self-Audit Program continues and is modified when necessary.

• Employee recognition is important. Possibly an employee party or luncheon could be planned when high survey scores are received on annual and interim surveys to recognize their efforts.

Making the Proper Reflection

The Self-Audit Program can be a valuable tool in the public image building process. The long-term care administrator can ensure that his facility is both in compliance with existing rules and regulations and take advantage of that situation by letting the community in on the "secret."

Good patient care is, of course, reflective of a well-operated and managed facility, which can be the result of a continuous self-audit. Many members of the community will make decisions about the desirability of a nursing home based on these criteria. So why not make the system work for you? ***CLTC***

TOM STOKES

PERSONNEL/PART ONE

FILLING KEY MANAGEMENT SLOTS, RETENTION, KEYS TO SUCCESS

BY HERBERT P. WEISS and ROBERT A. REITZ

Ultimately, it is quality of care and services that is affected most by high turnover.

Editor's Note: *This is the first in a three-part series on personnel concerns in the long-term care setting. This installment addresses the importance of filling key management positions with qualified individuals and retaining them. Next month's installment will address the use of on-staff and contractual housekeepers and dietary service workers.*

Retention of key management personnel is an all-important ingredient in the successful operation of the long-term care facility. Continuous staff turnover, especially at the department head level, can be extremely costly in terms of: unanticipated administrative time required to fill vacant positions; training expenses; recruitment expenditures through advertising; and reduced staff morale and increased frustrations due to impending changes in management.

Ultimately, the continuity and quality of patient care and services can be dramatically reduced in the facility by constant turnover of key management personnel.

Outside recruitment of personnel for management positions is often necessary, but it should be considered only as the last resort when upward mobility is a possibility. Opportunities for upward mobility can be a positive way in which to retain qualified personnel.

A Perfect Mechanism

Rentention of key management personnel can be fostered by an ongoing Manpower Planning Program. This program can be a perfect mechanism to identify total manpower needs of the facility and to identify individuals within the facility who are willing and qualified to fill vacant management positions.

There are three basic components to such a program.

- Identification and job performance assessment of key management and potential candidates for key management.
- Job enrichment and enlargement program.
- Competitive wage-fringe benefit program.

The success of this program is dependent upon the interdependence of the three components. It is essential that the facility staff understand the structure of the program and how it can provide advancement in their careers. The employee handbook and orientation for new employees, meanwhile, can promote the philosophy of career growth through promotion from within.

Building the Foundation

The identification and assessment process is the foundation of the program. Key management personnel in all departments are identified and cataloged along with potential candidates for key management positions. When a vacancy occurs in a key management position, all potential candidates are identified within the facility and notified of the vacant position. An example of how to organize an internal-search chart:

Vacant Key Management Positions	Potential Candidates In Facility
Director of Nursing	Assistant Director of Nursing, Charge Nurse.
Food Service Director	Assistant Food Service Manager or Head Cook (if the individual is certified or willing to be certified through a Food Service Managers Certification Program.
Other Department Heads	Identified qualified individual with management potential within the department. However, where technical requirements are not required, do not limit your selection to that department.

If a potential candidate within the facility is interested in the position, but is not actually qualified, that individual must be given appropriate rationale for the decision.

An ongoing Employee Appraisal Program can provide excellent information pertaining to the candidate's past and current job performance and potential to fill a vacant key management position. The management performance appraisal form should include:

- *Appraisal of major responsibilities, primary duties and important functions of the individual.* An assessment of quality of care and service should be included in the appraisal. The job description is important in making the appraisal.
- *MBO Appraisal.* The extent to which the individual has been successful in achieving mutually agreed upon objectives in his or her department.
- *Performance Indicators.* These quantifiable indicators do not reflect quality of care or service that has been achieved. An example of Performance Indicators are shown in the accompanying chart.

Enhance and Enlarge

In order to create a positive environment for professional growth and challenge to promote retention of facility staff, especially the identified key management personnel, it is important to develop and implement an ongoing Job Enhancement and Enlargement Program. Professional self-actualization can be supported by the administrator in a number of ways:

- Develop career paths for all personnel.
- Encourage personnel to enroll in degree and non-degree continuing education programs through educational allowances.
- Encourage development of management skills through distribution of current best-seller management books, *i.e., The One-Minute Manager.*
- Circulate easy-to-understand management literature to personnel.
- Encourage personnel to publish articles on interesting programs within the facility.
- Promote teamwork to accomplish goals by implementing the MBO Process.
- Encourage personnel to try innovative ways to provide patient care within the facility. Promote an environment that is supportive of creativity.

Most management textbooks stress that job enlargement does *not* equate to job enrichment. Make sure that the facility's environment provides the personnel with rewarding challenges and positive growth experiences. This will drastically reduce burn-out.

Money Talks

The administrator has to make a conscious management decision about pay practices and how they relate to other competitors in the local marketplace. A facility that has a noncompetitive wage-fringe benefit program will *not* be able to retain qualified key management personnel. Current salaries and benefit survey results can be obtained from state nursing home associations and the *Nursing Home Salary & Benefits Report*, published by Hospital Compensation Service. Phone surveys to facilities in the local marketplace can also provide valuable information.

In order to reward high job performance, the salary administration program must be based on a merit system. The aforementioned management appraisal form would be one instrument with which to measure and evaluate job performance. Based on the results of the performance appraisal, the overall performance level is determined. There are five possible performance levels.

- **PERFORMANCE LEVEL ONE:** (Marginal) Performance which is below expected standards for the job.
- **PERFORMANCE LEVEL TWO:** (Satisfactory) Performance which meets the basic requirements of the job.
- **PERFORMANCE LEVEL THREE:** (Highly Effective) Performance which consistently exceeds the basic requirements of the job.
- **PERFORMANCE LEVEL FOUR:** (Superior) Performance and results which substantially exceed requirements of the job.
- **PERFORMANCE LEVEL FIVE:** (Exceptional) Performance and results usually applied to a unique situation.

Once the performance level has been established, a salary increase can be calculated by referring to established salary increase guidelines. Each performance level should be assigned a minimum and maximum salary increase amount.

When determining the increase

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amount, the performance level scale should be viewed as a continuum. For example, an individual who has performed at a level between Performance Level Two (Satisfactory) and Performance Level Three (Highly Effective) would be given an increase that would fall between the minimum and maximum increase amounts assigned to Performance Level Two.

Once the performance level has been established, a salary increase can be calculated by referring to established salary increase guidelines.

The appraisal process can be an excellent way to motivate, counsel and develop personnel and maintain and increase productivity.

An ongoing Manpower Planning Program can "groom" capable and qualified personnel into employees who can shoulder greater burdens of responsibility. Remember that a positive message is sent out to all personnel when promotion from within takes place. Retention of qualified key management personnel can be translated into reduced recruitment expenditures and continuity of management.

PERFORMANCE INDICATORS FOR KEY PERSONNEL

ADMINISTRATOR:

- Annual Administrator Controllable Profit Before Taxes (express as percentage variance from budget for most recent fiscal year).
- Survey Results (number of time lost claims, total time lost days, total dollar reserves most recent fiscal year).
- Employee Turnover (hourly percentage, nurses percentage for most recent fiscal year).
- Receivables (total dollars on 90-day accounts, total dollars on 60-day accounts for most recent fiscal year).
- Unemployment Compensation Experience Rating.

DIRECTOR OF NURSING:

- Annual Controllable Payroll Costs (express as percentage variance from budget for most recent fiscal year).
- Survey Results (number and nature of nursing public disclosure items, number of repeat deficiencies most recent annual survey).
- Employee Turnover (nursing assistants percentage, nurses percentage for most recent fiscal year).
- Nurses' Vacancy Rate (express as a 12-month average for most recently concluded fiscal year).
- Worker's Compensation (number of nursing time lost claims, total nursing time lost days, most recent fiscal year).

FOOD SERVICE MANAGER:

- Annual Food Cost (express as percentage variance from budget for the most recent fiscal year).
- Annual Payroll Cost (express as percentage variance from budget for most recent fiscal year).
- Survey Results (number of dietary public disclosure items and number of

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Personnel — Part I

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repeat deficiencies, raw and corrected sanitation scores).

- Worker's Compensation (number of time lost dietary claims, total dietary time lost days for most recent fiscal year).
- Employee Turnover (dietary employee turnover rate for most recent fiscal year).

RECRUITERS / PLACEMENT SERVICES

The following companies place and recruit health care professionals.

John Conway Associates
2040 W. Wisconsin Ave.
Milwaukee, WI 53233

The Corson Group
641 Lexington Ave.
New York, NY 10022

The Dean Group
1973 Springfield Ave.
Maplewood, NJ 07040

Dietary Consultants Inc.
347 Seneca Rd.
Hornell, NY 14843

Garrett Associates
100 Galleria Parkway NW
Suite 675
Atlanta, GA 30339

Health Industry Consultants Inc.
7353 S. Alton Way-Penthouse
Englewood, CO 80112

Hogan Associates
26250 Euclid Ave.
Suite 811
Cleveland, OH 44132

Hospital Staffing Services
2455 E. Sunrise Blvd.
Suite 706
Ft. Lauderdale, FL 33304

Houchins & Associates Inc.
250 Piedmont Ave. NE
Suite 101
Atlanta, GA 30308

Medical Personnel Pool
303 SE 17th St.
Ft. Lauderdale, FL 33316

Medical Placers
P.O. Box 2555
Wilmington, DE 19805

Martin H. Meisel Associates
55 E. 87th St.
New York, NY 10028

North American Placement Services Inc.
4418 McArthur Blvd. NW
Suite 202
Washington, DC 20007

Olsten Corp.
Healthcare Services Division
1 Merrick Ave.
Westbury, NY 11590

Perry-Mohr Associates
2102 Business Center Dr.
Suite 203
Irvine, CA 92715

Physician Search
9502 B Lee Highway
Fairfax, VA 22031

Roth Young
P.O. Box 98286
Atlanta, GA 30359

Staff Builders Inc.
122 E. 42nd St.
New York, NY 10017

Tyler & Co.
1835 Savoy Dr.
Suite 205
Atlanta, GA 30341

Upjohn Healthcare Services Inc.
2605 E. Kilgore Rd.
Kalamazoo, MI 49002

Witt Associates Inc.
1415 W. 22nd St.
Oak Brook, IL 60521

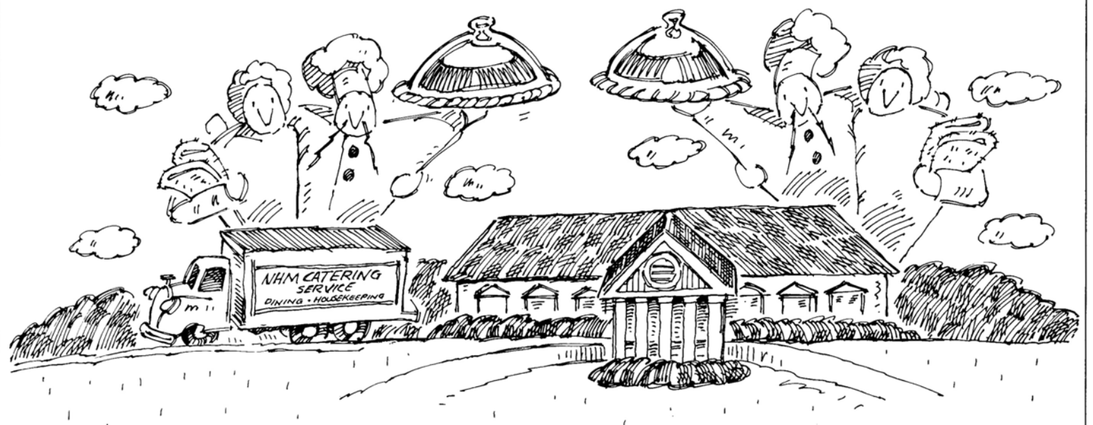
The Woodward Group
35 E. Wacker Dr.
Chicago, IL 60601

The Zivic Group
517 Washington
Suite 201
San Francisco, CA 94111

CLTC

CONTRACTUAL VS. IN-HOUSE: MAKING THE RIGHT CHOICE

BY HERBERT P. WEISS,
DANIEL P. McCARTNEY and JOSEPH P. ROBERTS



When choosing the plan for dietary and housekeeping, put emotion aside and be objective.

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When debating the question of using in-house management or outside contracting companies in the long-term care dietary and housekeeping departments, philosophical lines can be quickly drawn.

Practically everyone has an opinion which, they insist, cannot be swayed. But there is obviously a right situation and a wrong situation for exercising either option. The important point here is to know *when* and *how* to make the right choice.

Beware the Caveat

Support services such as dietary and housekeeping play an important and integral role in the quality and cost of patient care within a long-term care facility. Poorly planned and prepared meals, along with improper sanitation and infection control procedures, will have an adverse impact on the patients' health.

Poorly trained department heads may ineffectively utilize their staff and create unnecessary staff turnover within their departments. The administrator must be aware of the caveat — inefficient and weak department heads beget unnecessary expenditures, reduced patient care and *ensure* low survey ratings.

Therefore, it becomes necessary to objectively evaluate the dietary and housekeeping departments in terms of expenses and quality of services. An ongoing review will provide valuable information to determine if it would be more cost-effective and practical to use a contract service company rather than in-house mid-level management.

Writing on the Wall

The old adage and rule-of-thumb, "Don't change it if it works," is an important and guiding principle in making any management decision. If the department head operates the department in an efficient and cost-effective manner while providing high-quality services, it makes no sense to tamper with success. Actively promoting the retention of such individuals through recognizing their superior effort via merit raises and implementing an ongoing job enrichment and enlargement program is critical.

There are a number of indicators with which an administrator can evaluate the desirability of using a contract service company: poor location affecting recruitment and retention of key management personnel; type of facility construction and physical plant lay-out; inefficient and weak department heads who cannot control their departmental expenditures, staffing, and quality of services; and finally, facility revenues.

The following questions should be asked honestly in the administrator's evaluation of the dietary and housekeeping departments to determine appropriate management action:

DIETARY DEPARTMENT

- Is the facility location detrimental to recruitment and retention of a qualified foodservice manager and personnel?
- Is the foodservice manager competent? Does he or she have the initiative to implement new programs? What is the foodservice manager's strengths and limitations? Can the individual overcome limitations within a reasonable time?
- What are the departmental expenditures (above or below budget)?
- What is the quality of food served, service and sanitation?
- How much time must be allocated to supervise the foodservice manager in making sure the dietary department is operating in an efficient and effective manner?
- Does the foodservice manager meet the administrator's standards? Are the facility's standards as high as they should be?
- Is high-quality food being purchased for the best price? How much food is overproduced? How much food is underproduced?
- How often is the menu changed to add variety and choice to the patients' diets?
- Does the dietary department's patient care program meet the patient's needs rather than just comply with minimal state regulations?
- What was the score on the last health inspection survey? Were there repeated major deficiencies?
- Is there a high turnover in departmental staff? Is overtime kept to a minimum?

HOUSEKEEPING DEPARTMENT

- Is the facility location detrimental in recruitment and retention of staff?
- Is the building clean, odorless and orderly on an ongoing basis?
- Is the staff stable, well-disciplined and knowledgeable about their jobs?
- What is the executive housekeeper's strengths and limitations? Can the individual overcome limitations within a reasonable time?
- How much time must be allocated to supervise the executive housekeeper in making sure that the housekeeping department is operating in an efficient and effective manner?
- Does the executive housekeeper meet the administrator's standards? Are the facility's standards as high as they should be?
- What was the score on the last health inspection survey? Were there repeated major deficiencies?
- What are the departmental expenditures (above or below budget)?
- Are the cleaning supplies being purchased for the best price? Are the cleaning supplies being excessively and improperly used by departmental staff?
- Is there a high turnover in departmental staff? Is overtime kept to a minimum?

These key questions will provide a clear picture as to the operational efficiency and effectiveness and quality of services provided by the housekeeping and dietary departments. A poor rating in the review may well be red flags to begin to explore alternate forms of management.

Seeking Perfection

The selection process is very important in determining which contract service company best fits the distinct needs of the facility and is compatable with the administrator's philosophy on how services within the facility should be managed. The following actions and questions will provide information which will enhance the successful selection of the "perfect" contract service company:

- Develop goals to be achieved by the chosen contract service company. Ask companies how they would accomplish goals and objectives and obtain a list of goals that they feel important to accomplish.
- Develop a list of criteria that is considered important and assign a value to each item. Rate interested contract service companies as to how well they address each individual criterion in their proposal.
- Will the contract service company grant right to reject the on-site manager due to incompatability and conflicting management philosophies?
- Does the administrator have the right to terminate the service contract due to poor management and quality of service provided by contract service company personnel?
- Obtain a reference list from the contract service company. What are the present clients saying about the company? How long has the company had the account? What does the client say about the contract service company's strengths and limitations?
- Obtain copies of licensure surveys of facilities that are accounts of the contract service company. Poor management and continuity of serious licensure deficiencies can be easily identified.
- Obtain proposals from more than one contract service company to compare services, management fees, etc.

Information obtained during the selection process will enable the administrator to quickly find the pea under the right shell. A contract service company that is committed to high-quality service while effectively holding down departmental costs can provide the administrator with additional time and energy to manage other areas of the long-term care facility's ongoing operations. Selecting the right company pays off in both the short and long run.

Get Your Money's Worth

Continual monitoring of the contract service company will ensure that the quality of service is constant. A professionally operated company wants to be effectively managed by the administrator. The following ways may be utilized to monitor and evaluate the quality of services provided by the contract service company:

- The implementation of an ongoing quality assurance program with active support of the administrator and department heads will promote close monitoring of the contracted services. It must be clearly understood by the contract service company that problems should be corrected on a realistic schedule agreeable to all parties.
- The administrator must have access to on-site manager and district manager reports along with statistical information concerning food costs, housekeeping and dietary supplies, and staffing costs if applicable.
- The agreement should include a commitment of the contracting service company to leave pertinent records on-site if the contract is terminated.
- Regularly scheduled meetings between on-site manager and/or regional manager and the administrator to discuss existing problems and potential areas of concern will keep the lines of communication open between all concerned parties.
- The administrator should retain the option to have access to all departments, especially those managed by the contract service company, to monitor and evaluate the quality of service.
- An agreement to protect both the administrator and the contracting service company should be incorporated into the service contract to terminate the service contract for mutually agreed upon reasons.

Effective management through continual monitoring and evaluation of the contract service companies' performance will protect the facility's vested interest in providing high-quality housekeeping and dietary services at a reasonable cost.

The dispute between those individuals who support the use of contract service companies and those individuals who believe in in-house staffing takes place on a daily basis. Both sides fanatically believe they are right. Emotion must be put aside for objectivity. A careful examination must be made of the financial and manpower resources available to the facility. If warranted, alternative forms of management should be explored.

Photography by Mark Adams, Longbeach, California.

Beverly Enterprises Chairman Robert Van Tuyle and Sister Pat Murphy admire some of the handiwork created by residents of a Beverly-owned facility.

LONG LIFE WITH QUALITY

BY HERBERT P. WEISS, MA, NHA

The contributions of Sister Pat Murphy have helped Beverly Enterprises establish a model program for ensuring quality lifestyles for its patients.

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Sister Pat Murphy strongly believes in the old adage, "If you have a problem to be solved, go straight to the top." This is exactly what she did in March 1980, when in her role of West Los Angeles Ombudsman, she met with top corporate officials at Beverly Enterprises. A meeting was scheduled to discuss a complaint involving a local Beverly operated facility which was attended by Chairman Robert Van Tuyle, President David Banks, and other corporate management. In the course of their three-hour meeting, the complaint was quickly resolved. Broader areas of patient care and quality of life became the main focus of discussion between the three top corporate officials of the largest nursing home chain in the nation and this local West Los Angeles Ombudsman.

This three-hour meeting to discuss patient care was very instrumental in providing an introduction and opening the "corporate doorway" to Murphy. Van Tuyle invited her to be one of the representatives for Beverly Enterprises on the Local Task Force established by the Institute of the Blind in Los Angeles. In a three month period, this task force would examine ways in which special materials for the blind such as brail books, records, and cassettes could be more effectively utilized by activity coordinators and nursing home staff. Proper use of such materials would promote the quality of life for blind residents within a nursing home.

Through Van Tuyle's interest in and attendance at the Institute of the Blind Task Force Meetings, he observed Murphy's performance and contribution at the meetings. It became clearer to him that her philosophy and management priority of quality of life for patients was similar to that expressed by top Beverly Enterprise officers. Also, her dual experience as an Activity and Social Service Coordinator for three years, along with active involvement in the development and implementation of the West Los Angeles Ombudsman Program, would be the appropriate mix of qualifications and skills required to build Beverly Enterprise's Social Rehabilitation Program.

The continual dialogue with Van Tuyle at the Task Force meetings provided Murphy with small glimpses of Beverly Enterprise's philosophy of patient care. She saw how strongly the national nursing home chain supported the local task force throughout its duration, and its implementation of the recommendations. In October 1980, Murphy was offered and accepted the newly created position of Director for Activity Programs. She requested and received special permission from her Catholic Order, Lady of Victory Missionary Sisters, to work in the corporate world. Her executive salary was to be donated to her order due to the vow of poverty she made upon entering the nunnery.

Over the years, Murphy has become a visable, viable force in the field of aging. She is recognized nationally through her activities on behalf of Beverly Enterprises as a representative to educational, aging, and consumer advocate communities. She has been a lecturer for the American Health Care Association, and numerous State Activity Coordinator Associations. This is in part due to the philosophy of Beverly Enterprise to use its fiscal resources and staff to promote the professional role of the Activity Coordinator in fostering quality of life for the nursing home residents.

Civic groups and educational institutions have recognized her efforts to create a positive image of the elderly residing in the nursing home. Murphy has received the Paul Harris Fellows award from the Rotary International; the Better Life Recognition Award from the Brent Air Lions Club; the title of fellow of the UCLA/USC Long-Term-Care Gerontology Center; and finally, the honorary degree of Doctor of Humanities from Brean Hospital Chaplains Corporation International.

Murphy has taken advantage of the printed word to disseminate the positive role of the nursing home in providing care to its residents. Most recently, she has written articles for *Linkages*, a journal produced by UCLA/USC Long-Term-Care Gerontology Center and the *American Health Care Association Journal*. Her two booklets, *Healing With Time And Love* and *When Home Is Not The Answer* are utilized in nursing homes throughout the country.

Finally, it is Murphy's strong belief that the Activity Coordinator is a professional and plays a pivotal role in promot-

ing the quality of life within the nursing home. This influenced her to actively participate in the founding of the National Association of Activity Professionals. She was the organization's first president and has recently been re-elected by its membership to serve a second term.

Many experiences helped to shape the personal philosophy of Murphy which influenced the development and implementation of Beverly Enterprise's Social Rehabilitation Department. At this time, the program reaches 914 Beverly owned and operated facilities comprising over 102,000 beds. Having functioned as both an Ombudsman and as an Activity and Social Service Coordinator, she believes that it is extremely important to maintain a vital link between the residents and the community through encouraging volunteers to serve in the facility. Residents must not be isolated and separated from the community-at-large.

Furthermore, Murphy believes that the Activity and Social Service Program must continually foster the capabilities of the residents to function as independently as possible. The nursing home must not be viewed as an end to one's life or to one's contribution to society. Both the residents and the family can continue to grow and positively contribute to their communities. This philosophy is strongly incorporated into Beverly Enterprise's Social Rehabilitation Program.

Both the Activity and Social Service Program are intended to promote the quality of life within the nursing home environment. A discussion of the development and major components of each program is described as follows:

Activities Department

In the early 1980s, the profession of Activity Coordinator was at its adolescent stage of development. Individuals functioning in the role tended to be overworked; under-trained due to the lack of education programs focusing on recreation therapy for the aged; lacking support in the nursing home industry for the role to be viewed professionally; supervised by either the Director of Nursing or the Social Worker; and the role and function of the position poorly defined.

In the development of the Activity Program, an in-house survey was sent to Activity Coordinators working within the corporation. The results of the survey were not surprising to Murphy. She found that most Activity Coordinators tended to not view themselves as professional but as friends, helpers, etc. They had few guidelines to follow and few standards to reach. Most of the programs implemented in the Beverly facilities at that time were to be considered group programs. Programs were planned for large numbers of residents.

Furthermore, Murphy believes the Activity and Social Service program must continually foster the capabilities of the residents to function as independently as possible.

The information obtained from this survey led to the following:

- The Activity Coordinator was made a Department Head. This would promote the professional identity of the individual. Educational training in therapeutic recreation and related fields would be considered in the hiring of the Activity Coordinator.
- The Administrator was directed to allocate a minimum per licensed bed per month to the Activity Department budget. This allowed the Activity Coordinator to plan a calendar of events a year in advance.
- Four hours of programing were required in an eight hour day. Out of the required four programs, one must promote physical exercise; one must be structured to provide mental stimulation; and finally, two additional programs were to be developed and directed to specific group needs within the facility.
- Four hours in an eight hour day should be alloted to program design, meetings and documentation. The Activity Coordinator had to become a Manager of Resources instead of only providing "hands-on programming."
- There is a minimum of one activity program per night per week with the ultimate goal of providing programming on seven nights per week.
- Large recreation programs held in large rooms are deemphasized. Smaller programs designed to fit the distinct needs of the patients are held on the nursing home floor/wings. This reduces the time and manpower required to transport the residents to the activity program.
- All departments and their staff are required to support the psycho-social needs of the residents through assistance in the various aspects of the Activity Program. Job descriptions are interpreted to include this responsibility.
- Resident Councils are required to be held a minimum of one per month. The Activity Coordinator's role is to prepare the council officers and committee chairman for the actual meeting and after meeting duties. This will lessen the need for the Activity Coordinator or nursing home staff to attend the meetings. Resident independence and self-determination is strengthened by this philosophy.
- Resident Volunteer Programs are developed and implemented by the Activity Coordinator. This can be instrumental in promoting the residents' sense of being needed. Residents in various Beverly facilities participate in local telephone reassurance programs, RSVP, lead in-house programs, or belong to groups such as the Red Cross, Church groups, etc.
- Community volunteers are utilized to develop and implement evening and weekend programming. The Activity Coordinator is in charge of the supervision of volunteers when in the facility. It is their responsibility to delegate supervision to staff at the facility when they are not on-site.

The purpose of the Beverly Enterprise Activity Program is threefold in nature; to provide residents with choices in their participation in meaningful social and therapeutic activities which stimulate their interest; meet their distinct physical, emotional, mental, and spiritual needs; and finally, to maintain a vital link to the community through family members, staff and volunteers. The Activity Coordinator is considered a professional and an important member of the therapeutic team. This is supported by their Department Head status and clearly defined and detailed Activity Program Manual which carefully lays out the position's role and function. Finally, program output is influenced by the Administrator of the facility, community resources and regional and district supervision. This output can be evaluated through the corporation's Quality Assurance Program which can examine concrete program standards.

Social Services

After the Activity Program took its form and standards were developed to measure its output, individual's functioning in the role of Social Service Coordinator took immediate notice. They were not sure how you could measure a human service but expressed interest to Murphy and her regional and division staff that the Social Service Program needed more detailed standards. A survey of Social Service Coordinators by regional and division staff revealed that these individuals viewed their role as providing one-to-one counseling to residents. Murphy felt that this might limit the impact and resources of the Social Service Department and that the resident would rely heavily on the Social Service Coordinator rather than on their own internatal resources. The results of this in-house survey led to the following characteristics of the Social Service Program:

- Focus of counseling shifted from one-to-one to self-help groups. This counseling modality would enable residents to utilize their own and facility resources to cope with their difficulties.
- Four self-help groups were scheduled each week and targeted to new resident admissions to promote adjustment; families of new residents to help them cope with placement of their member in the facility; and finally, two groups were to be focused on the distinct needs of the residents within the facility, *i.e.* stroke, diabetes and self-feeding.
- Self-help groups can be assigned to a trained volunteer or to another staff person. This would increase the number of self-help groups available to the residents.
- Self-help groups were to be short-term, intensive, with the main goal of bringing isolated residents into the mainstream of facility life.

Finally, the role and function of the Social Service Coordinator became more concretely defined and the standards established could be evaluated through the Quality Assurance Program. The major areas of responsibility of the Social Service Coordinator are:

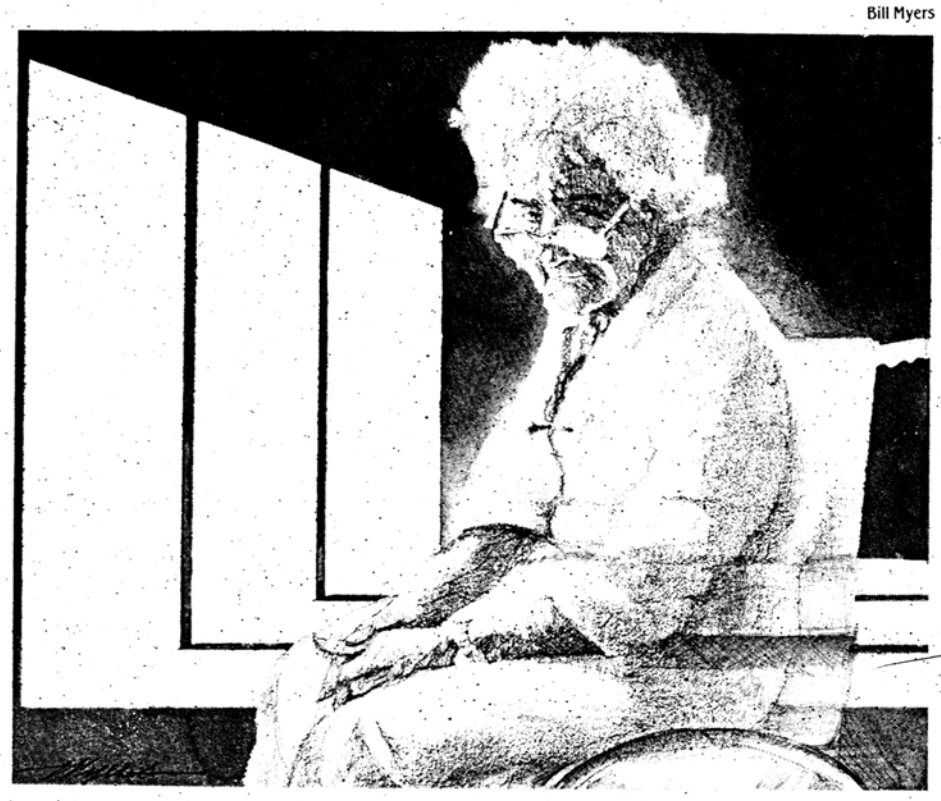
- Pre-Admission — Determining the level of care of the potential resident if the individual requires nursing home care. This pre-admission interview can provide the potential resident and family with the implications of nursing home admission; provide information as to the facility's philosophy of care; and insight into the potential adjustment problems of the resident and their family.
- Admission — Psycho-Social problems can be identified at this time and the appropriate intervention can be implemented.
- Crisis Intervention — Development of relationships with community agencies, service providers is important to increase facility's resources. Determining the level of resident satisfaction in room and table assignments is important to involve appropriate staff to reduce potential problems.
- Discharge Planning — Social Service Coordinator is part of the nursing staff to determine appropriate time and place of discharge. It is a major responsibility of the Social Service Coordinator to develop ways to promote closure to the residents of the facility in the event of a death or transfer of an individual. Finally, discharged residents are contacted after they are placed in an alternate setting to determine how they are functioning.
- Family Counsel — In collaboration with the Administrator, the Social Service Coordinator provides direction to the Family Counsel which meets on a quarterly basis. Officer and committee structure is intended to make it more difficult for one individual to take control and provides family members with opportunities for leadership.
- Residents' Rights — The Social Service Coordinator maintains a close observation of the Residents Rights and ensures that the rights are protected.

Beverly Enterprise may be viewed by some as a corporate Goliath in an era of the rise of national chains that can marshall resources to build empires. Largeness should not be considered bad and as such fearful, negative views must not filter the positive contributions that Beverly Enterprise and other national chains have made to promote quality of life. Beverly has established and set high standards for its Activity and Social Service Programs and provides a guideline for other facilities to follow and modify to fit their distinct needs. Activity and Social Service output can be measured through its on-going Quality Assurance Program. Sister Pat Murphy has left a powerful message for all professionals and consumer advocates in the field of aging . . . Long life with quality. **CLTC**

Gaining The Upper-Hand In The Survey Process

BY MAGGIE SYBERT, NHA AND HERBERT P. WEISS N.H.A.

Bill Myers



Regulations in the health care delivery system for a long time were voluntary with minimal government involvement. In the late 1960's, the Federal government took an active lead in promoting access to the elderly to health care services through the enactment of Medicare and Medicaid legislation. Numerous nursing home scandals at that time revolving around poor patient care created public fervor and support to protect the frail elderly through government intervention and its promulgation of extensive, detailed regulations.

As the Federal government began to function in the role of third party payor, regulations were viewed as a necessity to ensure provider accountability. One such avenue to promote quality and provide accountability is through the survey process. Administrators are very aware of this process. Poor survey results might become a story in the local newspaper...manpower cost increases due to the staff required to comply with regulations. In the early 1980's, the National Council of Health Care Centers (now affiliated with the American Health Care Association) estimated that the typical nursing home is subjected to no less than 30 inspections by different regulatory agencies each year. These inspections are mostly related to physical plant and paperwork requirements. The cost of meeting the mandated government standards may add from $8 to $15 per day to the cost of care for each patient. Even though there is mild interest at both the Federal and State level to stream-line the regulatory process...the survey process is here to stay.

Know Thy Regulation

There is no magic in obtaining a good score on a survey conducted by either the local, state or federal regulatory agencies. Whether you are contemplating prelicensure for a new start-up operation, a certification survey (Title XVIII, Title XIX), an annual validation survey, an interim or accreditation survey...knowing the regulations and education of staff to such regulations are essential ingredients to a successful outcome of a survey.

The survey team will initiate a comprehensive review and evaluation of the facility's task oriented functions and/or written policies and procedures. This

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review will determine if an acceptable operational standard is evidenced...in order to achieve compliance, one must comply with the multitude of regulations.

The administrator can obtain a listing of regulations from appropriate regulatory agencies and accrediting organizations. Proposed and newly-enacted regulations and amendments to existing regulations can be acquired through both the State and Federal Register. Also, regulatory agencies usually through official notification, announce such new or amended regulations. Finally, both state and national nursing home associations actively monitor the state and federal regulatory climate. Active involvement in these organizations and receiving their newsletters can provide current information as to regulations and their impact on the operations of the facility.

Starting From Scratch

Any one who has had the opportunity to open a new facility will tell you that it is a monumental task to obtain the necessary approvals from the appropriate agencies...and numerous criteria must be met prior to a prelicensure survey. Agencies that are involved in the opening of a new facility are the State Health Planning Agency, the State Health Department (divisions within this Department include Licensing and Certification, Engineering and Maintenance for Plans Review and Approval), the State Fire Marshall, the local fire bureau, the local health department, and the Department of Housing. It can clearly be seen that there are a multitude of interested parties who are going to make sure the facility is in compliance with some law or regulation.

The tangible approvals from these agencies are reflected in the form of "sign-offs" — a final determination that has an authorizing signature of a project coordinator or department head with a specific review agency. These agency approvals may be communicated verbally, and should always be verified through written documentation. An appropriate caveat...One must cross all "t's" and dot all "i's."

Most state licensing agencies will require a prelicensure questionnaire to be completed for their review. This questionnaire should be processed in a timely manner but not so far in advance of the proposed target date for opening as to make the information on the form obsolete. The demographic information compiled on this form is required for establishing state licensure and federal certification for Medicare (Title XVIII) and Medicaid (Title XIX).

This questionnaire form will also request information pertaining to ownership of facility, a listing of professional and consultant personnel who are affiliated with the facility, a listing of services and programs, and the established fiscal reporting period. Finally, the facility representative signing the document acknowledges the intent to comply with established participatory guidelines as stated in Medicare and Medicaid. Once this prelicensure information is submitted to the regulatory agency, the facility is recognized as a "real living entity." At this time, prelicensure requirements will mandate the development of policy and procedure manuals. A dead-line will be established by the regulatory agency to receive the manuals. This will allow both survey coordinators and surveyors adequate time to thoroughly review all applicable policy and procedures by service area prior to issuing the facility its license. Once the facility is ready to open, the State Health Planning Agency will officially notify all regulatory agencies of the facility's readiness to receive pre-opening certification. This agency will determine at this time if all conditions of the original certificate of need have been met. Finally, if the facility chooses to participate in the Medicare and Medicaid program, the appropriate applications and attachments (HCFA 1516-form) must be carefully filled out. This form is similar to the prelicensure questionnaire. All blocks must be filled in with the appropriate signature and date. Inaccurate information will slow down the certification process.

Looking Under The Carpet

The Annual Relicensure Survey is conducted by an interdisciplinary survey team usually between 90 to 120 days prior to the expiration date of the current facility license. This survey should last at least two days with all departments being throughly reviewed. At the conclusion of this comprehensive survey, an exit interview will take place... the surveyors will verbally advise the administrator of noted deficiencies. Survey results are public information and facility specific information can be obtained at the local Social Security Office, Public Assistance Office and through the licensure agency via public disclosure laws. In some states, such information can be obtained at the local library. Poor survey results will have a detrimental impact of the facility's reputation in the community.

Therefore, the Administrator should promote compliance on a continual basis and can utilize the following methods:

- Periodically review and utilize information contained in past survey reports. Surveyors will focus in on those areas.
- Monitor and evaluate contents of the Facility Utilization Review Audits conducted by PSRO.
- Quality Assurance Programs and Self Assessment Evaluation programs are available through State and National nursing home associations. The American Health Care Association (AHCA) has developed a detailed program entitled, *Quest For Quality.* The Texas Health Care Association and the Health Facilities Association of Maryland have taken the idea of AHCA's quality assurance program and developed programs reflecting their distinct state licensure requirements.
- While it may be time consuming, review a copy of HCFA-1569 (Medicare/Medicaid Nursing Facility Report). This will allow a comparison between the regulations and the facility's written policy guidelines.
- There are numerous publications that can help you stay in compliance. A valuable easy-to-use resource guide available from AHCA entitled *HEW Interpretive Guidelines and Survey Procedures* can be used to determine if the facility is in compliance with the Conditions of Participation for Skilled Nursing Facilities 20 CFR Part 405. Also, Nanex Systems Corporation, located in Sykesville, Maryland has developed a detailed publication entitled, *State and Federal Survey Guide For Nursing Home Administrators Providing Services Under The Medicare and Medicaid Program.* This handbook represents the most up-to-date and comprehensive compilation of criteria and needed documentation to pass a State and/or Federal survey for Medicare and/or Medicaid providers and suppliers.
- Consultants should be utilized to help ensure that the facility remains in compliance. These individuals can keep you informed as to proposed regulations, newly enacted regulations relating to their field of expertise.

It takes an on-going effort of the Administrator, the Department Heads and facility staff to maintain compliance to regulations. The whole is truly greater that its individual distinct parts.

A facility that implements an on-going quality assurance program and self-audit

program should not have any problems obtaining a good survey results on the Interim Survey. This survey is usually conducted 60 to 90 days following the most recent survey. This time-frame may vary between states. The purpose of this on-site visit is to validate that the prior deficiencies have been corrected in a satisfactory manner. Also a random audit of the patient charts along with monitoring daily patient activities take place to ensure minimal standards are being met by the facility. As in the annual licensure survey, the surveyors will identify deficiencies at an exit conference.

Shoot-out At The OK Corral

Murphy's Law states that often circumstances may dictate a good or bad survey day...regardless of the actual survey results. Many an Administrator will say that surveyors are subjective and the deficiencies cited depend on the temperment, purpose of the survey and personality of the surveyor. This view may be reinforced by the Administrator's view that the surveyor has to find some deficiency to justify a survey. How many survey summary reports state that the facility provides excellent care to the patient even though the nursing department has been cited for not having physician orders signed on a timely basis.

It is important to realize that the survey results can be influenced by how the Administrator interacts with the survey team. Paper deficiences will be listed on the survey report and not that good hands on patient care is provided by the staff of the facility.

In order to reduce the possibility of a lower survey score due to a poor relationship with the survey team, the following approaches should be examined:

- Do not adopt an adversarial role when communicating with the surveyor. There is no advantage in this situation. A communication barrier will reduce the flow of information between both parties. In that a surveyor is in control of the survey score, such an approach would be costly.
- If the Administrator feels uneasy around a surveyor, a key member of the Administrative staff should be invited to participate in the exit conference. This will be a positive learning experience for the staff member and will allow the administrator with a way in which to validate his/her perception of the survey process.
- Focus on guidelines. Do not be concerned about asking for clarification regarding differences in interpretation of standards and guidelines. The most common obstacle is the new or revised guideline that has been mandated without knowledge of the Administrator. While it may not be acceptable to be cited for such a deficiency, surveyors are not responsible for "official" notification to providers. Keep this in perspective and be aware of any regulatory change.
- Provide information to the Survey Team in their review process. Required manuals, files should be placed in a central location, i.e., conference room for their convenience.
- The exit conference can be a valuable experience. Take advantage of this mandated process. In order to develop a facility response to the deficiences cited, ask permission to tape the session and take detailed notes of the conversation. If it is possible, ask that a written copy of the cited deficiences be left at the facility at the end of the survey. Finally, include Department Heads in the exit interview. This will be an education experience for them.

Making The Most Out Of The Survey

The survey process is a permanent fixture and is here to stay. Make the most of it. Schedule meetings to discuss the results and obtain input from staff as to how to correct deficiencies within realistic time-frames. A plan of correction can be developed and implemented on a timely basis in response to the cited deficiencies. If the survey results are positive, make it known to the community via letter sent to family and press release. Reward staff for good survey scores. Some organizations provide bonuses, trips, staff parties. However, the administrator should not overlook intrinsic awards. Personal satisfaction, self respect and the opportunity to grow from the experience may be more valuable to certain staff members in the facility.

Finally, if the survey score is poor, disciplinary action or even termination of the responsible staff member may become a necessity. This action should take place immediately after a survey.

Through keeping current with regulations and a continual self-audit of the facility, the Administrator will enhance the success of obtaining good survey results. Open communication between Administrator and surveyor team is important in reducing misunderstanding and potential subjective citing of deficiencies. The regulatory survey and its results should become a major source of information in the facility's on-going review of its services. **CLTC**

Organization Of Policy And Procedure Manuals

1) Keep The Policy And Procedure Manual Simple
   - Prepare each policy and procedure on a individual sheet of paper.
   - In the event a policy and procedure is modified, manual can be updated without destroying the overall continuity and appearance of the contents.
   - The table of contents will be the only major modification to the manual.
2) Manual Should Be Organized To Flow Concurrently With Regulatory Manuals.
3) Cross-reference All Policy And Procedures With Federal/State/Local numeric references (i.e. prefix tags).
   - In the event there is an issue regarding non-compliance this approach may serve as immediate indicator regarding the intent to comply. This may not eliminate the surveyor's concern regarding the semantic's or an interpretation of a written policy and procedure, but it is evidence that a policy statement exists in relationship to the cited guidelines.
4) Segregate and Group Information Into Relative Inter-related Topics.
   - Examples might be Administrative policy and procedures, Patient Care policy and procedures, Emergency preparedness, Personnel (SOP), Consultant contracts-Provider service agreements. These consultant and provider service agreements should clearly define the responsibilities and services to be rendered, minimal number of hours for a specified period of time, termination clause, and method of payment. Also, evidence of current license and proof of liability coverage should be on file.

Creating the Aging Agenda: Congressional Aging Committees

by Herbert P. Weiss, MA, NHA

For most professionals in the field of aging, the federal legislative process remains a mystery.

Local newspapers, trade newsletters and journals throughout the nation attempt to demystify this on-going legislative process and continue to identify federal legislation that has been introduced, amended, failed or enacted into law that will have an impact on the elderly.

Everyday, one can find quotes or maybe detailed articles written by Congressman Edward R. Roybal (D-Cal.) or Senator John Heinz (R-Pa.) about current aging issues such as social security pension reform, quality of care in nursing homes, catastrophic insurance, the impact of early hospital discharge on the elderly due to DRG reimbursement, housing and employment of the older adult.

Congressman Roybal and Senator Heinz have become visible, outspoken advocates for the nation's elderly, in large part due to their respective chairmanship positions in the House Select Committee on Aging and the Senate Special Committee on Aging. Their select and special committees on aging work closely with standing committees in the House and Senate to develop sound legislation and aging policies (only standing committees can introduce legislation). These two committees assisted the House Committee on Energy and Commerce to force the Department of Health and Human Services to fund the Institute of Medicine's Committee on Nursing Home Regulation and provided oversight of the study.

The two Aging Committee's congressional hearings have identified and have publicized problems in the delivery of health care to the elderly, receiving local and national media attention.

The Heinz Report, entitled Nursing Home Care: The Unfinished Agenda (released in May), was critical of the care provided in nursing homes and brought back memories of the Moss Committee nursing home investigations in the early 1970s.

Even though this Special Committee investigative study is similar to the IOM's report in its recommendations, the Heinz Report is stronger in its condemnation in examining quality of care in nursing homes. The report has sparked other legislative studies on patient care provided in nursing homes. States have quickly responsed to the implied implications in the Heinz report that there is a large number of nursing homes across the nation that provide poor patient care.

The House Select Committee on Aging held a hearing on April 8 to examine the interdependence of generations and their common stake in programs for both the young and old. This hearing also took a critical look at a belief held by some that the elderly and young are in conflict due to recent Gramm-Rudman budget cuts for Health and Human Services Programs. At this congressional hearing, the Gerontological Society of America released its report, "The Common Stake: The Interdependence of Generations."

In both cases, the House Select Committee on Aging and the Senate Special Committee have been active to promote public dialogue on the issues of quality care in nursing homes and the effect of allocation of limited resources to the different age segments of society.

Therefore, it becomes obvious of the importance of the House Select Committee on Aging and the Special Senate Committee on Aging in setting the political agenda to develop federal legislation and policies for programs directed to the elderly.

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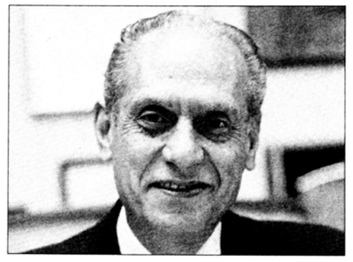
Reducing Fragmentation in Aging Policy

In the late 1950's, as congressional involvement in the area of aging increased, it became clear to Senator Pat McNamara (D-Mich.) and his senatorial colleagues that the Senate should address the special needs of the elderly. Through the efforts of Senator McNamara and others, the Subcommittee on Problems of the Aged and Aging was established in 1959. This subcommittee brought attention to the elderly in its brief two years of existence and created interest in the Senate to establish the Special Senate Committee on Aging through the enactment of Resolution 33 on February 13, 1961. Permanent status was granted to this special committee by the enactment of Resolution 4 on February 1, 1977.

As more monies were allocated and Congressional oversight was required for Medicare, Medicaid, and programs created by the Older Americans Act, support grew in the House of Representatives to establish its own committee that would address the needs of the elderly. The House Select Committee on Aging was created by a floor amendment offered by C.W. Bill Young (R-Fla.) to H.R. 988, the Committee Reform Amendments of 1974. Approved by a vote of 323 to 84, the amendment established this select committee as a permanent body.

There was strong support in the House for the establishment of this select committee because as in the Senate, Congressional jurisdiction over programs affecting the elderly had become fragmented among numerous committees. There were over seven standing committees in the House responsible for programs directed to the elderly. Also House members wanted their own counterpart to the established Senate Special Committee on Aging.

House Select Committee on Aging — Full Committee



Edward R. Roybal (D-Cal.), Chairman

Matthew J. Rinaldo (R-N.J.), Ranking Minority Member

Both the House Select Committee on Aging and the Senate Special Committee on Aging have principle oversight and investigative responsibility for issues pertaining to the elderly and they play an important role in creating the aging issue agenda at the federal level. These two committees have the luxury of both time and resources to examine both current and future issues that will have an impact on the elderly. Technical analysis on aging issues to be studied are often obtained from the General Accounting Office (GAO), the Library of Congress, and the Office of Technological Assessment (OTA) to supplement data obtained through congressional hearings and committee staff investigations. Two types of committee reports on various issues in aging are available upon request from both the committees on aging; one with testimony, the other by subject.

Congressman and Senators are allowed to serve on only two major standing committees in their respective house. However, congressional rules allow them to serve on the special and select committee on aging because these committees have no legislative authority.

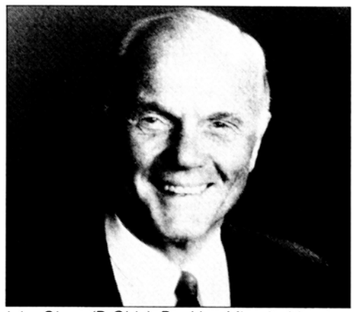
Membership appointment to the House Select Committee on Aging and the Senate Special Committee is considered by some as a "political plum" because these two committees are considered noncontroversial and the committee members are highly visible to the large number of elderly voters in their legislative districts.

The large membership on these two committees, 65 members of the House Select Committee on Aging and 19 members on the Senate Special Committee on Aging, provide a potential source of co-sponsors for bills and support of introduced legislation.

The chairmen of these two committees on aging also hold important positions on standing committees that add to the influence of their respective committees. Congressman Roybal can discuss the positive merits of a bill that he and the committee members of the House Select Committee on Aging favors because of his position on the House Appropriations Committee. Senator Heinz can lobby for legislation of interest to the Senate Special Committee on Aging because of his position on the Senate Finance Committee.

Senate Special Committee on Aging

John H. Heinz (R-Pa.), Chairman



John Glenn (D-Ohio), Ranking Minority Member

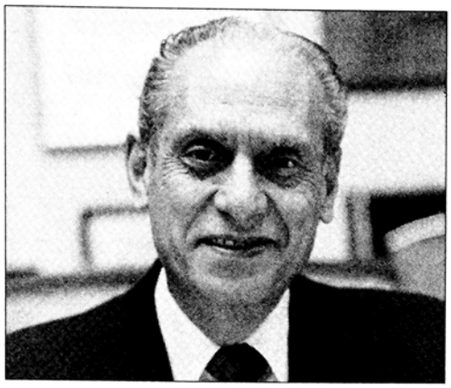
The House Committee

The House Select Committee on Aging has 65 members. Even though one-third of its membership is Republican, issues are most often addressed in a bipartisan fashion.

Chairman Roybal and ranking minority member Matthew J. Rinaldo (R-N.J.) determine which aging issues will be addressed by the full committee and are assisted by 20 staff members.

An additional 23 staff members are assigned to the four chairmen and ranking minority members of the following

House Select Committee on Aging — Subcommittees/ Retirement Income and Employment



Edward R. Roybal (D-Cal.), Chairman

Tom Tauke (R-Iowa), Ranking Minority Member

subcommittees to study issues in their respective areas of aging:

- Chairman Edward R. Roybal and ranking minority member Thomas J. Tauke (R-Iowa) of the Retirement Income and Employment Subcommittee;
- Chairman Claude Pepper (D-Fla.) and ranking minority member Ralph Regula (R-Ohio) of the Health and Long-Term Care Subcommittee;
- Chairman Don Bonker (D-Wash.) and ranking minority member John Hammerschmidt (R-Ark.) of the Housing and Consumer Interests Subcommittee;
- Chairman Mario Biaggi (D-N.Y.) and ranking minority member Olympia J. Snowe (R-Maine) of Human Services Subcommittee.

Subcommittee chairman and their staff have the flexibility to choose what aging issues will be studied within their area of jurisdiction. This flexibility allows the House Select Committee on Aging to cover more issues and provides the subcommittee chairman with an active role in the activities of the full committee.

In order to gather information and investigate identified problems, the full committee and four subcommittees have conducted 29 national hearings, 16 field hearings, and one joint hearing with the Task Force on Social Security and Women during the first half of the 99th Congress. These congressional hearings have examined a multitude of topics including pension plan termination; Alzheimer's disease; elder abuse; potential intergenerational conflict due to decreased federal monies; the fragmentation of elderly housing policies; the reauthorization of the Older Americans Act; the impact of COLA freezes for Social Security recipients; and the potential cuts in the Medicare and Medicaid programs.

Chairmanship of the House Select Committee on Aging has rested mostly on the shoulders of Congressman Pepper (D-Fla.) and Congressman Roybal (D-Cal.). In 1974, William J. Randall (D-Mo.) was appointed to serve as the first chairman of the select committee. In 1976, Congressman Pepper (D-Fla.) became the second chairman of the select committee and has spent his entire political career representing his elderly constituents with zeal, gaining bipartisan respect in both houses of Congress.

During his tenure as second chairman of this select committee, from 1976 to 1983, issues surrounding mandatory retirement, transportation, and the stability of the Social Security system were targeted by him as priority issues. He brought the problem of elder abuse to public consciousness through congressional hearings and coined the term "elder abuse." Even though Congressman Pepper retains a subcommittee chairmanship, he gave up chairmanship of the select committee in 1983 to become Chairman of the House Rules Committee. This move would allow him to protect the viability of the Social Security Program and ultimately, the social security checks of the elderly recipients.

In 1983, during the 98th Congress, Congressman Roybal took over the Chairmanship of the select committee from Congressman Pepper. He was a good choice to become Chairman due to his interest in aging and his longevity on the committee. Congressman Roybal's interest in the elderly and health care began over 40 years ago when he served as President Pro Tem and Chairman of the Health and Welfare Committee of the Los Angeles City Council. He and his subcommittee chairmen continue their mission to study problems of the elderly and encourage coordination between the public and private sector to develop programs that encourage positive aging.

Senate Committee on Aging

From the ashes of the Subcommittee on Problems of the Aged and Aging, arose the Senate Special Committee on Aging that has for more than a quarter of a century served as the watch dog and protector of the nation's elderly. Its visibility and the active role it took on promoting debate on aging issues added support in 1974 to Congressman C.W. Bill Young and his colleagues in the House who wanted to establish their own committee on aging.

From a modest budget of $85,000 allocated by Senator Hill, Chairman of the Labor and Public Welfare Committee in 1959, the special committee's budget increased to over $1 million in 1986. Its small staff, who assisted five senators at the establishment of the committee, has increased to 34 staff members who provide the technical expertise on aging to a committee membership of 19 senators. As in the House Select Committee on Aging, the 10 Republican senators and nine Democratic senators approach most aging issues in a bi-partisan manner.

House Select Committee on Aging — Subcommittees/ Health and Long-Term Care

Claude Pepper (D-Fla.), Chairman

Ralph Regula (R-Ohio), Ranking Minority Member

Due to the small size of the Senate and its tradition against having subcommittees, the organizational structure of this committee does not have subcommittees. Chairman Heinz and ranking minority member John Glenn (D-Ohio) determine the direction and issues that will be examined by the staff members and investigators of the committee.

Six chairmen have directed the activities of the Special Committee since its inception. Senator Pat McNamara, Michigan's senior Democratic senator and ex-pipe fitter who served on the Committee on Labor and Public Welfare, became the Special Committee on Aging's first chairman. Other prominent senators would follow over the years: George Smathers from Florida; Harrison Williams from New Jersey; Frank Church from Idaho; Lawton Chiles from Florida; and John Heinz from Pennsylvania who became the current chairman in January 1981.

Once Senator Heinz was elected to the Senate in 1977, he brought his knowledge, expertise and insight into the problems of the elderly that he had gained while serving on the House Select Committee on Aging as a Congressman. This interest and expertise in the area of aging was recognized by *50 Plus* magazine in which he was named one of the nation's top 10 effective legislators in 1983.

Over the years, the Senate Committee on Aging has taken on an advocacy role for today's elderly with a realization that the future elderly must also be protected.

During the 99th Congress, numerous national hearings and field hearings have been held across the county to examine such issues as: unnecessary surgery; the impact of quality of care under the Medicare DRG reimbursement system; the impact of PPS on the delivery of care; the impact of an increasing elderly population on society. Special investigators have examined the use of pacemakers, abuse in Medicare, End Stage Renal Disease, kidney transplant program and the quality of care provided in nursing homes.

Also, the Special Committee staff directs much energy and effort in the annual development and distribution of a multi-volume publication entitled *Developments of Aging*. This publication is considered by some to be the bible for those professionals in the aging field.

The Special Committee on Aging has taken an active role in the Senate of highlighting issues and has actively assisted various standing committees of the Senate to enact legislation.

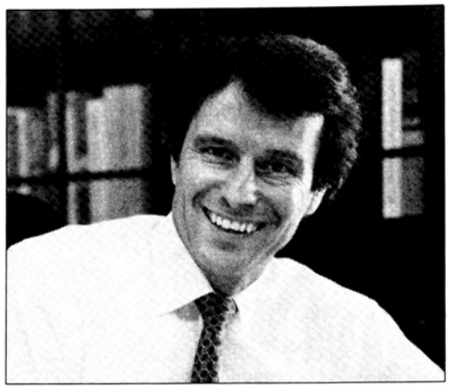
In Conclusion

Even when the legislative maneuvering took place in 1974 to collect votes to establish the Select House Committee on Aging, there were Congressmen like John Brademas (D-Ind.) and others who asserted that the proposed responsibilities of the new committee were already being fulfilled by existing House subcommittees. A concern, similar to Congressman Bradema's concern came to the surface in 1977 in the Senate in which a reorganizational proposal would have abolished the Special Committee on Aging and aging issues would have been assigned to the Committee of Human Resources.

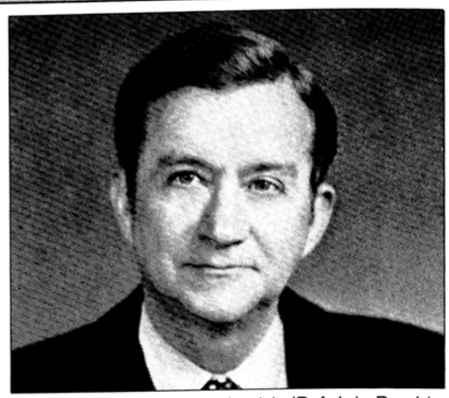
And in 1986, again the fiscal impact of Gramm-Rudman has brought jurisdictional turf issues back to the surface. However, both the Select and Special Committee on Aging have permanent status and only a vote from the floor of the House or Senate could abolish their statuatory permanance. This action seems highly improbable due to their popularity in both Houses.

With a growing elderly population, the select and special committee on aging provide a focal point of advocacy for the elderly in both Houses and direct public dialogue on aging issues...to create the aging agenda. **CLTC**

House Select Committee on Aging — Subcommittees/ Housing and Consumer Interests

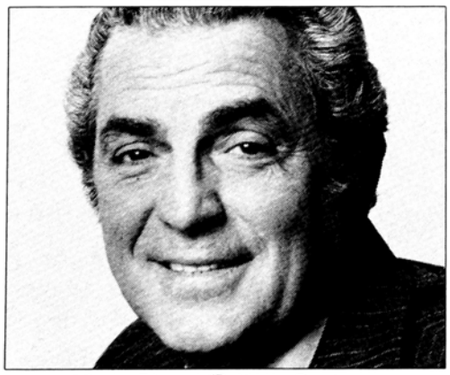


Don Bonker (D-Wash.), Chairman



John Paul Hammerschmidt (R-Ark.), Ranking Minority Member

House Select Committee on Aging — Subcommittees/ Human Services



Mario Biaggi (D-N.Y.), Chairman

Olympia Snowe (R-Maine), Ranking Minority Member

EDITOR'S NOTE: This article was prepared with the assistance of Stephen R. McConnell, Staff Director of the Senate Special Committee on Aging; Fernando Torres Gil, Staff Director, House Select Subcommittee on Aging; and Kathleen G. Cravedi, majority staff director for long-term care of the House Subcommittee.

The Heinz Report: Actions and Reactions

Report surprised most everyone, including government officials.

A string of phone calls from individuals concerned with quality of care in nursing homes in 1983 set in motion a series of events that led to Senator John Heinz releasing what amounted to a political bombshell in the spring of this year.

Due to these calls, Chairman John Heinz (R-PA) of the Senate Special Committee on Aging and his investigative staff became concerned that nursing homes were not delivering the quality of care they were paid to deliver. Federal, state and private spending for nursing home care added up to more than $30 billion annually.

From 1984-86, Senate Select Committee on Aging investigators, with the assistance of the Government Accounting Office (GAO) and the Inspector General's Office (IGO) of Health and Human Services, (HHS), started to compile information and data concerning the care provided by nursing homes.

Committee staff analyzed federal data depicting the quality of care in certified nursing homes, and selected a nonrandom sample of these facilities for in-depth examination of hard copy inspection reports for a period covering five years. Published research and court filings were reviewed as well as internal documents from both state and federal government agencies.

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Information was also obtained through hearings. In 1985, four hearings were held in different parts of the country on the prospective payment system for hospitals and its impact on care.

Senate staff became aware of how the prospective payment system was impacting on the delivery of long-term care services to older adults. It became clear from these hearings that nursing homes were having to care for sicker patients and some states had an inadequate supply of skilled nursing facility beds to admit such heavy care patients. A few states were shown to limit Medicaid expenditures by imposing a moratorium on new nursing home bed construction. Also, a former nursing home admissions director and state ombudsman discussed the problem of the discrimination of Medicaid-eligible Medicare beneficiaries in finding available beds. The Select committee staff also found that the prospective payment system brought patients who needed sophisticated and technical care to hundreds of nursing homes that chronically and repeatedly failed to meet minimal federal standards of care that were developed in the 1970's, before heavy care patients began to be admitted to nursing homes.

Paul R. Willging, Ph.D., executive vice-president of the American Health Care Association (AHCA) waited to board his flight at the Salt Lake City airport to go to Reno. As he passed time, Dr. Willging watched in surprise the lead story on the 6:00 p.m. NBC Evening News on a television in the airport lobby. This news program brought the Heinz report to millions of Americans across the nation, stating that nursing homes were little more than warehouses where the old were placed to die.

Sheldon L. Goldberg, executive-vice president of the American Association of Homes for the Aging (AAHA) was also visiting the west coast. On the morning of May 21, 1985, he heard about the Heinz report on Good Morning America.

The staff of both nursing home associations were not provided with the opportunity for advanced discussion with Senate Special Committee staff responsible for the investigation and did not receive early draft copies of the Heinz report. Copies of testimony of the witnesses were not provided to them at the May 21, 1986 hearing. However, copies were made available to press.

Officials from the Health Care Financing Administration (HCFA) were not provided notice as to what the hearing would focus on. Secretary Otis Bowen of the Health and Human Services Administration declined to attend and sent Dr. William L. Roper, Administrator of HCFA to represent the Agency. A copy of the Heinz report was made available to Roper one hour before the hearing.

At the hearing, a report "Nursing Home Care: The Unfinished Agenda," known informally as the Heinz report, was released. The report revealed that in 1984, almost a third of the country's skilled nursing facilities failed to meet at least one basic federal standard to assure the health and safety of the residents. Nearly a thousand of the 8,852 homes failed to meet three or more such standards, and a substantial number were considered to be chronic offenders.

It was also noted that between 1982 and 1984, violations for failure to provide physician supervision of patients jumped 75 percent; subjection of patients to mental, physical or chemical (drug) abuse rose 75 percent; and failure to provide 24-hour nursing care went up 61 percent.

Chairman Heinz compared the substandard nursing homes to "19th century asylums" and told the committee "we've allowed bed, board, and abuse to replace the medical and rehabilitative care the law demands."

A videotape showing nursing home residents with severe bedsores from a California nursing home was used to show the Senate Select Committee members the severity of problems in nursing homes.

Dr. Roper of HCFA stated in his testimony that the quality of care in nursing homes had improved in the last 10 years since the original survey and monitoring system was first implemented for the Medicare and Medicaid program. He told the senators attending the hearings that "HCFA was responsible for monitoring the care in almost 50,000 health care facilities in the United States, of which about 20,000 are nursing homes providing care to more than 1.75 million Medicare and Medicaid recipients." With so many facilities, Dr. Roper admitted that it would be inevitable that isolated incidences of substandard care would occur. And when that happened, HCFA would react immediately.

The Heinz report recommended that federal legislation and improved regulation were needed to strengthen the nursing home inspection system; that states needed to respond better to consumer complaints; to implement a full array of "intermediate sanction" penalties and receivership authority; elevate the nursing home resident's rights to a condition of participation; strengthen the Long Term Care Ombudsman program; expand the hospital swing bed program; to issue instructions to states and regional offices to enforce existing laws such as penalties for repeat offenders; define minimum items and services to be provided under the basic daily Medicaid rate; prohibit Medicaid discrimination; and require Bowen to report within two years to Congress with a recommendation for a reimbursement system for Medicaid that is based on patient mix and level of care.

Industry Responds

On May 21, 1986, AAHA sent out a press release to respond to the Heinz report. Goldberg stated that his association supported many of the recommendations of the report and that "the American public should not be given the erroneous impression that *all* nursing homes are deficient.

Goldberg laid blame for substandard care in some nursing homes on the federal law [CFR Sec. 1902 (a)(13)(A) enacted in 1983, which gave states more leeway in setting "reasonable and adequate" reimbursement rates for nursing homes. He said that too many states have set rates that "fail to account for the intensity of skilled nursing patients' care needs."

Finally, Goldberg made it clear that unsatisfactory care in many nursing homes were the result of turnover in nursing home ownership, which in some states is up to 30 percent. This turnover has been concentrated in the "for-profit" sector. not-for-profit homes, he pointed out, were run by voluntary boards of trustees who had relatives in the facilities and are personally committed to having high standards.

On May 27, 1986, Dr. Willging from AHCA sent correspondence to Heinz asking him how he could characterize the existing survey and certification system as inadequate in evaluating the quality of care in nursing homes while at the same time using the data from the system to "castigate an entire industry." He also provided the chairman with examples of the flawed data that supported the allegations in the report that nursing homes were providing poor care. Willging concluded by supporting many of the report's recommendations, including improved intermediate sanction regulations, patient oriented survey systems, a strengthened ombudsman program, and a fair and equitable reimbursement system.

Willging tried to lessen the negative impact of the Heinz report by stating the position of AHCA through an article in *USA Today.*

On May 29, 1986, Dr. Willging tried to lessen the negative impact of the Heinz report by stating the position of the AHCA through an article in *USA Today.* He stated that the Heinz report was statistically flawed and that nursing homes must comply with hundreds of federal and state requirements.

Dr. Willging further stated that key requirements, called "conditions of participation," were developed to assure that nursing homes meet certain defined standards. In recent years, however, the "conditions" had been criticized for their emphasis on paperwork and their failure to assess the care actually provided to the patient. He added that because of the survey's emphasis on paperwork, a citation noting non-compliance with the 24-hour nursing requirement might be viewed as a nurse not on duty and not a paper work error. Statistics cited in the Heinz report reflected this type of deficiency.

Dr. Willging also noted that the nursing home industry had come a long way and inadequate reimbursement was one major cause of substandard nursing home care.

On June 26, 1986, Heinz responded to Dr. Willging's correspondence stating that the methodology utilized by his investigative staff was not flawed. He stated, "to the contrary, nursing home inspection reported contains more than ample evidence to show that these citations do, indeed, involve grossly deficient patient care — not just paperwork errors." Heinz assured Dr. Willging that the "numerical findings were based upon careful and conservative analysis of data that the HCFA's Medicare/Medicaid Automated Certification System (MMACS) provided to the committee by the General Accounting Office (GAO)."

And Heinz described how a GAO survey of experts in nursing home care strongly affirmed the appropriateness of the 25 requirements chosen by the committee staff for analysis. Had the Senate Committee investigators chosen to focus on all 541 requirements for federal certification, it was his opinion that 99 percent of the 8,852 skilled nursing facilities in the sample were not fully in compliance in 1984.

Other Reactions

HCFA developed a preliminary reaction to the Heinz report after the hearing. Its reaction supported many of the concerns of the nursing home industry including their charge that the methology utilized in the report was flawed.

Also, both AHCA and HCFA requested a list of the names of the facilities that were described in the case studies as providing substandard care in the Heinz report. Senate Committee investigators due to legal issues did not respond to their request.

HCFA staff in the preliminary reaction pointed out that even though nursing homes had deficiencies at the time of the survey, the Heinz report does not take into account the fact that many facilities correct the deficiencies within days after the survey.

It was the opinion of HCFA staff that the Heinz report exaggerated the nature of many deficiencies. For example, deficiencies in "24-hour nursing service" does not of itself mean there are no nurses to care for patients. It might mean that the surveyor has cited the facility for not having enough nurses due to heavy care patients and the facility is provided reasonable time to hire additional nurses.

The Heinz report also did not recognize that surveyors who find problems that are serious and endanger the patient's life are instructed to either have the facility im-

(continued on page 70)

Heinz *(continued from page 22)*

mediately resolve the problem or begin termination action.

Finally, HCFA staff felt that the Senate Special Committee staff used obsolete data from 1982-1984. Due to HCFA data that is current, it would be difficult if near impossible to replicate Heinz report methodology. HCFA data indicated that no skilled nursing facilities were deficient in three conditions as found through the Heinz report methodology.

On June 26, 1986, the Special Senate Committee on Aging released the Heinz report at a nationally publicized hearing. Newspapers and television networks across the nation briefly carried the bleak news that nursing homes were not providing quality care.

Memories of national Congressional hearings held by Senator Frank E. Moss (D-Utah) from 1969 to 1973 came to the minds of the public who had read the newspaper coverage of the hearings from those years. The Heinz report could have been a carbon copy of the well-publicized reports from those hearings *Nursing Home Care in the United States: Failure in Public Policy*. However, only if one did not examine the dates on the two reports.

Being true to the function of the Senate Special Committee on Aging, nursing home care made the public agenda during that warm day in June. Even though a negative attack was made from data called flawed by both federal government officials and leadership of the two nursing home associations, the hearing created the awareness of the importance of quality assurance in nursing homes to Congress and the nursing home industry.

> Newspapers and television across the nation briefly carried the bleak news that nursing homes were not providing quality care.

And Congress is aware of the need for improving quality in nursing homes. Five major bills have been introduced during the 99th Congress to promote quality of care in the nation's nursing homes; HR 4485 by Claude Pepper (D-FL); HR 4279 by Olympia Snowe; S 2119 by William S. Cohen (R-Maine); HR 5450 by John D. Dingell (D-Michigan); and S 2604 by John Heinz (R-PA).

Paul Kerschner, Ph.D., president of the National Foundation for Long Term Care, in a national publication, has called for the development and implementation of a national program for accreditation and compliance for nursing homes. Such a program would be overseen by a panel of professionals from AHCA, AAHA, consumer groups, the American College of Health Care Administrators (ACHCA), and the Joint Commission on Accreditation of Hospitals (JCAH).

Under the leadership of Mark Finkelstein, president of the American College of Health Care Administrators, he calls his membership to proactively work with media's misguided views of care in nursing homes in the area of quality of care. Finkelstein will use his position as president to become a vocal advocate for the nation's elderly.

In conclusion, the Heinz report sent a chilling message to those in the nursing home industry, "if you don't keep your house clean, the federal government will do it for you." **CLTC**

STOCKWATCH

FIGURES CURRENT
AS OF OCTOBER 17, 1986.

SELECTED PUBLICLY TRADED NURSING HOME COMPANIES(1)

	Market Value of Company (2)	Number of Nursing Home Beds	Price Range of Common Stock During Last 12 Mos.	Price of Common Stock as of 6/19/86
	(000)			
American Medical Services Inc.	$ 83,533	3,613	$22.00-$13.38	$18.63
Beverly Enterprises	945,472	115,003	22.75-14.13	16.00
Care Enterprises	43,679	12,673	8.38-3.83	3.88
Forum Group, Inc.	167,735	4,539	16.75-7.88	8.38
Geriatric & Medical Centers, Inc.	71,990	4,000	8.88-5.68	7.63
Greenery Rehabilitation Group, Inc.	105,300	892	19.00- 9.13	12.00
Manor Care	729,142	18,377	25.50-15.75	18.25
National Health Corporation	128,986	6,081	22.75-15.75	22.00
National Medical Enterprises, Inc.	1,877,122	46,516	25.68-19.25	23.88
Owens-Illinois	2,428,766	15,000	45.75-25.75	40.30
Southmark	358,229	19,000	14.38-8.38	9.13
Summit Health Ltd.	171,875	7,089	11.50-5.13	5.50
Varicare, Inc.	28,000	1,922	8.25-6.50	7.25

(1) Some of the above companies operate in additional segments of the health care industry as well as in other businesses outside the health care industry. This should be taken into consideration in reviewing the above information. Also, all price and earnings data has been adjusted for stock splits through October 17, 1986.

(2) The market value equals the number of shares outstanding multiplied by the current price of the common stock.

Inside Washington

HCFA Defends Its Record to Ensure Quality of Care

Reacts strongly to Heinz report.

by Herbert P. Weiss

At a Senate Special Committee on Aging hearing held on May 21, 1986 the Heinz report was released. The public dialogue created by this scathing report, officially entitled "Nursing Home Care: The Unfinished Agenda," painted a very bleak picture for the elderly who might require nursing home care. It also sent the message to the American public that more federal and state effort was needed to improve the quality of the nation's nursing home care.

The Heinz report implied that the federal and state quality assurance efforts had not been effective in improving the overall quality of care in nursing homes. The public dialogue and controversy created from this report will ensure that quality of care will become an even more important political issue to be confronted by the 100th Congress and the Health Care Financing Administration (HCFA).

William L. Roper, M.D., recently appointed administrator of HCFA, attended the May 21st hearing of the Senate Special Committee on Aging representing Secretary Otis Bowen of the Department of Health and Human Services (HHS).

Herbert P. Weiss, MA, NHA, is Editor of Aging Network News. He is a doctoral student in Policy Sciences Department at the University of Maryland at Baltimore County with a major in aging. He is licensed as a nursing home administrator in the District of Columbia.

Dr. Roper had expected the members of the Senate Special Committee to ask his agency to quickly move forward in the implementation of the Institute of Medicine's (IOM) Committee on Nursing Home Regulations recommendations. It did not occur to him that this hearing would become a national forum to publicize alleged poor quality of care rendered in thousands of nursing homes across the country.

With the up-coming Senate hearing looming and only two weeks in his position as administrator of HCFA, Dr. Roper's staff had limited their briefing to such topics as the Patient Care Services (PaCS) Tool known as the new long-term care survey; the revised termination procedures from the Medicare and Medicaid program; intermediate sanctions; and the IOM report. Along with this staff briefing, Dr. Roper brought to the hearing his expertise and knowledge about the delivery of nursing home care from his previous professional experience as a physician and health officer of the Jefferson County Health Department and assistant state health officer in Alabama. He had personally confronted the issue of nursing home care through his involvement of placing a parent in a facility.

At the Senate hearing, Chairman John Heinz (R-Pa) of the Senate Special Committee on Aging, spoke of his committee's two-year investigation and concern about the care provided by nursing homes. Chairman Heinz stated, "What we found is that thousands of our oldest citizens live in nursing homes which more closely resemble 19th century asylums than modern health care facilities." This powerfully and emotionally charged quote found its way into thousands of newspapers and publications across the country. Electronic media brought the quality of nursing home care issue identified by the Heinz report into the living rooms of millions of Americans.

It seemed to some individuals attending the hearing that Dr. Roper was caught off guard by the direction in which the Senate hearing had taken due to the focus and intensity of the questions directed to him by the senators. They bombarded him with questions and wanted to know why abuse and neglect were still prevalent in the nursing home industry and how HCFA could allow chronic offenders to continue to deliver poor care to America's elderly.

In his prepared written testimony, Dr. Roper described HCFA's accelerated termination procedures, intermediate sanction rules, the PaCS nursing home survey and the "look behind" surveys initiated by HCFA regional offices. Dr. Roper made it clear to those senators present at the hearing that "with so many facilities providing care to so many persons, it is inevitable that isolated incidences of substandard care will occur." He stated that when those facilities were found, they would be terminated from the Medicare and Medicaid program…and he tried to respond to the senator's concerns of poor care delivered in nursing homes.

To Chairman Heinz, it was clear that the federal, state, and the private payors were not getting the quality of care that $30 billion annually might purchase. To the older adult and the American public, the possibility of being admitted to a nursing home became a potentially frightful experience to be feared. The leadership of the American Health Care Association, the American Association of Homes for the Aging and the American College of Health Care Administrators were concerned about the Senate Special Committee on Aging's staff conclusion that a high percentage of nursing homes were providing substandard care and the potential

negative impact on the public perception of the nursing home industry. And to some nursing home administrators across the country, the Heinz report represented another political rationalization "to bash nursing homes" for national publicity.

HCFA's Reaction

The Heinz report surprised most everyone in the long-term care delivery system, including HCFA officials. After the emotional and somewhat sensational hearing, Dr. Roper conferred with some of his professional staff to determine if he had been provided all the information pertaining to the regulation of quality of care in nursing homes. His staff was just as surprised about the topics discussed at the Senate hearing.

Dr. Roper directed his staff to provide him with a prepared internal monthly report, covering such topics, as to the number of providers in the Medicaid and Medicare program, the number of terminations from each program and comparative data concerning cited deficiencies taken from state and federal data. At any moment in time, he would know about HCFA's survey and certification process.

In order to defuse the potential damage of the Heinz report at the state level, on June 17, 1986, Dr. Roper sent correspondence to the governors of every state. He asked the governors to assist him in ensuring the nation's ill and elderly receive quality of care and to assure the health, safety and rights of residents in nursing homes. He pointed out that state agency personnel perform annual surveys to assess the extent that nursing homes are in compliance with federal regulatory requirements...and if deficiencies were found, the state agency would determine the acceptability of a plan of correction. If very serious compliance problems were found, the state agency would recommend that the facility be terminated from both the Medicare and Medicaid program. The letter concluded by describing the PaCS nursing home survey and the importance of and rationale of unannounced nursing home surveys.

Dr. Roper also directed Lou Hayes, associate administrator for operations to notify regional administrators that quality of care in nursing homes was to be considered a priority of HCFA. Quality of care would become the new "buzz word" for 1986 in the corridors of the HCFA building complex located in Baltimore, MD.

After having time to review the Heinz report, HCFA staff disputed its negative conclusion, especially Senator Heinz's statement that nursing homes resembled 19th century asylums. One high level HCFA staffer felt that the Heinz report was a "disservice to the American public and blew problems in nursing homes out of proportion."

Those HCFA professionals within the agency assigned to determine the validity of the Heinz report were handicapped by the Senate Special Committee on Aging's investigative staff who would not discuss more fully the data, methodology utilized or issues that were analyzed.

> The HCFA response calls the Heinz report's conclusion that one-third of certified nursing homes are substandard, "at best, indefensible, subjective judgements."

HCFA staff stated in their official response to the Heinz report that the Senate Committee's report conclusions were drawn from data independently obtained from the HCFA database, the Medicare/Medicaid Automated Certification System (MMACS). The information and data presented in the report was never discussed with HCFA program management and third party sources (i.e., Government Accounting Office and the Inspector General of Health and Human Services) were contacted to access the data system. Consequently, the HCFA response concluded that the "information presented [in the Heinz report] is distorted, misleading, and at best, outdated 2 to 4 years, contributing to some of the fundamental flaws in the analyses and conclusions."

Also, due to legality issues, the names of the facilities cited in the Heinz report's four case studies (that took up one-third or 16 pages of the report) would not be released by Senate investigators to either staff of the American Health Care Association or HCFA for their examination. Thomas G. Morford, Director of the Health Standards and Quality Bureau, stated that this refusal to release the names of the facilities hindered any enforcement or corrective action that could be directed to those facilities and subjected the cited case studies to some "skepticism."

After the release of the Heinz report, it became clear to high level HCFA officials that an analysis of report was in order. Mark Moran, Acting Division Director of Data and Program Analysis; Mark Bernsohn, Senior Program Analyst; and a Junior Program Analyst worked on the HCFA data analysis. They did not know the methods utilized by the Senate Committee investigators to collect and analyze the data and were unable to replicate the Senate Special Committee on Aging's data tabulations. However, based on their knowledge of the HCFA certification process and utilizing current data from the MMACS, HCFA's internal analysis of data was completed by the third week of June 1986 with a preliminary draft reviewed by staff during the first week of July.

The Response

After numerous revisions and editings by Thomas G. Morford and Sharon Harris, chief of the survey and certification process and other professional staff, the HCFA response took its current form. After four levels of review Dr. Roper accepted the HCFA response in early August 1986. The HCFA response was sent to all HCFA regional offices to enable staff to respond to Congressmen's concerns about nursing home care located in their Congressional jurisdiction. A copy was forwarded to the office of Secretary Bowen. Copies of the HCFA response were delivered to key congressmen including the staff of the Senate Special Committee on Aging for their review and response.

In the strongly worded response, HCFA stated that it disagreed with the Heinz report's conclusions "that many nursing homes are egregiously substandard" and strenuously objected to the report's "sensationalistic tone."

The HCFA response calls the Heinz report's conclusion that one-third of certified nursing homes are substandard, "at best, indefensible, subjective judgements."

The Heinz report's conclusion that 582 (7 percent) of the nation's 8,852 SNFs were found "chronically deficient SNFs that were found in violation of at least three critical health and safety conditions in at least three of the last four" was disputed through HCFA's analysis. Current data analyzed by HCFA staff indicated that "there are no SNFs deficient in these three conditions."

HCFA questioned the Heinz report conclusions that in 1984, 3,036 (34 percent) of certified SNFs failed to comply with "the most essential" of the many federal health, safety, and quality standards, and that 100 (11 percent) of these SNFs were cited for violating three or more "critical minimum standards."

Even though HCFA could not respond to the Senate Committee's allegations or statistics directly due to data base differences and age of data, (the Heinz report

HCFA *(continued from page 20)*

non-compliance or degree of compliance of related standards can be determined as to whether pertinent conditions have been met or not met. The HCFA response notes that "there could be 1,000 cited deficiencies in what the [Senate] committee considered a critical element. However, the majority of those citations may be for very minor infractions which a well-trained surveyor would cite but which would in no way affect the compliance status of the related standard or condition."

> Consumer groups and nursing home representatives were not contacted who might have stated positive comments about the nursing home regulatory process.

Final Observations

Finally, the HCFA response makes a few more observations. Consumer groups and nursing home industry representatives were not contacted who might have stated positive comments about the nursing home regulatory process. Existing enforcement methods such as fines, state receivership, and other civil and criminal penalties were not mentioned...and recent HCFA and state efforts through the new termination procedures, "Look-Behind" procedures, and PaCS to "aggressively attack" poor quality of care were not mentioned by the Heinz report. Also, in the last two years, the MMACS system has been the focus of HCFA's staff attention in order to improve the timeli-

> The report's intent was to place the quality of nursing homes issue firmly on the political agenda of the 100th Congress.

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Concord *(continued from page 36)*

revenues and lose sight of your original goals."

While Concord's corporate offices are located in Nashville, Severino and the operations staff are based in Delaware.

"It is an arrangement we grew comfortable with with HGI and it gives us two solid bases of operation in the part of the country we are most interested in — the East," said Sloan. "Nashville is a very important financial center for health care, while Wilmington is close to the facilities we have acquired and in an area where we will be acquiring more."

> "Than danger is you can get caught up in revenues and lose sight of your original goals," said Sloan.

While the home office must set forth certain guidelines and parameters, "it is the administrator who determines the performance and standing in the community of his or her facility. They are responsible for two things — delivering the care and running a multi-million business. In that sense they have to be included in a managerial sense within the company," said Sloan.

"Our philosophy is to develop realistic goals and create the environment to reach those goals," said Severino. "I have seen unrealistic goals frustrate and drive away quality people. We don't want that to happen."

Maximizing the performance of personnel goes back to establishing manageable growth goals, said Sloan. "When you are growing too rapidly what often happens is that when you have gotten to about 80 percent of where you want to be with one acquisition, you have to pull out the team to go on to the next project. We will try to reach 100 percent of our goals one plateau before going on to the next."

Concord was founded initially by raising $500,000 from a group of individual investors.

"That gave us the resources to put the original team together and then explore a number of larger venture capitl firms. That exploration led to an intial funding of $3.75 million by Citicorp Investment Management and Paul Nazem and Co.," said Sloan. "They are excellent partners that will continue with us as we grow." ***CLTC***

HCFA *(continued from page 118)*

ness of data input and to increase the accuracy of the information in the data base and the effectiveness of the system to be utilized as a quality assurance monitoring tool.

> The HCFA response made it clear that the Heinz report failed to mention whether any of the cited deficiencies were corrected or if the facilities had an acceptable plan of correction prior to certification.

In summary, a reality of politics is that one will strive to prove any point that they might wish to publicly make by the data utilized, interpretation of data, layout of data, the timing of its release and strength of delivery. Dialogue between the Senate Committee on Aging and the Administration (HCFA) has proven this point. Both parties have placed their data and conclusions before the American public...and their estimates concerning the number of chronically deficient nursing homes providing poor care are different.

The Heinz report shook up the American public and made the nursing home a more frightful place to go in old age... However, the reports intent was to place the quality of nursing home care issue firmly on the political agenda of the 100th Congress.

The HCFA response may not blunt the public fears created by the Heinz report, but it was written to respond to allegations that the survey and certification process does not work and to defend its record of protecting the public and assuring that quality of care is delivered in 20,000 nursing homes across the nation.

Everyone will agree that the underlying moral to this political drama that has unfolded in the nation's capital is that whatever percentage cited, in either the Heinz report or the HCFA response, one bad nursing home is one too many. Statistics either inflated or deflated represent human beings. ***CLTC***

Inside Washington

Covering the Cost of Long-term Care: Searching for Answers

Government, private studies seek options in private sector coverage.

by Herbert P. Weiss

In February 1986, President Reagan in his State of the Union Address placed the issue of catastrophic long-term care and its impact on the elderly on his Administration's agenda when he called for a major initiative on "...how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."

During his speech, President Reagan directed Secretary Otis Bowen, M.D., Secretary of the Department of Health and Human Services to provide him with recommendations as to how to provide affordable insurance to protect the life savings of the elderly which would be threatened by catastrophic illness. Secretary Bowen named James Balog, Chairman of the Private/Public Sector Advisory Committee on Catastrophic Illness and appointed a 13-member committee consisting of consumers, employers, insurers, financial experts, medical professionals and health providers.

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Through six public forums held throughout the country, hundreds of organizations and individuals provided testimony on catastrophic illness to the committee and its four staff members.

In August, this Blue Ribbon Committee presented its recommendations to Secretary Bowen. In the area of catastrophic long-term health care expenses, the report noted the following options deserved careful consideration: educating the public about long-term care protection with state and local governments taking a greater role in this public education; encouraging the development of private insurance policies for long-term care in skilled and intermediate care facilities; promoting tax-preferential IRA and other savings arrangements to stimulate purchase of long-term care insurance; improving data on cost and utilization for long-term care services; encouraging practical research and demonstration projects; removing legislative barriers to employers for providing long-term care insurance; and clarifying the appropriate scope of "skilled nursing services" and "home health services" under Medicare to include a broader range of nursing and other health services?

The findings of this report, supporting private sector long-term care initiatives with no recommendation for massive changes in the current way in which long-term care is financed, was presented by Secretary Bowen to President Reagan. Due to reported internal disagreements on what Secretary Bowen's final recommendations will be to the President, it is not clear whether he will discuss the issue of catastrophic financing during his 1987 State of the Union Address.

Congressional Initiatives

Congress has been active in exploring ways to finance costly catastrophic long-term care. The U.S. House Select Committee on Aging held a hearing on "America's Uninsured and Underinsured" in September to discuss the problems of lack of basic and catastrophic coverage for millions of Americans. When President Reagan announces his proposal on catastrophic insurance coverage, the Select Committee will hold a hearing to examine the President's catastrophic health care proposal as well as other congressional proposals.

Enacted legislation has also mandated detailed study of the issues surrounding catastrophic long-term care. In April, under a mandate of the Consolidated Omnibus Budget Reconciliations Act of 1986, the Task Force on Long-term Health Care Policies was established. Secretary Bowen selected Daniel P. Bourque, President of the National Committee for Health Care Policies to serve as chairman and appointed 18 individuals to form the ranks of the task force. A report and recommendations of the task force will be presented

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Cost *(continued from page 16)*

to Secretary Bowen and to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate by October 7, 1987.

Dennis L. Dewitt, executive director of the task force recognizes the controversy of the long-term care financing issue that will be studied by his task force. He said, "We're tip toeing into an area that has been reserved for the states [state insurance commissions] which ought to be reserved for the states." The recommendations from this task force will likely confront issues on consumer protection and identify ways in which to stimulate private sector long-term care inititives. There will be no recommendations for major federal government intervention to financing long-term care.

The 99th Congress was active in exploring ways to provide elderly with assistance in financing of long-term care services. Legislation was introduced to finance costly long-term catastrophic care through home equity conversion; medical expense deductions; special tax credits, deductions, and exemptions for caregivers; individual health savings accounts; improving coordination of the Medicare and Medicaid program; implementing Medicare and Medicaid demonstration projects; Medicare coverage expansion; and through the establishment of research, training, information and support programs.

Talk, But No Action

No legislation on long-term care financing was enacted during the 99th Congress. Geza Kadar, Assistant Washington Counsel of the Health Insurance Association of America said "the House Ways and Means Committee and the Senate Finance committee which have jurisdiction over changes in Medicare did not look seriously at any bill that would have added nursing home care to the Medicare benefit structure. If anything, they were struggling desperately to find ways that would be politically acceptable to reduce existing promises and benefits for Medicare."

A Republican administration in an era of fiscal scarcity and mandated budget cuts through Gramm-Rudman will influence the direction of the 100th Congress. Medicare benefits will be reduced rather than expanded. This will take place in either a Democratic or Republican controlled Senate.

The recommendations of the Private/Public Sector Advisory Committee on Catastrophic Illness and the Task Force on Long-term Care Policies will influence the Administration's response to financing of long-term care services...through private sector long-term care initiatives with the federal government's role being to help stimulate the market.

Relying on the private sector to protect the elderly from costly catastrophic long-term care is not viewed by some as the best way to attack the problem.

One House Committee staffer states that most currently offered long-term care insurance policies on the market can only be afforded by a small percentage of the population, leaving both the lower and middle class with the prospect of fiscal bankruptcy if nursing home care is required. Furthermore, there is concern that "the fascination with private long-term care options will serve as a smoke screen for what in the end is the public responsibility for financing long-term care services," the staffer said.

Brookings Study

Preliminary research findings from a study conducted at the Brookings Institution by Senior Fellow Joshua M. Wiener, Ph.D., to determine the effects of private long-term care insurance on Medicaid expenditures buttress the concern expressed on Capitol Hill that there will be individuals who will not be covered by private sector long-term care reforms.

Based on the assumption that a person would not purchase private long-term care insurance policies if the price of the policy exceeded five percent of their income and they had less than $10,000 in assets, estimates from the Brookings/LTC Financing model reveal that 20 percent of the elderly could afford to purchase a policy in the years 1986-1990. The average annual policy premium for those years would be $771. From the years 2016-2020, over 45 percent of the elderly could purchase a policy with an average annual policy premium price of $1,078. Even though the results from the model reveal a increasing market penetration of private long-term care insurance, estimated Medicaid expenditures for the period 2016-2020 are reduced by only five percent. This computer simulation may reveal that people who can afford to purchase long-term care insurance are not those individuals who end up as Medicaid recipients in nursing homes[3]

Denise Spence, Senior Research Analyst at the Brookings Institution remarks, "It seems pretty clear that private sector LTC insurance is not going to do the trick. There are no magic bullets and the research indicates that they may not cover enough people at the lower end of the income distribution."

Long-term care options marketed by the insurance industry are considered by most in the insurance industry as a new frontier. It is the belief of many that in order to make the concept work, the American public, especially its younger members, will have to be educated to the facts of life that with old age comes a high probability of being inflicted with chronic diseases, increasing the need for costly long-term care services. Long-term care insurance marketed to corporations as new part of ongoing employee benefit and to a younger population who would be less at risk the most realistic way in which to lower the current high premiums.

At this time, the insurance industry is compiling data through experience to further broaden and market long-term care insurance. Susan Van Gelder, associate director for research policy and development of HIA, said, "It is our hope that future insurance products will reach a broader segment of the population with increased coverage and lower premiums."

Currently, it is estimated that over 32 insurers offering policies and at least that many under development with over 130,000 elderly being covered by policies. Federal, state, local government and insurance companies will have to sell the concept to the public who do not believe they will age or need costly nursing home care.

Supporting private sector long-term care initiatives may be considered a politically acceptable solution to protect an aging population from costly long-term care services in the era of limited government spending. However, federal government intervention may become a necessity if it is determined private sector long-term care initiatives do not reach all levels of income. Protection against costly catastrophic insurance should not be gauged on socio-economic status, but as a right of old age.

Footnotes

[1] Statement of the Health Insurance Association of America on Long-term Care Insurance presented by Arthur Lifson, vice president of the Equitable Life Assurance Society of the United States before the Private/Public Sector Advisory Committee on Catastrophic Illness on July 30, 1986 at Chicago, Illinois.

[2] Report to the Secretary of Health and Human Services from the Private/Public Advisory Committee on Catastrophic Illness, August 19, 1986.

[3] Wiener, Joshua, Ph.D., "Modeling Long-term Care for the Elderly: The Case of Private Insurance." A paper presented at the American Sociological Association Annual Meetings, New York, New York, September 2, 1986. ***CLTC***

Melcher Assumes Reins of Senate Aging Committee

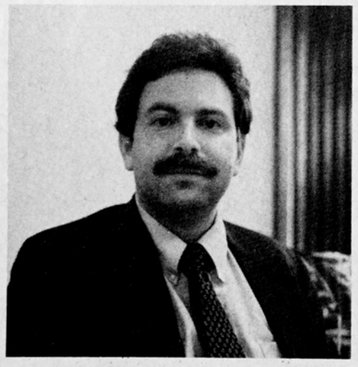
Observers await impact of changing of the guard.

by Herbert Weiss

After six years, the Democrats ended the Republican party's control of the U.S. Senate. Neither large amounts of money collected by the Republican PACS to fund important races or Ronald Reagan's personal support for Republican candidates could stop the Democratic momentum fired by local issues.

The Democrats captured a total of nine GOP seats, losing only one of their own. The final tally would reveal that the Democrats would have a 55-45 Senate majority, winning 20 out of the 35 Senate contests.

Being the majority party in the Senate carries what some might call "political perks." Most importantly, the Democrats will be able to assume committee chairmanships and establish committee agendas.



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When Ranking Minority Senator John Glenn (D-Ohio) choose to become Chairman of the Government Affairs Committee instead of the Senate Special Committee on Aging, many on Capitol Hill were not certain who would take the reins of this important aging committee.

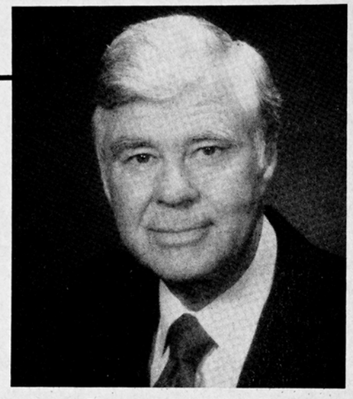
Melcher Assumes Post

On November 20, 1986, Senator John Melcher (D-Mont.), third-ranking Democrat on the Senate Special Committee on Aging, accepted the position of Chairman for the aging committee.

Up until his official acceptance, congressional staffers in both the House and Senate had thought Senator David Pryor (D-AR) would be the replacement for former Chairman John Heinz (R-PA), who became Ranking Minority Member of the committee due to the Republican loss of the Senate at the end of the 99th Congress.

Over the years, Senator Melcher has had an extensive public service career at the local, state and federal level. He began his political career as an alderman later being elected to the position of mayor of Forsyth, Montana for three terms. Later, he moved into the state political arena, being elected to the Montana House of Representatives and to the Montana Senate. He has served seven and a half years in the U.S. House of Representatives being elected to the 91st Congress in a special election in 1969, to fill a vacancy caused by the resignation of Republication James F. Battin and was reelected to three terms in the House. In 1976, Melcher was elected to the U.S. Senate.

When Senator Melcher became Chairman of the Senate Special Committee on Aging, national publications described him as an "unknown quantity." This is still true in that no detailed interviews with him have found there way into the printed page of periodicals directed to the provider in the aging network.



Senator John Melcher

However, *The Great Falls Tribune*, a newspaper in Montana outscooped numerous Washington correspondents of newsletters and journals directed to the health care provider. In an exclusive but brief interview to the Montana newspaper, Senator Melcher revealed that he chose the chairmanship of the Senate Aging Committee, "Because I feel I have not done enough for the elderly." He further states, "With 20 percent of the people being elderly [in Montana], I need to do what I can to help. I can do a lot more as Chairman." In this interview, Senator Melcher provides a small glimpse of his agenda; the need for national health insurance to cover catastrophic illness; health care issues; retirement income security; nutrition; and the high cost of drugs.

Fernando Torres-Gil, Ph.D., Staff Director of the House Select Committee on Aging believes that Senator Melcher will be in an excellent position to provide

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PHARMACIST *(continued from page 84)*

observe the nurse as if he or she were a state surveyor.

4. Chart and profile reviews — Normally, a consultant is contracted to review the charts and profiles. This review is necessary to uncover any pharmacy-related problems, but is usually only conducted about every thirty days. In order to save patients unnecessary problems from prescribed medications between outside reviews, the pharmacist should conduct a profile review *before* any medication is dispensed.

5. Intravenous programs — A conscientious pharmacist and pharmacy system should have the knowledge, resources, and capabilities to offer in-house services to patients requiring more complex care, such as enteral feedings; intravenous therapies, such as antibiotics, pain management drugs, hyperalimintation (nutritional infusion therapy), and chemotherapy.

Of course, these five points merely outline some of the contributions a conscientious pharmacist can make to a long-term care facility. As a final guideline, you should not base your pharmacist's abilities and value on just price and convenience. You should base them on:

- The number of prescriptions, per patient, in your facility.
- The number of problems uncovered by state surveyors in the pharmacy and nursing areas — Many nursing problems are in the drug administration and storage areas. Although these are "nursing problems," the actively involved pharmacist can work with the nursing staff to correct them.
- The number of administrative errors committed by the nursing staff — Often, it is not the fault of the nurses, but of the cumbersome systems with "built-in" error potential that contributes to the situation
- The quality of your physician order sheet, medication administration records, and treatment cardexes — Are the orders hand prepared and are administrative records carbon copies of the physician order sheets? Has the pharmacist worked to improve the efficiency of your current administrative system?
- Are the facility's policies and procedures tailored to be as error free and efficient as possible for your system, or have they been taken from "canned" computer programs?

Your pharmacist is conscientious only if he or she interacts with your facility's personnel to contribute to overall patient care, control pharmaceuticals from physicians orders to administration to the patient, and operates with a procedure that is as error-free and problem free as an experienced pharmaceutical management can provide. **CLTC**

MELCHER *(continued from page 18)*

leadership on advocacy for the Indian elderly and issues effecting the rural elderly, two areas that have not been explored in detail by either of the two aging committees.

Senator Melcher has named Max Richtman, former Staff Director of the Select Committee on Indian Affairs, to the position of Staff Director of the Senate Special Committee on Aging. Richtman replaces Stephen R. McConnell who will become Minority Staff Director to Ranking Minority Member John Heinz of the committee.

With a reputation for detail, Senator Melcher has personally examined the existing committee office space in the Senate Dirksen Building to determine if it will meet the requirements of his new staff.

Senator Melcher is personnally involved in the current interview process to fill vacant majority staff positions of his new committee. It is generally viewed that senior policy level positions of his committee will be filled early this month.

Interaction

It will be interesting to view the committee dynamics between Chairman John Melcher and Ranking Minority Member John Heinz, two strong willed individuals. Dr. Torres-Gil reflects on the potential interplay between the two Senators. "It is my guess that Senator Melcher and Senator Heinz will work well together because Heinz is very moderate and progressive on aging issues as Melcher will be and I think they will make a good team."

Unfortunately Senator Melcher is not a member of the important Senate Finance Committee that has legislative jurisdiction over Medicare, Medicaid and Social Security legislation. He will probably look to Senator Heinz and other members of his committee (David Pryor, D-Ark.; John H. Chaffee, R-RI; David Durenberger, R-Minn.; and Bill Bradley, D-NJ) who sit on the Senate Finance Committee to promote issues and legislation identified as important by the Senate Special Committee on Aging.

From a state with a large elderly population and a reelection bid looming in 1988, Senator Melcher in his new position as Chairman of the Senate Special Committee on Aging could gain enormous visibility to his constituent elderly. And even though some consider him an "unknown quantity," Senator Melcher will become known as a major national figure in developing aging policy and will become an active participant on catastrophic care debate. With a new support staff, and not being tied down to traditional ways to thinking about health care delivery and aging issues, Senator Melcher may well create new ways in the 100th Congress for solving old problems. **CLTC**

to nursing homes and other alternate care, non-hospital facilities.

Frank Resnik, vice president of Medline Industries, has been named president of the new company, according to James S. Mills, chairman of the board of Medline Industries. Resnik formerly was responsible for the Special Sales Division of Medline Industries. Other key appointments are John Mangiameli, formerly vice president of extended care sales for Medline Industries, to vice president of sales for Medline HealthCare Company and Jack Orlov, formerly a sales representative for Medline Industries to vice president of sales for national accounts/caring, the dealer division of Medline HealthCare Company.

Retirement Housing Corp., Campbell, White Affiliate

Retirement Housing Corporation of Dallas, Texas and Campbell, White and Associates, Inc. of Fort Smith, Arkansas have announced their affiliation as of January 12, 1987.

Retirement Housing Corporation has been active in the retirement industry for three years in all areas except licensed health care (nursing homes). Campbell, White and Associates, Inc. has specialized in nursing home facilities for three years and currently is involved in the management of over 17 projects.

Retirement Housing Corporation and Campbell, White and Associates, Inc. will operate through a master facility contract and serve clients on a national basis.

JiCo Forms New Management Team

A new management team has been named to head JiCo Health Services, Inc., of Oklahoma City, and E. W. (Dub) Jiles, president of the corporate parent, JiCo, Inc.

New top executives of JiCo Health Services are:

- Mike Fogarty, president — formerly administrative head of the Medical Services Division of the Oklahoma Department of Human Services, and
- Eugene L. Copenhaver, vice president for operations — previously manager of the State Veterans Center at Sulphur for 21 years and former director of the Oklahoma War Veterans Commission.

JiCo's flagship property, the 96-bed Cimarron Nursing Center and Retirement Village at Kingfisher, Oklahoma, went into service in 1986.

Ground has been broken for construction of a similar 100-bed elder care facility in the area west of Mercy Hospital in Oklahoma City, and JiCo is under contract to build and operate still another living center at Clinton, Oklahoma.

ARA Opens New Alzheimer's Care Center

ARA Living Centers, Houston, which manages some 270 long-term health care facilities, has opened a new 28-bed Alzheimer's Care Center in Levelland, Texas.

The Care Center, which utilizes special environmental design modifications in the care of Alzheimer's victims, is one of 20 such centers operated by ARA. "A new application of products to control sound, special lighting modifications, plus the use of selected color themes and textures were employed to comprise a therapeutic environment," said Gary Houser, ARA's vice president of Special Programs. Dr. Joanne Shroyer, of Texas Tech University, served as the design consultant.

Trade Group, Consumer Advocates Seek Common Ground

Unusual alliance attempts nursing home reform during 99th Congress.

by Herbert P. Weiss, MA, NHA

During the final days of the 99th Congress (1986), the American Health Care Association (AHCA), representing 9,000 nursing homes and the National Citizens Coalition for Nursing Home Reform (NCCNHR), a national consumer advocacy group, overlooked their philosophical differences and adversarial attitudes to develop and lobby for a nursing home legislative reform package that would promote quality of care in the nation's nursing homes.

Some would consider this brief liasion between the two national organizations to be a historic event. In its 11-year history, NCCNHR had never officially met with AHCA to develop and lobby for any federal legislation pertaining to the enforcement and standards of care. Over the years, both organizations had faithfully opposed each other on many issues at congressional hearings and other public forums pertaining to nursing home quality of care issues.

The timing of this joint effort, opposition of several special interest health care groups and the political realities of Capitol Hill were instrumental in ensuring that the legislative reform package or "agreement" developed by AHCA and NCCNHR would not be enacted during the final days of the 99th Congress.

The IOM Report. After two and one-half years, in March 1986, the Institute of Medicine Committee to Study Nursing Home Regulation officially released its 415-page report entitled, "Improving the Quality of Care in Nursing Homes" at a joint hearing of three Subcommittees of the House.

Chairman Henry Waxman (D-Ca.) of the Subcommittee on Health and the Environment of the House Energy and Commerce Committee, Chairman John Dingell (D-Michigan) of the Subcommittee on Oversight and Investigation of the House Energy and Commerce Committee (He is also Chairman of House Energy and Commerce Committee) and Chairman Claude Pepper (D-Fla.) of the Subcommittee on Long-Term Care of the House Select Committee on Aging, listened to Sidney Katz, M.D., Chairman of the Committee to Study Nursing Home Regulations and other members (who were chosen to represent different philosophical views of long-term care) of his committee present the findings of the IOM report.

Waxman's staff stated that due to the fact that this hearing was only intended to receive the findings of the IOM report, no representatives from the nursing home industry, consumer advocacy group, or Administration officials were invited to testify.

Staff members of AHCA and NCCNHR viewed the IOM report as one of the most comprehensive national studies ever initiated to examine the nation's nursing homes and the survey and certification process. Elma Holder, Executive Director of the NCCNHR and other consumer advocates have perceived the IOM report as an important blue print for the nursing home reform movement.

Congress also viewed the IOM report with keen interest and quality of care in nursing homes would again make the political agenda of Capitol Hill. During the 99th Congress, six major bills were introduced to promote quality of care in the nation's nursing homes through the implementation of specific recommendations of the IOM report: HR 4279 by Congresswoman Olympia Snowe (R-Maine); HR 4485 by Congressman Pepper; S 2119 by Senator William S. Cohn (R-Maine); HR 5450 by Congressman John D. Dingell (D-Michigan) and Congressman Henry Waxman (D-Ca.); S 2604 by Senator John Heinz (R-Pa.) anf Senator John Glenn (D-Ohio); and HR 5067 by Congressman Fortney H. (Pete) Stark (D-Ca.) and Congressman Ralph Regula (R-Ohio).

Launching the Campaign. On May 21, 1986, Chairman John Heinz of the Senate Special Committee on Aging released a committee report entitled "Nursing Home Care: The Unfinished Agenda", informally known as the Heinz report. In this controversial report, which received broad media coverage, Chairman Heinz compared nursing homes to 19th century asylums.

The IOM report and the Heinz report brought the issue of quality of nursing home care to the forefront. At the staff level at AHCA, it became clear that the association would have to confront the negative publicity generated by the Heinz report and the broad quality of care issue addressed in the IOM report.

AHCA was again in a defensive posture even though they were supportive of most of the recommendations of the IOM report and currently proposed regulatory reforms to the survey and certification process. (They were not supportive of IOM recommendations concerning federal intermediate sanctions, "Medicaid access", and pre-employment requirement for training nursing assistants in academic institutions.)

Timing was right for NCCNHR to launch its National Campaign for Quality Care in Nursing Homes to increase public awareness of the IOM report and to promote implementation of its recommendations.

Public attention was directed to the issue of quality of care in nursing homes through the release of the Heinz report and a television movie entitled "Amos" which graphically revealed "alleged" nursing home abuse to millions of Americans across the country.

Fourteen other national organizations interested in health care for the elderly joined NCCNHR at a press conference on June 26, 1986 in a Senate hearing room to initiate the national quality of care campaign. Senator Glenn, Congressman Regula, Senator Heinz, Congressman Pepper, Congressman Stark, and Actor Kirk Douglas, who was named honorary chairman (and he played Amos in the television movie) of this campaign endorsed the efforts of the 15 national associations who attended this press conference (22 national associations now belong to the coalition for quality care in nursing homes).

AHCA and the American Association of Homes for the Aged (AAHA) were not invited to join this quality of care campaign because NCCNHR viewed this campaign as solely a consumer campaign. However, they were invited to bring any materials expressing their support for the campaign to distribute to the participants and news media who attended the press conference.

Congressional Activity. On June 26, 1986, Senators Heinz and Glenn introduced S 2604, "The Nursing Home Quality Reform Act", in the Senate. This bill would be similar to Congressman Pepper's HR 4485 which was introduced earlier in the 99th Congressional Session.

During the last week of July 1986, the House Energy and Commerce Committee, the House Ways and Means Committee and the Senate Finance Committee (standing committees who have oversight responsibility for the Medicare and Medicaid program) would act on the Budget Reconciliation Act to make cuts in the Medicare and Medicaid programs to meet the congressional budget objectives.

AHCA staff became increasingly concerned in mid-July because of reports that congressional staff members of Senator Heinz in the Senate and Congressman Waxman in the House were preparing amendments to the Budget Reconciliation Act on nursing home quality of care. (Congressman Waxman had gone on record after the release of the IOM report stating that he would introduce legislation to implement the reports recommendations before the August recess. AHCA felt that it would not be inconceivable for his legislation to be attached to the Budget Reconciliation Act as an amendment.)

AHCA staff were worried that both Senator Heinz and Congressman Waxman would act in haste to introduce potential amendments that would make major fundamental changes to the nursing home industry and provide no public hearing for those who opposed such legislation. While no public hearing had been scheduled at the release of the IOM report, AHCA anticipated that these potential amendments would incorporate features of the report.

AHCA staff thought that the Senate amendment would be similar to Senator Heinz's bill S 2604 introduced at the end of June. However, they were not sure what Congressman Waxman's bill or potential amendment would look like. A week before the Budget Reconciliation Act mark-up, Congressman Waxman's staff members were still in the process of drafting their bill. Through AHCA membership grass-roots lobby of the House Ways and Means Committee, House Energy and Commerce Committee and the Senate Finance Committee, the association's position and the controversy of the legislation became apparent to the members serving on the three standing legislative committees. Bill Hermelin, Vice-President of Congressional Affairs and Gary Capistrant, Director of Congressional Relations of AHCA met privately with Congressman Waxman to discuss the impending opportunity to review his bill (or amendment) for technical comments.

Amendments on nursing home quality of care were never attached to the Budget Reconciliation Act in either the House or the Senate at the end of July.

Before the Congressional recess in August, it became clear to AHCA staff that legislative action pertaining to nursing home quality of care would again occur in the fall. Capistrant reflected, "There was a lot of steam behind the IOM report. If you don't act on reports quickly they end up gathering dust on a book shelf. As time passes the probability of the report having policy impact diminishes."

Joining Forces. In early August, Capistrant and Julie Trocchio, Director of Patient Care and Delivery at AHCA met with Congressman Ron Wyden (D-Oregon), member of the House Select Committee on Aging and House Energy and Commerce Committee. Before coming to Washington, Congressman Wyden was former Governor of the Portland Oregon Gray Panthers and had gained a good reputation among both consumer advocates and AHCA because of his functional grasp and understanding of the technical issues of long-term care. Congressman Wyden, acting in the role of "peace-maker" suggested to Capistrant that AHCA take the initiative to contact NCCNHR to work out a nursing home legislative reform package.

The political process started to move ever more swiftly in the final days of the 99th Congress. AHCA made contact with NCCNHR to schedule a meeting to explore common interest in developing a legislative reform package. On August 14, 1986, Elma Holder, Barbara Frank, Associate Director of NCCNHR, and Tobby Elderman of the NCCNHR Board of Directors met with Capistrant and Trocchio. NCCNHR attended this first meeting to determine the seriousness of AHCA's attempt to negotiate a nursing home reform package.

Once NCCNHR made the decision to continue to meet with AHCA after four meetings, a draft agreement developed during that time was circulated to the members of the National Coalition for Quality Care in Nursing Homes.

At these meetings, it became clear to Holder that AHCA supported many of the IOM recommendations except federal intermediate sanctions and "Medicaid access." Meetings scheduled toward the beginning of September would frame mutual legislative issues on paper to further negotiate and develop a final nursing home legislative reform package.

On August 15, 1986 Congressman Waxman and Congressman Dingell introduced HR 5450. AHCA and NCCNHR obtained a draft copy of the legislation an hour before it was introduced.

NCCNHR was very concerned that the draft legislation neglected the issue of nurses aide training, eliminated the requirement of nursing home administrator licensure, weakened the current nurse staffing requirement in nursing homes, and the resident assessment provisions were considered inadequate. AHCA was opposed to the elimination of the SNF/ICF distinction, "Medicaid access" and federal intermediate sanctions.

On the morning of the 15th, NCCNHR, the American Nurses Association and other associations who were opposed to the draft legislation contacted Congressman Waxman's office to urge them not to introduce the legislation without making revisions. Waxman's staff stated that they were ready to introduce their bill in order to promote dialogue on the issue and it would be introduced on the 15th of August. However, due to the political pressure directed at the Subcommittee of Health and the Environment of the Energy Commerce Committee, the legislation was revised at the last moment to increase the nurse staffing requirements substantially. The hearing for HR 5450 would be scheduled for September 19, 1986.

Holder stated that the introduction of HR 5450 by Congressman Waxman, which lacked key nursing home reform provisions, made it more appealing to sit down with AHCA to develop a stronger nursing home legislative reform package.

Independent of these meetings with NCCNHR, Paul Willging, Ph.D., Executive Director of AHCA; Capistrant; and Trocchio met with Stephen McConnell; Staff Director; David Shulke, Investigator; and Lucia Divenere, Professional Staff of the Senate Committee on Aging on September 4, 1986. Chairman Heinz of the Special Aging Committee would introduce a version of his bill S 2604 as an amendment to the Senate Medicaid Fraud and Abuse Bill on September 10, 1986 during mark-up session.

From this September 4th meeting with the staff of the Senate Committee on Aging, AHCA became aware of and opposed at this meeting the following items that would be in the Heinz amendment: federal intermediate sanctions, "Medicaid access", and the requirement to check for criminal records of nursing assistants (they supported this in concept only and stated it would not be realistic to implement). AHCA was supportive of increased surveyor training, provisions on residents rights and increasing the flexibility of the survey and certification process.

Final Stages. On September 8, 1986, AHCA had concluded that it had done as much as it could do to limit the potential damage of Senator Heinz's amendment that would be introduced on September 10th in the Senate version of the Medicaid Fraud and Abuse Bill (HR 1868) during mark-up session. The association would support its consideration in both the Senate Finance Committee and on the floor of the Senate. However, AHCA staff would attempt to modify the amendment's impact during the meeting of the House/Senate conference committee. On September 10, 1986, the Senate Finance Committee voted unanimously to approve the amendment. This amendment had almost all of the provisions discussed at the September 4, 1986 meeting, including an added provision for nurse aide training.

On September 17, 1986, AHCA and NCCNHR reached the final stages of negotiation with the completion of the final draft of nursing home legislative reform package. Even though AHCA never considered giving up their opposition on federal intermediate sanctions, a compromise was made on the issue of "Medicaid access." Holder was extremely pleased with the final draft, but she made it clear to Capistrant and Trocchio that NCCNHR and other consumer advocate groups would lobby for federal intermediate sanctions during the 100th Congress.

A copy of the final draft of nursing home legislation reform package developed by AHCA and NCCNHR was distributed to the membership of the coalition of organizations participating in the Campaign for Quality Care in Nursing Homes, to the staff of the Senate Special Committee on Aging and Subcommittee on Health and the Environment of the House Energy and Commerce Committee and other congressional leaders.

Fifteen member organizations of the coalition endorsed the final draft of the agreement but some organizations and consumer advocates expressed their concern that federal intermediate sanctions were not included in the final draft of the negotiated legislative package, a key recommendation in the IOM report. Even though NCCNHR asked the membership of the coalition for feedback during the sessions, concern was expressed about the process. Some felt that all organizations in the coalition should have actively been involved in the substantive decision making process between AHCA and NCCNHR.

On September 18, 1986, Congressman Waxman's staff informed AHCA and NCCNHR and other interested parties that the Subcommittee of Health and the Environment hearing on HR 5450 was cancelled (scheduled for September 19) because the bill would not have a possible chance to be enacted during the 99th Congress and they needed to allocate their

time to legislation that had strong possibilities of being enacted.

However, AHCA and NCCNHR met with the subcommittee staff on the 19th to discuss the final draft of their nursing home legislative reform package. Congressman Waxman's staff supported the concepts on issues addressed in the nursing home legislative reform package and suggested that AHCA and NCCNHR translate the concepts into legislative language. After this was done, the staff would review and revise the language if necessary before turning it over to the Legislative Counsel of the House Energy and Commerce Committee on September 23, 1986.

On September 24, 1986, a meeting was held between Administration officials from the Health and Human Services (HHS), staff of both the House Ways and Means Committee and House Energy and Commerce Committee, AHCA and NCCNHR. After a review of the legislative language, HHS officials stated that federal legislation was not needed to implement the changes sought by AHCA and NCCNHR but could occur through regulation.

In early October in what some would consider the final days of the 99th Congress and others would so aptly name "The Congress That Would Not Die," political realities of Capitol Hill would end the chance for enactment of the AHCA/-NCCNHR agreement and the possibility of the Senate Medicare Fraud and Abuse Bill with the Heinz amendment attached (Senate version of HR 1868) of ever reaching the Senate Floor.

In conclusion, in the final days of the 99th Congress, AHCA and NCCNHR, in a sincere attempt, pushed aside their differences and the painful memories of past skrimishes in order to find common legislative ground. Their final nursing home legislative package had the possibility of being the first piece of major nursing home reform legislation enacted in 15 years. Timing, the controversy of not including federal intermediate sanctions in the final draft of their legislative package agreement, and the political realities of Washington proved to be formidable obstacles. It is hoped that from the ashes of political defeat of the nursing home legislative reform package in the 99th Congress, will arise a new alliance during the 100th Congress, to bring about needed nursing home reform. ***CLTC***

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Quality of Care: Bringing it Into the Community

by Herbert P. Weiss, MA, NHA

As the federal government allocated large amounts of money to the Medicare and Medicaid programs in the mid-sixties, the issue of quality of care became increasingly important to policy makers. Over the last 20 years, congressional concern pertaining to quality of care has focused mostly on the nursing home setting.

In the early 1970s, Senator Frank E. Moss (D-Utah) released a series of reports from his committee's hearings, entitled "Nursing Home Care in the United States: Failure in Public Policy." In the mid-eighties, congressional reports again would resurface about issues of quality of care in nursing homes. On May 21, 1986, the Heinz Report, entitled "Nursing Home Care: The Unfinished Agenda," was officially released to the American public. This report expressed congressional concern about the poor quality of care delivered in nursing homes across the country. Chairman Heinz would compare the substandard nursing homes identified in the report to "19th century asylums."

Due to public and congressional concern about quality of care, five major bills were introduced in both the House and Senate during the 99th Congress to promote quality of care in the nursing home setting.

Concern about quality of care was also directed at the delivery of home health care during the 99th Congress. Congressional staffers, policy makers and special interest groups also expressed for the first time their concern about the well-being of older adults receiving quality of care in their home through home health care services. Even though documented problems were not seen as severe and rampant as those identified in some nursing homes, it was apparent that the increasing use of home health care would reduce quality of care provided by home health care services.

> "This patchwork of overlapping, uncoordinated and limited oversight mechanisms resulted in significant fragmentation in accountability."

Due to the newly implemented DRG Reimbursement System, large numbers of elderly were being released early from hospitals to their homes ("quicker and sicker") while the Administration was reducing funding for home care and community-based programs. Some congressional staffers felt that the decrease in federal funding would produce pressure on home health care providers to cut their costs without reducing access to the large number of elderly who would require care at home — creating the potential setting for poorly delivered care and patient abuse.

Rapid Growth. With the older adult desiring to remain independent and policy makers supporting community-based programs, the home health care industry grew rapidly over the years. Certified home health agencies increased from 1,275 in 1966 to 6,005 in 1986. The total number of home care agencies, including both Medicare and non-Medicare, is currently estimated to be as high as 10,000.

Federal payment to home health care programs has also increased steadily since the early 1970s. Between 1974 and 1980, Medicare reimbursement of home health providers grew 34 percent annually. Since 1980, Medicare home health expenditures have doubled from $772 million to $1.5 billion in 1983.

Community-based programs received funding from other federal programs. Title XX expenditures in 1980 for community-based care were over $2 billion. Older American Act expenditures were over $724 million. In 1982 the disabled elderly spent $2 billion out of pocket for home-based care and durable medical equipment and supplies.

With a 50 percent increase in certified home health agencies eligible to receive Medicare and Medicaid funding and home health care becoming the fastest growing portion of the Medicare budget, policy makers were concerned about the inadequate data and knowledge concerning quality or reliability of care. The location of home care services made their actual delivery essentially invisible to public and professional scrutiny.

Key Issue. Professionals in the aging network expressed their concern about quality of care provided to the elderly within their homes. Some 65 percent of over 1,000 home care professionals recently surveyed indicated quality of care in community-based services was a key issue. Lack of training of personnel and the quality of homemaker/personal care and home health aide services were reported to be a major problem by a majority of the case managers interviewed in the National Long-Term Care Channeling Demonstrations.

Industry groups such as the Joint Commission on Accreditation of Hospitals

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Provisions of the Homecare Quality Assurance Act

The Homecare Quality Assurance Act (H.R. 1700), introduced during the 100th Congress will:

- Establish a federal bill of rights for home care consumers under Medicare, Medicaid, the Social Services Block Grant and the Older Americans Act.
- Set "home health" and "home help" quality assurance standards and require agency compliance as a condition of participation under Medicare, Medicaid, the Social Security Block Grant and the Older Americans Act.
- Require that home care agencies have a plan of care policies that identify services to be provided, provide a means for identifying additional client needs and include coordination mechanisms with other service agencies.
- Require that home care agencies have appropriate administrative policies, including governance structures, fiscal and personnel management, and client records.
- Require that PROs conduct quality assurance and appropriateness of care monitoring for all home health agencies funded under Medicare or Medicaid.
- Require that states have a quality assurance monitoring mechanism for home help services funded under the Social Services Block Grant Program and the Older Americans Act.
- Amend the Older Americans Act to include and provide separate funding for home care ombudsman activities for the purpose of investigating and resolving home care as well as nursing home and board and care complaints.
- Require federal survey of home care agencies, with allowances "deemed status" for agencies accredited by organizations or certified by states having standards at least at stringent as federal conditions of participation.
- Encourage states to establish comparable quality standards and survey procedures for home care agencies under state programs serving consumers of all ages.
- Require that states establish Consumer Boards to conduct oversight activities, provide input into the award and evaluation of the PRO and home help monitoring mechanisms, engage in consumer education and receive input from home care beneficiaries.
- Require that PROs, state home care monitoring mechanisms and ombudsman programs have toll-free hotlines to receive questions and complaints from beneficiaries, providers and others concerning home care quality issues.
- Require that sanctions, including intermediate sanctions and civil penalties, be available to ensure compliance with quality assurance standards.
- Require that DHHS set minimum proficiency standards for all persons delivering home care services and fund training programs for personnel and caregivers, and encourage states to develop licensing requirements for home health providers.
- Require that DHHS establish guidelines and provide funding for home care training grants, home care demonstration projects and home care quality assurance studies, including research on training and wage levels.
- Require that DHHS implement and administer all provisions of the Act in conjunction with a national home care quality assurance council representing providers, consumers, states, accrediting bodies, fiscal intermediaries, PROs, researchers and others.

(JCAH), the National League for Nursing (NLN) and the National Home Caring Council (NHCC) were aware of the inadequate federal quality assurance systems and began to develop accrediting programs.

In addition to industry groups becoming active in developing accreditation programs, the American Bar Association (ABA) became interested in quality of care issues in home health care due to the increasing number of elderly who utilized the services and public support for community-based care. In order to study the complexities of home care, the ABA submitted and received a grant from the Adminstration on Aging to examine the quality of care issues surrounding home care.

Chairman Edward R. Roybal (D-California) of the House Select Committee on Aging recognized that home care played a vital role in permitting older persons to continue living independently with their families. Chairman Roybal recognized that an inadequate federal quality assurance system was in place and would not protect the elderly from poor service and abuse. Few sanctions were available for use if inadequate or poor quality home health care was found outside of decertification for Medicare-certified home health agencies.

In order to highlight this area of concern, a hearing was held by the House Select Committee on Aging on July 29, 1986, at the Rayburn House Office Building. Eighteen members of the House Select Committee on Aging were present at this hearing.

In his opening remarks, Chairman Roybal commented that home care services generally enjoyed a good reputation but stories of inadequately trained aides and "outright neglect and abuse" were surfacing.

At this hearing, John H. Pickering and Charles P. Sabatino officially released the ABA report, entitled "The Black Box of Home Care Quality."

Sabatino stated that regulatory provisions for both medically oriented services (Medicare certified) and nonmedically oriented services were fragmented, coming from state licensure laws, Medicare Conditions of Participation (if home health agency is Medicare certified), requirements under the states Medicaid Program, the states Medicaid waivers programs, the state social service block grant programs, and the states Older Americans Act.

Pickering said that "this patchwork of overlapping, uncoordinated and limited oversight mechanisms resulted in significant fragmentation in accountability."

The report recognized the lack of data

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and that the existing standards focus primarily on capacity to provide care rather than on the quality of the care provided. Current evaluation systems are weak and ineffective and there are few sanctions available to the regulator if poor care is found.

Other witnesses from the National Council on Aging, the American Association of Retired Persons and the National Association of Home Care addressed issues of inadequate staff training, fragmented regulations, the need for standards, monitoring of service delivery, establishment of a grievance mechanism for clients and enforcement, and consumer education about selecting an appropriate agency.

After this hearing, the staff of the House Select Committee on Aging met with various special interest groups to develop legislation to promote quality of home health care. On Oct. 9, 1986, Chairman Roybal introduced H.R. 5680, "The Homecare Quality Assurance Act." This legislation was designed to promote health, safety and well-being of individuals receiving health and social services in their homes by establishing a federal bill of rights for home care consumers, quality assurance standards for home care programs, a Nursing Home and Home Care Ombudsman Program, and a system to monitor and enforce quality under Medicare, Medicaid, the Social Services Block Grant Program and the Older Americans Act. Because the legislation was introduced so late in the session, it was not enacted.

A Starting Point. On March 18 of this year, Chairman Roybal reintroduced his legislation to promote quality of care in the home health care arena. (See sidebar). He sees his bill, H.R. 1700, "The Homecare Quality Assurance Act of 1987," as "a way to provide a starting point for debate on a number of dimensions of the home care quality issue — measurement of quality assurance, standards, approaches to monitoring and enforcement, training, or consumer education and protection."

Val Halamandaris, president of the National Association for Home Care, views home health care reforms in the 100th Congress in a positive light. He states, "You can't sweep problems under the rug. We have a great record but my recurrent nightmare is that this area will become polluted. I will be in a witness seat and a sure, young counsel will say to me, 'You had the chance and you blew it.' When problems do arise, we have to deal with them."

Quality of care is a right of old age, be it provided in a nursing home or the elderly's home through home health care services. The federal government in the time of Gramm-Rudman will demand that they get quality for their money and scarce resources available to provide health care to the elderly.

Data are now becoming available as to quality of care provided through home health care. Congress must confront the quality of care issue in home care as strongly as it has done in the area of nursing home reform. ***CLTC***

REFERENCES

"Black Box of Home Care Quality" hearing before the Select Committee on Aging, House of Representatives, 99th Congress, Second Session, July 29, 1986. Comm. Pub. No. 96-606.

"The Black Box of Home Health Care Quality." A report presented by the chairman of the Select Committee on Aging, House of Representatives, 99th Congress, Second Session. Prepared by the American Bar Association, August 1986. Comm. Pub. No. 99-573.

LTC CALENDAR

JUNE

Conference: Home Healthcare '87 — Opportunities in the High Technology Sector. Essex House, New York, N.Y., 8-9. (Frost & Sullivan Inc., 106 Fulton St., New York, N.Y. 10038; 212-233-1080).

Seminar: Developing Effective Computer Documentation. Loews Summit, New York, N.Y., 9-11. (Laurel Lewis, Information Mapping Inc., 275 Wyman St., Waltham, Mass. 02154; 617-890-7003).

National League for Nursing. 18th Biennial Convention & Exhibition. Sheraton Washington Hotel, Washington, D.C., 14-18. (Lorraine Mazza, NLN, 10 Columbus Circle, New York, N.Y. 10019; 212-582-1022).

National Association for Senior Living Industries. 1987 U.S. Mini Tour Series. Marriott Copley Place, Boston, Mass., 16-17. (NASLI, 125 Cathedral St., Annapolis, Md. 21401; 301-263-0991).

Retirement Housing Conference. Marriott Copley Place, Boston, Mass., 18-19. (National Real Estate Dept., Laventhol & Horwath, 919 Third Avenue, New York, N.Y. 10022; 212-980-3100, ext. 713).

JULY

American Society on Aging. Summer Series on Aging, University of California at Berkeley, 13-14. (ASA, 833 Market St., San Francisco, Calif. 94103; 415-543-2617).

American Hospital Association. Annual Convention & Exhibition. Georgia World Congress Center, Atlanta, Ga., 27-29. (Robert Donovan, AHA, Division of Conventions & Meetings, 840 Lakeshore Dr., Chicago, Ill. 60611; 312-280-6711).

AUGUST

Florida Association of Homes for the Aging. 1987 Annual Convention & Professional Exhibit Show. Stouffer Orlando Resort, Orlando, Fla., 19-21. (FAHA, 226 W. Pensacola St., Suite 201, Tallahassee, Fla. 32301; 904-222-3562).

SEPTEMBER

National Association of Food Equipment Manufacturers. NAFEM/87 Exhibition & Seminar, Las Vegas Convention Center, Las Vegas, Nev., 19-22. (NAFEM, 111 East Wacker Dr., Chicago, Ill. 60601; 312-644-6610).

7th Annual Bristol-Myers Symposium on Nutritional Research. Fairmont Hotel, San Francisco, Calif., 21-22. (Helen Shaw Miller, program coordinator, Office of Continuing Education, University of California at Davis, School of Medicine, 2701 Stockton Blvd., Sacramento, Calif. 95817; 916-453-4390).

CLTC

INSIDE WASHINGTON

Congress Takes Issue With Reagan's Budget

House and Senate proposals to be considered during 100th Congress.

by Herbert Weiss

As the 100th Congress begins it session, the huge federal budget deficit continues to cast its shadow over Capitol Hill. The mandated cuts, legislated by the Gramm-Rudman-Hollings Deficit Act to reduce the federal budget deficit, have sparked heated debates in both the House and the Senate about funding levels for social services and health care programs for the elderly.

During the first six years of the Reagan Administration, military spending increased while billions of dollars were slashed from Medicare, Medicaid and other programs assisting the poor and elderly. Addressing a joint session of Congress in 1981, President Reagan assured both the American public and Congress that a social safety net was firmly in place to protect the poor and elderly — those individuals who would be affected by draconian program cuts mandated by what David A. Stockman, former director of the Office of Management and Budget, termed the "Reagan Revolution." However, millions of elderly and poor were affected by these budget cuts, with the safety net becoming unraveled and frayed.

"Zero-sum" Policy. In an era of federal budget cutting with an exponentially increasing older population, new costly programs will not be enacted and funding for existing programs will be reduced or capped. Dr. John E. Hansan, manager, senior living trends, with the Futures Group Inc., describes policy making during the 100th Congress as "zero-sum," in which "almost every dollar added to one program will be taken from some other program."

Dr. Hansan further states that the cost for existing programs (Social Security, Medicare and Food Stamps) will continue to grow automatically because of the increasing number of older adults who will become eligible for the programs and services.

> In an era of federal budget cutting with an exponentially increasing older population, new costly programs will not be enacted and funding for existing programs will be reduced or capped.

Programs that have bipartisan support and popular public appeal, such as catastrophic coverage for the elderly, will be enacted only with minimal federal government involvement, with older adults most likely paying high premiums to receive coverage. In the "Gramm-Rudman era," the federal government will look toward the private sector to provide such initiatives to protect the elderly from costly nursing home care.

Reagan's FY 1988 Budget. In January 1987, President Reagan presented his $1 trillion dollar budget to Congress which called for increased spending for defense and reductions in spending for domestic programs. The Administration is calling for new reductions in the federal budget, totalling nearly $80 billion over the next five years.

Highlights of the Reagan FY 1988 budget cuts include:

- The budget would bring in $13 billion in additional Medicare premiums and copayments from those over 65.
- Federal payments to provide health care will be reduced by $21 billion over the next five years.
- Medicare benefits would be denied to those eligible for Medicare until one month after they turn 65.
- Medicaid would be permanently capped to reduce the program's growth, with a $1 billion cut being made in 1988.
- Virtually all new housing construction would be eliminated, including Section 202 for the elderly and handicapped.
- The Congregate Housing Services Program, which helps prevent unnecessary institutionalization by providing meals and services to the frail elderly in Section 202, and public housing would be terminated.
- Over $30 billion dollars would be cut from Medicare payments to hospitals.
- 10 percent, or about $600 million, would be sliced from the budget of the National Institute of Health.

Congressional Response. The Administration's budget has caused concern in both the House and Senate, where leaders are opposing the drastic cuts. Congressional leaders responded negatively to the budget's assault on programs provided to the nation's elderly.

Congressman Edward R. Roybal (D-Calif.), chairman of the House Select

Committee on Aging, pledged continued congressional opposition to the Administration's budget cuts. Regarding the Medicare reduction in the President's budget proposal, Roybal viewed the Administration's efforts to cut Medicare by $12.1 billion in FY 1992 as "grossly unfair." "Cuts of this magnitude mean direct and indirect reductions of over $342 per beneficiary," Roybal calculated.

"Even on the issue of 'revenue increases' the Administration fails to get its act together," noted Roybal. "On the one hand, the President tells the American public that this is a no-tax-increase budget, while his budget contains all sorts of hidden revenue increases, including the unacceptable 40 percent jump in the Medicare premium, which will cost American taxpayers billions."

Congressman Claude Pepper (D-Fla.), chairman of the House Rules Committee and the House Select Committee on Health and Long-Term Care, and the oldest member of Congress, blasted the Administration's budget plan. "If this budget is really the President's vision of where our nation is going, he is one of a few in this town and most certainly the only one of the 28 million older Americans who holds that perspective," he states.

Pepper then provided Reagan with a backhanded accolade, saying, "The only positive thing I can see in it (the Administration's FY '88 budget) for older Americans is that at last Social Security is not a part of (the budget cuts)."

Senate Response. Opposition was also loudly expressed in the Senate. Chairman John Melcher (D-Mont.) of the Senate Special Committee on Aging and 12 members of his committee sent a letter to Chairman Lawton Chiles (D-Fla.) and ranking member Pete V. Domenici of the Senate Budget Committee opposing the Reagan FY 1988 budget.

In the letter, Chairman Melcher and his bipartisan cosigners opposed the total budget proposal, especially the Medicare cuts of $5.1 billion contained in the President's budget, and particularly those cuts which would increase costs to beneficiaries. Melcher also noted that Medicaid cuts of $26.9 billion in the Administration's FY 1988 budget would either require states or counties to pick up the additional costs, reducing access to needed medical care.

House and Senate Proposals. Both the House and the Senate Democrats rejected Reagan's FY '88 budget and the House and Senate Budget Committees have drafted their own proposals. The Republicans sitting on these two Budget Committees oppose the Democratic budget proposals and have not offered their alternatives for consideration.

After Republican refusal to participate in the drafting of the House budget proposal, the Budget Committee voted along party lines (21 Democrats to 14 Republicans) to release its budget proposal for vote on the floor of the House.

> The Administration is calling for new reductions in the federal budget, totally nearly $80 billion over the next five years.

During consideration on the House floor, the Reagan FY '88 Budget and budget proposals offered by the Black Caucus and Congressman William E. Dannemeyer (R-Calif.) were considered. The three alternative budget proposals were defeated on the floor.

House Resolution Approved. On April 9, 1987, the House Budget Resolution was approved by a vote of 230 to 192 (no House Republican supported the Democratic Budget Resolution), and it recognizes the fiscal realities that must be met by Congress in the second year of the Gramm-Rudman-Hollings Deficit Act. This legislation requires the House and Senate to reduce the federal budget deficit this year from $175.7 billion to $108 billion, moving toward a balanced budget by FY 1991.

In the FY 1988 House Budget Resolution, developed by Chairman William H. Gray and his committee, revenues would be collected through $18 billion in new taxes and $3.8 billion in user fees and enhanced tax collections. The House Budget Resolution also proposes reductions of $8.75 billion in defense spending and $8.75 billion in domestic spending, creating equity in cuts between the defense and human services sectors.

Chairman Roybal views the House Budget Resolution as a viable and more realistic option to the Reagan FY 1988 budget. Roybal states, "I strongly supported the House Budget Resolution, especially for what it does to prohibit any increase in Medicare beneficiary out-of-pocket costs, to minimize cuts in Medicare (a 1988 reduction of $1.5 billion) and to prevent cuts and make improvements in Medicaid (a 1988 increase of $600 million)."

Senate Proposals. In the Senate, Chairman Lawton Chiles obtained the necessary votes of his committee (13 Democrats to 11 Republicans) to send his budget proposal resolution to the floor with a favorable recommendation. In addition, Chairman Chiles sent three other budget proposals to be considered by the full Senate.

The three budget proposals, which received no favorable recommendations from the Senate Budget Committee, are the Reagan FY '88 budget proposal; a budget proposal introduced by Sen. Ernest F. Hollings (D-S.C.) which would raise taxes by $34 billion in 1988 to reduce the federal budget deficit to the $108 billion ceiling mandated by the Gramm-Rudman-Hollings Deficit Act; and the 1988 Sequestor budget proposal, which would reduce spending through deep across-the-board reductions in the budget to reach the Gramm-Rudman-Hollings target of $108 billion.

Chairman Chiles' budget proposal would reduce the federal budget deficit by $37 billion and reduce the projected deficit to $134 billion. Military spending would be reduced by $6.9 billion while domestic spending would be cut by $10.3 billion. Revenues would be increased through collecting $18.5 billion in new taxes and through other revenue-raising measures.

Health Care. In the area of health care, the Chiles budget proposal would increase spending for Medicaid by $200 million, reduce Medicare provider payments by $3.3 billion, increase funding for the National Institute of Health and AIDS research by $500 million, and additionally fund $200 million for discretionary health care programs for low-income persons.

The full Senate is scheduled to review the Chiles budget proposal and the three alternate budget proposals after the Easter recess. The Senate budget proposal may not be approved as quickly as the House budget proposal due to Republican opposition and the possibility of a filibuster on the Senate floor.

After the passage of the Senate Budget Resolution, a Conference Committee made up of members of both houses will work out the differences between the House and Senate Budget Resolutions. The revised bill will be sent back to both houses for final approval.

In the era of Gramm-Rudman, both the House and the Senate in the 100th Congress will not have much latitude in creating or expanding existing programs for the elderly. At a conference in Washington, D.C., one speaker aptly described the setting for the budget fight during the 100th Congress as "canes or guns."

CLTC

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House and Senate proposals to be considered during 100th Congress.

by Herbert Weiss

As the 100th Congress begins it session, the huge federal budget deficit continues to cast its shadow over Capitol Hill. The mandated cuts, legislated by the Gramm-Rudman-Hollings Deficit Act to reduce the federal budget deficit, have sparked heated debates in both the House and the Senate about funding levels for social services and health care programs for the elderly.

During the first six years of the Reagan Administration, military spending increased while billions of dollars were slashed from Medicare, Medicaid and other programs assisting the poor and elderly. Addressing a joint session of Congress in 1981, President Reagan assured both the American public and Congress that a social safety net was firmly in place to protect the poor and elderly — those individuals who would be affected by draconian program cuts mandated by what David A. Stockman, former director of the Office of Management and Budget, termed the "Reagan Revolution." However, millions of elderly and poor were affected by these budget cuts, with the safety net becoming unraveled and frayed.

"Zero-sum" Policy. In an era of federal budget cutting with an exponentially increasing older population, new costly programs will not be enacted and funding for existing programs will be reduced or capped. Dr. John E. Hansan, manager, senior living trends, with the Futures Group Inc., describes policy making during the 100th Congress as "zero-sum," in which "almost every dollar added to one program will be taken from some other program."

Dr. Hansan further states that the cost for existing programs (Social Security, Medicare and Food Stamps) will continue to grow automatically because of the increasing number of older adults who will become eligible for the programs and services.

In an era of federal budget cutting with an exponentially increasing older population, new costly programs will not be enacted and funding for existing programs will be reduced or capped.

Programs that have bipartisan support and popular public appeal, such as catastrophic coverage for the elderly, will be enacted only with minimal federal government involvement, with older adults most likely paying high premiums to receive coverage. In the "Gramm-Rudman era," the federal government will look toward the private sector to provide such initiatives to protect the elderly from costly nursing home care.

Reagan's FY 1988 Budget. In January 1987, President Reagan presented his $1 trillion dollar budget to Congress which called for increased spending for defense and reductions in spending for domestic programs. The Administration is calling for new reductions in the federal budget, totalling nearly $80 billion over the next five years.

Highlights of the Reagan FY 1988 budget cuts include:

- The budget would bring in $13 billion in additional Medicare premiums and copayments from those over 65.
- Federal payments to provide health care will be reduced by $21 billion over the next five years.
- Medicare benefits would be denied to those eligible for Medicare until one month after they turn 65.
- Medicaid would be permanently capped to reduce the program's growth, with a $1 billion cut being made in 1988.
- Virtually all new housing construction would be eliminated, including Section 202 for the elderly and handicapped.
- The Congregate Housing Services Program, which helps prevent unnecessary institutionalization by providing meals and services to the frail elderly in Section 202, and public housing would be terminated.
- Over $30 billion dollars would be cut from Medicare payments to hospitals.
- 10 percent, or about $600 million, would be sliced from the budget of the National Institute of Health.

Congressional Response. The Administration's budget has caused concern in both the House and Senate, where leaders are opposing the drastic cuts. Congressional leaders responded negatively to the budget's assault on programs provided to the nation's elderly.

Congressman Edward R. Roybal (D-Calif.), chairman of the House Select

Committee on Aging, pledged continued congressional opposition to the Administration's budget cuts. Regarding the Medicare reduction in the President's budget proposal, Roybal viewed the Administration's efforts to cut Medicare by $12.1 billion in FY 1992 as "grossly unfair." "Cuts of this magnitude mean direct and indirect reductions of over $342 per beneficiary," Roybal calculated.

"Even on the issue of 'revenue increases' the Administration fails to get its act together," noted Roybal. "On the one hand, the President tells the American public that this is a no-tax-increase budget, while his budget contains all sorts of hidden revenue increases, including the unacceptable 40 percent jump in the Medicare premium, which will cost American taxpayers billions."

Congressman Claude Pepper (D-Fla.), chairman of the House Rules Committee and the House Select Committee on Health and Long-Term Care, and the oldest member of Congress, blasted the Administration's budget plan. "If this budget is really the President's vision of where our nation is going, he is one of a few in this town and most certainly the only one of the 28 million older Americans who holds that perspective," he states.

Pepper then provided Reagan with a backhanded accolade, saying, "The only positive thing I can see in it (the Administration's FY '88 budget) for older Americans is that at last Social Security is not a part of (the budget cuts)."

Senate Response. Opposition was also loudly expressed in the Senate. Chairman John Melcher (D-Mont.) of the Senate Special Committee on Aging and 12 members of his committee sent a letter to Chairman Lawton Chiles (D-Fla.) and ranking member Pete V. Domenici of the Senate Budget Committee opposing the Reagan FY 1988 budget.

In the letter, Chairman Melcher and his bipartisan cosigners opposed the total budget proposal, especially the Medicare cuts of $5.1 billion contained in the President's budget, and particularly those cuts which would increase costs to beneficiaries. Melcher also noted that Medicaid cuts of $26.9 billion in the Administration's FY 1988 budget would either require states or counties to pick up the additional costs, reducing access to needed medical care.

House and Senate Proposals. Both the House and the Senate Democrats rejected Reagan's FY '88 budget and the House and Senate Budget Committees have drafted their own proposals. The Republicans sitting on these two Budget Committees oppose the Democratic budget proposals and have not offered their alternatives for consideration.

After Republican refusal to participate in the drafting of the House budget proposal, the Budget Committee voted along party lines (21 Democrats to 14 Republicans) to release its budget proposal for vote on the floor of the House.

> The Administration is calling for new reductions in the federal budget, totally nearly $80 billion over the next five years.

During consideration on the House floor, the Reagan FY '88 Budget and budget proposals offered by the Black Caucus and Congressman William E. Dannemeyer (R-Calif.) were considered. The three alternative budget proposals were defeated on the floor.

House Resolution Approved. On April 9, 1987, the House Budget Resolution was approved by a vote of 230 to 192 (no House Republican supported the Democratic Budget Resolution), and it recognizes the fiscal realities that must be met by Congress in the second year of the Gramm-Rudman-Hollings Deficit Act. This legislation requires the House and Senate to reduce the federal budget deficit this year from $175.7 billion to $108 billion, moving toward a balanced budget by FY 1991.

In the FY 1988 House Budget Resolution, developed by Chairman William H. Gray and his committee, revenues would be collected through $18 billion in new taxes and $3.8 billion in user fees and enhanced tax collections. The House Budget Resolution also proposes reductions of $8.75 billion in defense spending and $8.75 billion in domestic spending, creating equity in cuts between the defense and human services sectors.

Chairman Roybal views the House Budget Resolution as a viable and more realistic option to the Reagan FY 1988 budget. Roybal states, "I strongly supported the House Budget Resolution, especially for what it does to prohibit any increase in Medicare beneficiary out-of-pocket costs, to minimize cuts in Medicare (a 1988 reduction of $1.5 billion) and to prevent cuts and make improvements in Medicaid (a 1988 increase of $600 million)."

Senate Proposals. In the Senate, Chairman Lawton Chiles obtained the necessary votes of his committee (13 Democrats to 11 Republicans) to send his budget proposal resolution to the floor with a favorable recommendation. In addition, Chairman Chiles sent three other budget proposals to be considered by the full Senate.

The three budget proposals, which received no favorable recommendations from the Senate Budget Committee, are the Reagan FY '88 budget proposal; a budget proposal introduced by Sen. Ernest F. Hollings (D-S.C.) which would raise taxes by $34 billion in 1988 to reduce the federal budget deficit to the $108 billion ceiling mandated by the Gramm-Rudman-Hollings Deficit Act; and the 1988 Sequestor budget proposal, which would reduce spending through deep across-the-board reductions in the budget to reach the Gramm-Rudman-Hollings target of $108 billion.

Chairman Chiles' budget proposal would reduce the federal budget deficit by $37 billion and reduce the projected deficit to $134 billion. Military spending would be reduced by $6.9 billion while domestic spending would be cut by $10.3 billion. Revenues would be increased through collecting $18.5 billion in new taxes and through other revenue-raising measures.

Health Care. In the area of health care, the Chiles budget proposal would increase spending for Medicaid by $200 million, reduce Medicare provider payments by $3.3 billion, increase funding for the National Institute of Health and AIDS research by $500 million, and additionally fund $200 million for discretionary health care programs for low-income persons.

The full Senate is scheduled to review the Chiles budget proposal and the three alternate budget proposals after the Easter recess. The Senate budget proposal may not be approved as quickly as the House budget proposal due to Republican opposition and the possibility of a filibuster on the Senate floor.

After the passage of the Senate Budget Resolution, a Conference Committee made up of members of both houses will work out the differences between the House and Senate Budget Resolutions. The revised bill will be sent back to both houses for final approval.

In the era of Gramm-Rudman, both the House and the Senate in the 100th Congress will not have much latitude in creating or expanding existing programs for the elderly. At a conference in Washington, D.C., one speaker aptly described the setting for the budget fight during the 100th Congress as "canes or guns."

CLTC

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Nursing Home Reforms Sought by Unique Coalition

Unified approach seen as best way to push legislative package in 100th Congress.

by Herbert Weiss

When the Institute of Medicine (IOM) Committee on Nursing Home Regulation released its 415-page, hard-hitting report on "Improving the Quality of Care in Nursing Homes" in March 1986, the document was viewed by many in the aging network as one of the most comprehensive studies ever made of the federal and state nursing home regulatory and enforcement system. The report also provided the impetus for a unique coalition of consumer advocacy, provider and professional groups to place nursing home reform on the agenda of the 100th Congress.

Elma Holder, executive director of the National Citizens' Coalition for Nursing Home Reform (NCCNHR), and other consumer advocates perceived the IOM report as an important blueprint for the nursing home reform movement. For years, consumer advocates had tried to implement changes like those reflected in the report.

The nursing home industry also supported Holder's view of the report's importance. Gary Capistrant, director of congressional relations at the American Health Care Association (AHCA), recognized the importance of quick action to implement its recommendations. He stated, "There was a lot of steam behind the IOM report. If you don't act on reports quickly they end up gathering dust on a bookshelf. As time passes the probability of the report having policy impact diminishes."

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First Attempt. Many other national organizations supported Holder's and Capistrant's assessment of the impact of the report and the need to act promptly on the report's recommendations.

On April 2, 1986, NCCNHR began to organize bi-weekly meetings involving 20 national organizations to discuss the IOM recommendations. These meetings did not focus on practical legislative proposals but on what was the best approach to provide services to nursing home residents.

After the measure's introduction, many national organizations stepped up lobbying efforts for their individual nursing home reform issues.

On June 26 last year, in a Senate hearing room, NCCNHR and 15 national associations launched the "Campaign for Quality Care in Nursing Homes" to generate congressional action on nursing home reform.

In mid-August, Congressmen John D. Dingell (D-Mich.) and Henry Waxman (D-Calif.) introduced H.R. 5450 to implement specific recommendations of the IOM report. After the measure's introduction, many national organizations stepped up lobbying efforts on Capitol Hill for their individual nursing home reform issues, even though they still met as a coalition.

At this point, AHCA and NCCNHR put past differences aside and utilized the IOM report as a framework to develop a joint nursing home legislative reform package, which was ultimately endorsed by more than a dozen national organizations. Even though other national organizations were not actively involved in these closed meetings, they were provided with an opportunity to comment on the various early drafts and the final draft of the reform package.

Setback. The AHCA/NCCNHR legislative package had the potential to become the first piece of major nursing home reform legislation enacted in 15 years. However, due to timing, controversy over the lack of federal intermediate sanctions in the final draft of the legislative package and concern voiced by several national organizations about their minimal involvement in developing the AHCA/NCCNHR reform package, political barriers were created that defeated the measure's passage during the 99th Congress.

Barbara Frank, associate director of NCCNHR, recognized that the various "groups had to be responsive to each other's practical and political needs." And since NCCNHR wanted to get nursing home reform legislation on the books in the 99th Congress, it decided not to push for intermediate sanctions. NCCNHR's strategy was simple: Once comprehensive nursing home reform legislation was enacted in the 99th Congress, it would lobby in the 100th Congress to amend the legislation to include intermediate sanctions.

It became apparent to NCCNHR and other national organizations that a unified voice would be the only practical way to lobby for enactment of a nursing home reform legislative package during the 100th Congress. The coalition of national associations now would have to work more closely with each other and come to terms with their diverse philosophical beliefs in order to hammer out a true consensus plan.

Grappling With Issues. Under NCCNHR's leadership, representatives from 20 national organizations attended biweekly meetings from April to November 1986 to discuss a multitude of issues pertaining to quality of care in nursing homes. Participants were determined to develop the best approaches to providing services to nursing home residents and put "flesh onto the IOM report." Practical implications, cost and political obstacles were not considered during this phase.

After the failure to enact nursing home reform legislation at the end of the 99th Congress, NCCNHR brought the coalition together on Nov. 12, 1986, to identify issues and map out a strategy to reach consensus on issues during the 100th Congress. At this meeting, 12 issues were identified: Residents' Rights, Ombudsman Program, Medicaid Discrimination, Resident Assessment, Elimination of SNF/ICF Distinction, Nurse Aide Training, Nurse Staffing, Social Services, Mental Health, Survey and Certification, Enforcement of Laws and Regulations, and Medicaid Payment.

Subcommittees were established to develop draft position papers on each of these issues, and a joint meeting was held in mid-December to review the drafts. It became obvious that some subcommittees needed more time to properly develop their position papers, and another meeting was held on Jan. 22, 1987, to examine each of the drafts separately.

At this meeting, coalition participants examined both concept and wording of the first draft position paper, "Residents' Rights." The first issues reviewed were those not considered controversial, and easy for most to support.

Ten meetings of the full group were held from February to April to develop the exact wording of the consensus position and wording for the 11 other draft position papers. The American Association of Homes for the Aging (AAHA), American College of Health Care Administrators, Catholic Health Association and AHCA attended these regular meetings and the earlier ones to represent the concerns of the nursing home industry.

Several subcommittees still met along with the regularly scheduled group meetings in this two-month period to further refine position papers that were considered controversial. In these marathon meetings, usually one or two issues were addressed, with participants taking drafts back to their boards of directors for approval.

During the development of these position papers, both AAHA and AHCA staff kept key committees in their respective associations involved by sending committee members all draft copies of the 12 position papers.

Although consensus was reached on many points, there were some areas in which agreement on every aspect of a specific issue could not be achieved.

Supplemental Positions. Although consensus was reached on many points, there were some areas in which agreement on every aspect of a specific issue could not be achieved. Supplemental positions on seven issues were developed to provide a way in which an organization could support a position paper on an issue and still have an opportunity to voice its concern for a specific point.

According to Julie Trocchio, director of patient care and delivery at AHCA, "Once we decided on a format of consensus plus supplemental papers as a way of dealing with differences in policy, many realized that the consensus process would probably be a reality. There would be a product."

Many of the supplemental positions were minor points in the overall agreement. However, in a few situations, such as the "Enforcement of Laws and Regulations," "Nurse Staffing" and "Medicaid Discrimination" position papers, supplemental positions represented more substantial differences.

On April 10, 1987, the coalition completed its work and the 20 participating organizations provided their boards with copies of the position papers for final approval. NCCNHR circulated copies of the position papers to 50 other national organizations which had expressed interest in being kept informed of the activities of the coalition.

Consensus Achieved. On April 24, NCCNHR and its coalition held a press conference to announce the official release of the public policy positions under the rubric, "Campaign for Quality Care in Nursing Homes." Sen. David Pryor (D-Ark.) hosted this unique press conference and described how the consensus document was developed: "A miracle has occurred... We celebrate consensus and call for action of these many that care about older Americans."

In the days following the press conference, S. 1108, sponsored by Sen. George J. Mitchell (D.-Maine), and H.R. 2270, sponsored by Congressmen Dingell and Waxman, were introduced in Congress. Senator Mitchell's bill in large part reflected the coalition's positions and Dingell and Waxman's bill touched on several of the coalition's recommendations.

Medicaid Funding. The federal budget deficit will cast its shadow on nursing home reform legislation during the 100th Congress. The House has proposed $600 million for new programs in Medicaid, while the Senate has allocated no increase for Medicaid spending. These differences were expected to be resolved in Conference Committee by mid-June. How much money allocated to the Medicaid program by the House and Senate by the Conference Committee will determine how many new initiatives can be funded. Full consideration of the Mitchell and Dingell/Waxman bills is dependent on money allocated to Medicaid by the House and Senate to implement the bill's provisions.

NCCNHR and members of the coalition are in the process of determining the cost of the recommendations and will submit their data to the Congressional Budget Office, Senate Finance Committee, House Ways and Means Committee and the House Energy and Commerce Committee. This information will be important for "political consideration" in an era of Gramm-Rudman and a huge federal budget deficit.

Evelyn F. Munley, health policy analyst at the American Association of Homes for the Aging, and an active participant at the Coalition meetings, views the work of the group positively, noting "It (the coalition) became a great avenue for exchanging information." Those who attended the regular meetings learned a lot from each other. In some cases, notes one participant, "Political differences were put aside for practical differences."

Getting the coalition to work together and develop position papers supported by more than 50 national associations did not happen by chance. Both Munley and Trocchio credit the leadership of Barbara Frank of NCCNHR as instrumental in bringing the diverse groups together to support so many issues, especially the controversial ones. It appears that Congress has heard this unified voice clearly. **CLTC**

Reauthorization of Older Americans Act

Maintaining status quo in the Gramm-Rudman era.

by Herbert Weiss

When the Older Americans Act (OAA) was signed into law by President Johnson on July 14, 1965, a new federal program was created to plan and coordinate social and nutrition services for older adults at the state and federal levels. Community service employment opportunities for low-income elderly also were developed.

Since its enactment the OAA has been amended 11 times and its reauthorization will again take place during the 100th Congress. The House has acted with speed to pass its version of the reauthorization act, but action in the Senate has been slower.

A Senate staffer noted, "The 1987 reauthorization is an opportunity for making significant improvement to the OAA within the confines of the federal budget deficit. The House has moved fast to amend the act, which some consider both significant and interesting....The Senate, as is its nature and tradition, is moving more cautiously."

The House. The House Education and Labor Committee completed mark-up of its reauthorization bill by voice vote on May 12. Two weeks later, the bill came to the House floor for consideration, with more controversial issues being debated through amendments. The House version of the OAA reauthorization bill was passed by a 379-8 vote. In essence, the House OAA reauthorization bill and amendments do not significantly change the current act, but "fine tune" it.

H.R. 1451 reauthorizes all titles of the Older Americans Act for four years and authorizes a five percent increase in funds for all of the act's programs. It creates a new Part D under Title III authorizing $25 million for FY 1988 for in-home services for the frail elderly. These services include homemaker and home health aides; visiting and telephone reassurance; chore maintenance; in-home respite care for families, including adult day care services; and in-home support for Alzheimer's patients and their families.

The bill creates a new Part E under Title III which allocates $25 million for a number of services or combination of services. This additional funding will increase state flexibility to confront local problems and needs.

Ombudsman Program. The ombudsman program will receive a separate authorization of $20 million. The current expenditure for this program is estimated by the National Association of State Units on Aging to be $10 million. Brian Lutz, professional staff, House Select Committee on Aging, noted, "It was clear to House members that the ombudsmen were stretched beyond their ability to adequately perform their mandate under the act and that more resources were needed."

The ombudsman program is strengthened through the provision of immunity for ombudsmen for good faith performance of their responsibilities. Ombudsmen will have access to long-term care facilities, residents and their records and will be provided with legal advice and counsel when needed.

Rep. Don Bonker (D-Wash.), whose ombudsman legislation (H.R. 2042) provided the language for H.R. 1451, stated, "I am pleased that H.R. 1451 gives ombudsmen the tools needed to protect residents' rights and to advocate on their behalf. This program is the only OAA service specifically devoted to assisting residents of long-term care facilities, who are among our society's most frail and vulnerable citizens."

Advocacy. The issue of advocacy was addressed as part of the original bill by Rep. Dale E. Kildee (D-Mich.), chairman of the Subcommittee on Human Resources of the House Education and Labor Committee. The Democrats were trying to clarify the aging network and the older adult's ability to participate in advocacy activities.

During the House Education and Labor Committee mark-up, Rep. Mario Biaggi (D-N.Y.) offered an amendment to further strengthen the act's advocacy mandate by prohibiting the issuance of any regulation that would supersede the right to advocacy, including "reviewing, monitoring, evaluating and commenting on federal, state and local plans, budgets, programs or regulations affecting older individuals." Both Kildee and Biaggi intended to make sure that the prohibition laid out in Office of Management and Budget Circular A-122 against private non-profit grantees of federal funds to conduct certain advocacy activities did not apply to the OAA.

During the full committee consideration, Republicans created report language (which clarifies congressional intent of a bill) to "prohibit partisan political activity" to address their concerns that the OAA would foster partisan advocacy. In attempting to develop a compromise between more conservative Republicans and moderate Democrats, Rep. James M. Jefford's (R-Vt.) amendment on the floor was accepted, putting the report language created by the Republicans in full committee into the final legislative language of the bill.

Jefford's amendment was a substitute for one proposed by Rep. Dick Armey (R-Texas) that would have prohibited the use of federal funding "directly or indirectly by state agencies or area agencies on aging for partisan political purposes or for political lobbying with respect to legislation."

Other Provisions. H.R. 1451 also requires state and area agencies to identify the number and determine the needs of low-income and minority older adults; develop plans to satisfy their needs; and ensure the use of outreach to older adults who have the greatest social and economic needs.

Finally, H.R. 1451:

- Directs the Administration on Aging Commissioner to fund up to 10 long-term care research centers.
- Authorizes $25 million in FY 1989 to provide a program for information, referral and outreach to help low-income elderly understand eligibility requirements and procedures for food stamps, SSI and

Medicaid programs.

- Coordinates certain programs directed to victims of Alzheimer's disease.
- Strengthens client confidentiality in legal services.
- Freezes allowable administrative costs in Title V employment programs.
- Excludes income for the purpose of determining eligibility and rental payment levels for Section 8 housing programs of the Title V employee enrollees.
- Increases authorization levels in Title VI to Native Americans and permits older Indians to be also served by Title III.
- Requires the establishment of a 1991 White House Conference on Aging to be funded at appropriate levels.
- Modifies the line of command where the Administration on Aging Commissioner would report directly to the Secretary as opposed to the Office of the Secretary.
- Implements studies to examine the impact of Diagnostic Related Group (DRG) reimbursement, unsatisfied demand for supportive services at senior centers, the need for transportation services and the need/availability of tuition-free secondary education.

Additional Amendments. Chairman Edward R. Roybal (D-Calif.) and three other members of the House Select Committee on Aging leadership (Reps. Claude Pepper (D-Fla.), Biaggi and Bonker) introduced amendments on the House floor which were adopted into the final bill.

Key provisions of the amendments include: increased targeting to low-income minority elderly persons, more in proportion to their need; pilot projects to protect the rights and well-being of home care consumers; greater sensitivity to persons with mental health needs; initiatives to prevent and assist victims of elder abuse; and increased focus on the needs of Indian elders.

Chairman Roybal was pleased with the House version of the OAA reauthorization. "Clearly, I would have liked to have seen substantial increases in authorization levels and a commitment of resources which more accurately reflect the rapidly growing numbers of older Americans," he said.

Referring to Reagan Administration proposals, Roybal added, "I am particularly pleased that the bill rejects the notion that the eligibility age should be increased above the current level of 60 and does not include a means test or initiate mandatory fees for service."

Budget Deficit. The federal budget deficit has influenced the debate as to the services being considered by the 1987 reauthorization of the OAA. Rep. Pepper stated, "I was pleased with some of the changes made this year with the reauthorization of the OAA, among them, the creation of an agency in each state to monitor elder abuse and the strengthening of the ombudsman program.

"However, due to the federal budget deficit, we have had to restrict services under the OAA to the very neediest. We would like to increase funding so as to assist a greater percentage of the elderly population."

The Senate. Sen. Spark M. Matsunaga (D-Hawaii), chairman of the Subcommittee on Aging of the Senate Labor and Human Resources Committee, has slowed the pace of the Senate's consideration of S. 887, its bill to reauthorize the OAA. According to one Senate staffer, "Chairman Matsunaga is known to strive for compromise and agreement and is attempting to gain bi-partisan support before reporting the bill out of his subcommittee. He generally does not like to push controversial legislation."

Sen. John Melcher (D-Mont.), chairman of the Senate Special Committee on Aging, has been a strong supporter of the OAA during his 17 years in Congress and takes an active interest in the 1987 reauthorization. Chairman Melcher strongly supports S. 887.

A staff member of his committee said Chairman Melcher was to offer at least two amendments to S. 887 after the July 4 recess. One would establish the Volunteer Service Credit Demonstration Program in at least five states; the other would make certain adult day care centers were eligible for U.S. Department of Agriculture meal assistance.

Similar Proposals. As in the House, the Subcommittee on Aging of the Senate Labor and Human Resource Committee is considering a "basic" bill (S. 887) that has bi-partisan support, with more controversial issues to be debated through amendments. Essentially, S. 887 is very similar to H.R. 1451. The Senate bill reauthorizes all titles of the OAA for the next five years, while the House bill has four-year reauthorization. S. 887 increases the authorization levels of the House-passed version by five percent.

S. 887 will likely create a new Title to provide in-home services to the frail elderly and targeted services to low-income minority elderly. The Senate bill to be reported out of subcommittee is not likely to include as many studies and reports as was specified in H.R. 1451, but it is likely to include language to increase access to services by individuals with disabilities and to strengthen the long-term care ombudsman program. It probably will provide a demonstration program of outreach to elderly SSI, Medicaid and Food Stamp recipients (although it will likely be scaled back) as well as community service employment for older Indians.

Controversial Amendments. Controversial issues may be raised as amendments either in the Subcommittee on Aging, the Senate Labor and Human Resources Committee or on the Senate floor. Controversial amendments may include:

- Changing the funding allocation formula to state and area agencies by factoring in an area's proportion of "old-old" and minorities.
- Eliminating priority services, which presently include legal services, transportation and in-home services.
- Altering the allocation formula for the commodity reimbursement program. This debate centers around whether to continue the current reimbursement program based on the number of meals served or to switch to a set allocation formula.
- Permitting area agencies on aging to implement case management programs without going through the current waiver process. Currently, an area agency on aging may obtain a waiver from the state agency on aging to provide direct services by demonstrating need in their catchment areas.

S. 887 is scheduled for mark-up by the Subcommittee on Aging, and after the bill is reported to full committee and passed by the full Senate, a conference committee made up of members of both houses will work out the differences between the House and Senate reauthorization bills.

Bottom Line. In the short term, the 1987 reauthorization of the OAA will not drastically change the act. Reagan Administration proposals to drastically modify the act have fallen on deaf ears in Congress. According to one House staffer, "Congress has sent a message to the Administration: 'If it ain't broke, don't fix it.' "

For the first time since the enactment of the OAA in 1965, discussion has focused on in-home services for the frail elderly. This is in sharp contrast to previous reauthorizations of the OAA which focused on senior centers and congregate meal programs.

In the era of Gramm-Rudman, the older population continues to increase while funding for programs to benefit them is being cut or capped. "Maintaining the status quo" may aptly describe the 1987 reauthorization of the OAA. During future considerations of reauthorization, maintaining the status quo will hurt those truly in need, the exponentially increasing older population. In human terms, this means our parents, their parents and us. **CLTC**

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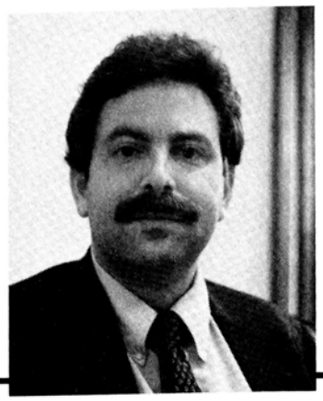
No LTC Provisions in Catastrophic Care Bill Passed by House

But many view proposal as a step in the right direction.

by Herbert Weiss



The House of Representatives, by an overwhelming margin of 302 to 127, passed its version of the long-awaited catastrophic care bill on July 22. The measure, H.R. 2470, provides increased protection for the nation's elderly and disabled Medicare beneficiaries, but falls short in that it does not include provisions for long-term care.

According to Rep. Edward R. Roybal (D-Calif.), chairman of the House Select Committee on Aging, "The House-passed catastrophic care bill is a step forward, but we have a long way to go before America's senior citizens and medically indigent get comprehensive health care protection."

Background. Title 18 of the Social Security Act, commonly known as Medicare, was enacted by Congress in 1965. Twenty years later, concern over rising out-of-pocket expenditures by the elderly for health care spurred efforts to expand the Medicare program to cover catastrophic and long-term care.

However, this was not politically feasible in the 99th Congress. While such a measure might be passed in the Democratically controlled House, it was deemed unlikely that catastrophic care legislation could be steered through the Republican-controlled Senate and the necessary votes obtained to override a threatened Presidential veto.

Reagan Opens the Door. During his January 1986 State of the Union Address, President Reagan placed the issue of catastrophic care on his administration's agenda, directing Health and Human Services Secretary Otis Bowen, M.D., to provide him with recommendations on how to provide affordable insurance to protect the life savings of the elderly which would be threatened by a prolonged catastrophic illness. In November of that year, Secretary Bowen released a report and recommendations from the Public/Private Sector Advisory Committee on Catastrophic Illness.

After heated discussion, the President on Feb. 12, 1986, endorsed the Bowen plan, which called for limited expansion of the Medicare program. The President's general recognition of the need for catastrophic coverage and the passage of control of the Senate to the Democrats during the 1986 elections opened the door for political support of such legislation. During the 100th Congress, Rep. Robert H. Michel (R-Ill.) introduced H.R. 1245, which was based upon Secretary Bowen's original plan.

Strong Interest. From the beginning of the 100th Congress, House Speaker Jim Wright (D-Texas) took strong interest in the catastrophic care proposal during the legislative mark-up and passage of H.R. 2470.

On May 4, 1987 Speaker Wright urged Democratic chairmen of the House Ways and Means committee, House Energy and Commerce Committee and House Select Committee on Aging to develop a more comprehensive catastrophic care bill than H.R. 1245, the Administration's bill, and to include a drug benefit package in the legislation. This would ensure that catastrophic care legislation in the House would have a Democratic imprint on it, even though the initiative began as a Reagan Administration proposal.

The debate became heated over the controversial drug benefit package in both the House Ways and Means and Energy and Commerce committees. The administration opposed the democratic drug benefit package because of its potential cost. The pharmaceutical industry feared the involvement of the federal government in establishing the new Medicare benefit of drug coverage because it would increase federal regulation of the industry and promote the wider use of less profitable "generic drugs."

During consideration of the catastrophic care legislation, the House Ways and Means Committee voted to set the initial deductible at $800 a year with 20 percent coinsurance, while the House Energy and Commerce Committee voted to set it at $500.

Compromise Reached. After the two House committees had completed their mark-up of H.R. 2941 (the expanded compromise bill, which would ultimately be incorporated in the text of H.R. 2470 when considered on the House floor), Speaker Wright called a meeting of the House Democratic health leadership. The intent was to resolve the differences of the two drug benefit package proposals and any other issues on the agenda. A compromise was reached and the drug benefit deductible was set at $500 with a 20 percent coinsurance payment.

Another potential blockage to the enactment of catastrophic legislation on the House floor was resolved at another meeting called by Speaker Wright. Rules Committee Chairman Claude Pepper (D-Fla.) and Congressman Roybal agreed at this meeting that they would not offer their long-term home care plan as a floor amendment during the vote on H.R. 2470.

In order to reduce the possibility of a Presidential veto and increase the probability of the enactment of a House

catastrophic care bill, a House staffer observed that, "Speaker Wright, Pepper and Roybal had agreed to find another legislative vehicle for their amendment in order to add increased home care benefits to the existing Medicare program."

The Passage. On July 22, 1987, a Republican substitute amendment was brought to the House floor for consideration. The amendment retained portions of the original Bowen plan, provided a modified prescription drug benefit package and included limited long-term health care. The Republican substitute amendment would have cost $18.1 billion over five years. The House defeated the amendment by a partisan vote of 242 to 190.

The final agreed-upon language of H.R. 2470 was offered by Congressman Dan Rostenkowski (D-Ill.), Congressman John D. Dingell (D-Mich.), Congressman Fortney H. (Pete) Stark (D-Calif.), Congressman Henry A. Waxman (D-Calif.) and Congressman Roybal. The bill was overwhelmingly aproved on the House floor and is now headed for the Senate.

Provisions. H.R. 2470 would:

- Place a $1,798 cap in 1989 on out-of-pocket expenditures for services covered by Medicare, including a $1,043 cap for out-of-pocket expenditures for covered physician and outpatient services, a $580 hospital deductible and a $175 deductible for Medicare-covered skilled nursing care.
- Ensure that 365 days of hospitalization would be covered by Medicare per year with an initial annual deductible of $544 in 1988 and $588 in 1989.
- Establish a new Medicare benefit for prescription drugs. It will pay 80 percent of the charges for such medicine after the first $500 of expense each year. Medicare currently does not pay for outpatient drugs.
- Allow 80 hours annually of respite care services for dependent homebound persons.
- Require all state Medicaid programs to pay Medicare copayments, deductibles and premiums for the elderly living below the poverty line.
- Expand the Medicare home health benefit to cover 35 days of home care per year. Current law allows for 21 days.
- Expand coverage for skilled nursing care from 100 to 150 days per year, with the patient paying $24 for each of the first seven days. The bill repeals the requirement that an older person must be hospitalized for three days before being eligible for Medicare convalescent care.
- Prevent the impoverishment of spouses of nursing home residents by allowing such spouses to keep from $925 to $1,500 per month in income and as much as $48,000 in assets.
- Increase the limits on Medicare payments for outpatient mental health care from $250 a year to $1,000.
- Extend hospice payments beyond 210 days.
- Create a U.S. Bipartisan Commission on Comprehensive Health Care to make recommendations to Congress on improving access to health and long-term care services.
- Require HHS to recommend to Congress any changes that should be implemented in federal requirements for certification of Medigap policies.
- Authorize $5 million for each of the next five years for HHS to support research on long-term care.
- Require HHS to conduct a national survey of adult day care to develop and recommend appropriate standards for Medicare coverage of adult day care.
- Extend the funding for four Social HMO demonstration projects.

H.R. 2470 would be financed through a small increase in the basic Part B premium of $2.60 per month, beginning in 1989. A supplemental premium based upon income would bring in additional income. Single elderly taxpayers with adjusted gross incomes of $6,000 or less would pay no suplemental premium, nor would married couples filing jointly who have less than $12,000 in adjusted gross income. In 1988, the maximum payment for high-income elderly tax payers would be $580 per year.

Summary. During the first session of the 100th Congress, the House Democratic leadership guided catastrophic care legislation from subcommittee consideration to passage on the floor.

Most applaud this endevor to protect the elderly from catastrophic illness. Others emphasize the legislation's limitations in not providing nursing home coverage. Janet Jenson, J.D., of the Older Women's League views the legislation "as at best a cruel joke." Jenson states, "While hospital care is expensive, it is also typically short in duration. It is chronic illnesses which last for months, and frequently years, that create truly catastrophic financial stress and H.R. 2470 does nothing to expand coverage of long-term care and/or cover costly nursing home expenses."

However, H.R. 2470 is a step in the right direction. Congress has only postponed confronting the issue of coverage of costly nursing home care, an issue that will in the future be hotly debated in an aging society. **CLTC**

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Effecting Nursing Home Reform Through the Courts

From the Smith case to PaCS, controversy continues to surround survey process.

by Herbert Weiss

In the early 1970s, newspapers across the nation gave front-page coverage to a fire that killed 32 nursing home residents in Ohio and to an outbreak of food poisoning that killed 36 nursing home residents in Maryland. Due to these publicized tragedies and others, Congress, consumer advocates and the American public became concerned about the care provided in the nation's nursing homes.

> Many felt that the federal survey and certification process examined paper documentation and not the actual direct patient care provided to elderly nursing home residents.

Poor Care. Due to increased federal and state involvement in the reimbursement of nursing homes through the Medicare and Medicaid programs, the issue of poor care in nursing homes became firmly placed on the Congressional agenda in the 1970s. From 1969 to 1973, the Subcommittee on Long-term Care, Special Committee on Aging, known informally as the Moss Committee, held hearings across the nation examining allegations of poor nursing home care. Over 3,000 pages of testimony were accumulated during those hearings.[1] In 1974, a series of reports were released by the committee that were critical of federal regulation of nursing homes.

In the early 1980s, many consumer advocates supported changing the focus of the existing federal survey and certification process from documentation to examination of actual direct patient care. Many felt that the federal survey and certification process examined paper documentation and not the actual direct patient care provided to elderly nursing home residents.

Proposed Changes. In May 1982, the Health Care Financing Administration (HCFA) proposed changes to the survey and certification process. The proposed changes: "would have eased annual inspection and certification requirements for facilities with a good record of compliance, and would have authorized states, if they so wished, to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH) in lieu of state inspection as a basis for certifying that the facility was in compliance with the federal conditions of participation and operating standards."[1]

These proposed changes were viewed as inadequate and were opposed by Congress and consumer advocates. It was their belief that the proposals would further weaken the existing survey and certification process. In the fall of 1982, Congress ordered HCFA to defer implementation of the proposed changes until August 1983.

Through a compromise reached between HCFA and Congress, HCFA funded the Institute of Medicine (IOM) of the National Academy of Sciences to study the existing federal survey and certification process. The IOM study, entitled *Improving the Quality of Care in Nursing Homes,* was released in 1986 and called for major changes in the nursing home regulatory system.

> Through a compromise reached between HCFA and Congress, HCFA funded the Institute of Medicine to study the existing federal survey and certification process.

Court Suit Filed. Congressional and public pressure to change the nursing home survey and certification process, combined with a class action suit filed in Colorado in 1975, prodded the federal government to change the way in which nursing homes were surveyed.

In May 1975, legal services attorneys representing two young disabled nursing home residents filed a class action suit

against a nursing home, the Colorado Department of Health and Social Services, and the Department of Health, Education and Welfare (HEW), later renamed the Department of Health and Human Services (HHS).

In the court suit, *Smith v. O'Halloran,* both of the young disabled nursing home residents complained that: "the federal nursing home system failed to ensure that residents receive their entitlement under the Medicaid law to high-quality medical and psychosocial care in a context in which their civil liberties are protected."[2]

In 1978, in an unusual move, the State of Colorado became plaintiff instead of defendant in the suit.

The plaintiffs sought to require HEW to replace the existing survey and certification system with one that would be "patient oriented" and more likely to ensure quality of care.[3]

In 1978, in an unusual move, the State of Colorado became plaintiff instead of defendant in the suit. The state conceded that the existing federal survey and certification process did not provide imformation to the survey agency to determine if high quality of care was rendered, but had to utilize the existing survey process to be reimbursed by the federal government.

In 1982, the suit against the federal government went to trial and a decision was issued on Feb. 8, 1983. Even though the district court recognized that the current system was "paper oriented" rather than "patient oriented", the court ruled against the plaintiffs.[2] The district court held that "the Secretary has the authority to implement different procedures but had no mandatory duty to do so."[3] States were held to be responsible for quality of care even though the federal governmemt paid the bill for Medicaid.

Decision Appealed. The plaintiffs appealed to the Tenth Circuit Court of Appeals, which reversed the district court's decision on Oct. 29, 1984. The Tenth Circuit Court held that the Secretary did have the statutory duty to establish a survey and certification process that provided the survey agency with information to determine whether Medicaid facilities were providing high quality of care.[3]

The court of appeals ruled that the current survey and certification system failed to provide information to the survey agencies to determine if high quality of care was provided in Medicaid facilities and remanded the case back to the district court to compel compliance.

On Aug. 9, 1985, the district court ordered the Secretary of HHS to publish a Notice of Proposed Rule Making (NPRM) by Oct. 31, 1985, describing a new survey system that would provide the survey agency with information to determine if Medicaid facilities were providing high quality of care. To comply with this court order, HCFA published the proposed NPRM on Oct. 31 and a final rule on June 13, 1986, announcing their intent to implement a new resident-centered survey process called Patient Care and Services (PaCS). Although the PaCS survey system was being developed prior to the Smith case, HCFA presented the patient assessment system as the "sole method of complying with the court mandate"[2]

'Flawed Procedures'. On March 24, 1987, citing the "flawed procedures" in the June 13, 1986, rule, District Court Judge Richard P. Matsch ruled that the promulgation of the PaCS survey process was invalid and ordered the Secretary of HHS to develop and publish a new NPRM by June 1, 1987. This was later extended to July 1, 1987.[3]

The district court also found that the rule itself was inadequate because it did not include details of the survey methodology.

The court found that the rule published on June 13, 1986, was invalid due to an inadequate NPRM and flaws in the rule-making procedure. The court ruled that the proposed NPRM published on Oct. 31, 1985, was inadequate because it did not include "the guidelines and forms that constitute the system," information which the district court concluded was "required for meaningful comment."[3]

The district court also found that the rule itself was inadequate because it did not include details of the survey methodology. Procedural flaws included "an insufficient 60-day comment period and the Secretary of HHS's failure to extend the comment period despite numerous requests for such action."[3] Finally, the court ruled that "the statement of basis and purpose failed to provide a sufficient description in the NPRM or to provide an adequate opportunity for comment."[3]

Controversy Again. Controversy surrounds the latest NPRM issued by HCFA in the July 1, 1987, proposed rules in the *Federal Register* in response to the district court order. HCFA states in this latest NPRM that the "Long Term Care Guidelines" (in Appendix E of the proposed rules) will serve only as a resource to assist surveyors in the survey process. They are "not intended to be an operational tool that is followed line by line, nor are they global or prescriptive."[3]

HCFA states that the 'Long Term Care Guidelines' will serve only as a resource to assist surveyors in the survey process.

Futhermore, HCFA does not believe that the court order requires them to publish the forms and guidelines in the Code of Federal Regulation because they consider "the documents in the appendix as interpretative detail to provide guidance to surveyors" and therefore should not be binding.[3] HCFA stated that incorporating such details in the Code of Federal Regulation would seriously deprive it of flexibility to be responsive to changes and improvements in the interpretative guidelines.

Kathleen Mullen, legal counsel to the plaintiffs in the Smith case, however, disagrees with HCFA's position. According to Mullen, "The July 1, 1987, proposed rule does not meet the court order because the court said you have to put into rule form (Code of Federal Regulation) the system that you rely upon. The Secretary states in the proposed rule that the care guidelines, which are the guts of the existing system, are not to be considered part of the legal system. We will comment on the proposed rule and file a motion with the court for a ruling that the Secretary's publication of the July 1, 1987, proposed rule does not comply with the court order."

Comment Period. Comments on the July 1, 1987, proposed rule were to be submitted to HCFA by Sept. 29, 1987. However, timing of submission of public comments has become a controversial issue. The Office of Management and Budget (OMB) is reviewing proposed conditions of participation that would significantly change the existing conditions of participation.

Elma Holder, executive director of the National Citizens' Coalition for Nursing Home Reform, questions the timing of the comment period. "Why are we making final comments on the new survey system when in fact we have new proposals being seriously reviewed by the federal government on proposed conditions of participation? Shouldn't we see what the new conditions of participation are going to look like before we totally lock into a new survey system?"

The Smith case has been a major influence in forcing the federal government to ensure that quality care is provided in the nation's nursing homes.

In Summary. The suit filed by two disabled adults in Colorado, known as the Smith case, has been a major influence in forcing the federal government to ensure that quality care is provided in the nation's nursing homes.

Toby Edelman, staff attorney for the National Senior Citizens' Law Center, states, "The Smith case has been an important catalyst for nursing home reform by keeping pressure on HHS to improve the federal survey and certification system."

Both young disabled adults certainly have had their day in court — and so have America's elderly who reside in nursing homes. **CLTC**

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GAO Report Paints Bleak Picture of Nursing Home Industry

Repeat noncompliance said widespread, but chief offenders often avoid penalties.

by Herbert Weiss

On May 21, 1986, the Senate Committee on Aging released a report, "Nursing Home Care: The Unfinished Agenda," known informally as the "Heinz Report." In it, Chairman John Heinz (R-Pa.) of the Senate Committee on Aging compared substandard nursing homes to "19th century asylums" and told the committee members at a press conference that "we've allowed bed, board and abuse to replace the medical and rehabilitative care the law demands."

Sixteen months later, Senator Heinz released a General Accounting Office (GAO) report, "Stronger Enforcement of Nursing Home Requirements Needed," which he said confirms the conclusions of his nationally publicized 1986 document.

Bleak Picture. At the Sept. 16, 1987, press conference held to release this latest issued GAO report, Heinz stated, "I wish I could say I was the bearer of good news. But the news from the GAO is not good, it's grim."

The GAO report found that:

• **Repeat Noncompliance is Widespread.** A total of 3,372 of the nation's 8,298 skilled nursing facilities and 2,005 of the 5,970 intermediate care facilities did not meet one or more of the requirements most likely to affect resident health or safety during three consecutive inspections.

• **Nursing Homes With Serious Deficiencies Avoid Penalties.** Inspection records were reviewed on 26 facilities in five states (Arkansas, California, Connecticut, Kansas and Wisconsin) to determine why they were able to continue to operate with repeated deficiencies. These facilities were selected because they had multiple repeat deficiencies. Deficiencies most frequently found in these facilities were inadequate nursing services, poorly maintained and dirty interior surfaces, malfunctioning or broken plumbing, uncontrolled odors, improper use of physical restraints and improper diets.

Of the 26 facilities, 15 were found during a total of 26 inspections to have deficiencies sufficiently serious to preclude continued participation in the Medicare and/or Medicaid programs if not corrected. Only three of the inspections ultimately resulted in decertification. For the other 23 inspections, the facilities were, as permitted by existing federal law and regulation, given the opportunity to correct their deficiencies and remain in the Medicare and/or Medicaid programs without penalty. Seven of the nursing homes inspected were again found to have serious deficiencies that would prevent continued participation in the Medicare and Medicaid programs in a subsequent inspection.

> Only three of the inspections ultimately resulted in decertification.

Two of the three homes that were decertified were readmitted to the Medicaid program within 76 days, even though they were still out of compliance with some of the requirements that caused them to be terminated from the program.

• **Less Serious Deficiencies Not Penalized.** Although 11 facilities that were reviewed also had repeat deficiencies, they were not faced with the threat of decertification because they were in substantial compliance. The deficiencies found did not immediately jeopardize patient health and safety. The facilities were able to submit an acceptable written plan of correction to eliminate identified deficiencies.

• **Justification of Repeat Deficiencies.** Medicare and Medicaid regulations permit nursing homes with most types of repeat deficiencies to be recertified only if they can adequately justify the repeated noncompliance. The Health Care Financing Administration (HCFA) was found to be reluctant to crack down on repeat violators because the primary penalty — decertification — was considered "too severe."

• **Alternative Penalties Needed.** GAO found that termination is too severe a penalty for many deficiencies. Two alternative sanctions mentioned in the report were civil monetary penalties and bans on new admissions until deficiencies are corrected.

• **The Industry Responds.** Both the American Health Care Association (AHCA) and the American Association of Homes for the Aging (AAHA) responded to findings of the GAO report. As in the 1986 Heinz report, both associations disputed the interpretation of data and the findings of the report that alleged most nursing homes were providing poor care.

Dr. Paul Willging, executive vice president of AHCA, viewed the GAO report as inaccurate in describing patient care delivered in the majority of America's nursing homes. "What the report fails to tell the public is that the overwhelming majority of nursing homes provide good to excellent care," he said.

Other surveys dispute the findings of the GAO report. Willging cited a recent HCFA survey which found only 29 skilled nursing facilities out of 9,265 did not meet federally established conditions of participation in three successive surveys. "Furthermore," he stated, "according to reviews conducted under the new patient-oriented survey system (PaCS), 97 percent to more than 99 percent of the SNFs were in compliance with requirements at the condition-of-participation level during the last survey cycle."

> HCFA was found to be reluctant to crack down on repeat violators because the primary penalty — decertification — was considered 'too severe.'

Hundreds of Regulations. Nursing homes participating in the Medicare and Medicaid programs must comply with hundreds of federal and state requirements. Skilled nursing facilities must meet over 400 requirements, broken down into conditions of participation which consist of groups of requirements called "standards." Each standard is made up of a series of detailed technical requirements called "elements." Regulation requires facilities to meet 18 conditions of participation, 86 standards and 340 elements.

Willging noted that, "in most cases where deficiencies were found, facilities were out of compliance with elements, not standards or conditions of participation," and that noncompliance with one of more than 400 requirements " is rarely an indication of poor quality care."

Sheldon L. Goldberg, executive vice president of AAHA, recognizes the need for rigorous federal and state oversight of nursing homes and supoorts GAO's call for stricter enforcement. However, Goldberg observed that while "the GAO was busy analyzing two to six years of old data, major reforms to the nursing home enforcement process were already taking place. The nursing home standards have not yet changed, but the inspection process GAO studied is now defunct." Due to the newly implemented PaCS survey, "the surveyors' time is now spent observing the delivery of care, interviewing residents and staff and investigating activities that directly affect resident's health and safety."

Both Willging and Goldberg agree that states should have the flexibility and authority to determine which regulatory enforcement mechanisms are appropriate, in reference to the GAO report's recommendation to create civil monetary penalties and bans on new admissions until identified deficiencies are corrected.

Summary. Legislation has been introduced in both the House and Senate to strengthen the nursing home regulatory system. A coalition of national organizations which form the rank and file of the "Campaign for Quality Care in Nursing Homes" continues to meet regularly to generate congressional action on nursing home reform legislation.

Barbara Frank, associate director the National Citizens' Coalition for Nursing Home Reform, believes that the GAO report "graphically demonstrates that the federal government has failed to develop and implement a system that assures quality of care for each nursing home resident. This responsibility has been affirmed in the Colorado court suit, *Smith vs. Bowen*. Consequently, too many residents do not receive adequate rehabilitative care, mental health care or proper attention to their rights."

Frank believes that the challenge during the 100th Congress is to enact legislation and implement new regulations that build on the recommendations of the Institute of Medicine report.

For over 15 years, government studies such as "Nursing Home Care in the United States: Failure in Public Policy," "Nursing Home Care: The Unfinished Agenda," "Improving the Quality of Care in Nursing Homes" and the GAO report "Stronger Enforcement of Nursing Home Requirements Needed" have painted a bleak picture of the care provided in nursing homes and called for nursing home reform.

Over the years, statistical methods utilized to collect data in the released reports have been disputed. During the 100th Congress, statistics and data from government reports must not be used to impersonally describe the impact of poor care. Either through nursing home regulatory reform initiated by Congress or through the nursing home industry "policy its own," most will agree with Senator Heinz's observation, that "for every rotten apple in the barrel, there are several decent ones. But with the health and safety of America's oldest and frailest citizens at stake, even one rotten apple is too many." **CLTC**

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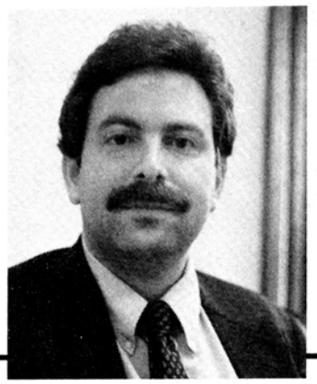
Catastrophic Care Measure Passes in the Senate

Outpatient drug benefit provision included; could result in Presidential veto.

by Herbert Weiss



Title 18 of the Social Security Act, known as Medicare, was enacted in 1965 to protect the elderly against costly acute hospital care. Coinciding with the celebration of the twentieth anniversary of Medicare, many Congressmen and Senators were concerned about the continual increase in the elderly's out-of-pocket health care expenditures. Over the years, Medicare has protected the elderly from costly acute care but not from costly long-term care services needed by an older population with multi-chronic disorders.

Cost of Prescription Drugs. Increased health care expenditures by the elderly are in large due to the cost of prescription drugs. About 12 percent of the population over 65 consumes approximately 30 percent of all prescription drugs. Since the elderly suffer from chronic disorders more than any other age group, they are forced to spend a higher percentage of their income on prescription medications.

A General Accounting Office (GAO) report released in July found that prescription drugs represent the largest out-of-pocket expenditure for three out of four older adults. In a recent American Association of Retired Persons survey, cost was given as the second most important reason for failure to fill a prescription.

The inclusion of an outpatient drug benefit in S. 1127, the Senate catastrophic care bill, would be beneficial to the elderly on a fixed income; however, it is not politically acceptable to the Reagan Administration. In the era of Gramm-Rudman, with a trillion-dollar federal budget deficit, new and potentially costly benefits are not likely to be supported by an administration that over the years has increased military spending, cut social programs and vehemently opposed tax increases. The outpatient drug benefit in S. 1127, with its potentially high cost, would almost certainly receive a Presidential veto.

Many statistical studies have been initiated to determine the cost of the outpatient drug benefit and, in most cases, the figures were inconsistent. A staff member on the Senate Finance Committee stated that the Congressional Budget Office estimated the cost of a drug benefit provision would be $2 billion, while the administration estimated a figure of $8 million. The staff member admitted, "Honestly, we don't know what it will cost."

> The inclusion of an outpatient drug benefit in S. 1127 would be beneficial to the elderly on a fixed income.

Drug Benefit Controversial. The drug benefit package is the most controversial provision in S. 1127. Opponents across the board cite its potential cost as the major obstacle.

The Pharmaceutical Manufacturers Association (PMA) fears the establishment of a Medicare outpatient drug benefit because it may lead to federal regulation, cost control of the industry and the promotion of the less profitable "generic drugs."

Those who support an outpatient drug benefit package stated that the proposed legislation does not go far enough. The Congressional Budget Office estimated that if the drug benefit in S. 1127 is implemented, only 14 percent of Medicare beneficiaries would receive help.

Bentsen Takes The Lead. Chairman Lloyd Bentsen (D-Texas) of the Senate Finance Committee, chief sponsor of S. 1127, is recognized by many in Washington as keeping catastrophic care legislation on track in the Senate. One Senate staffer reflected, "Actually, the whole bill was greased through the process during the Senate floor vote on Oct. 27, 1987. Bentsen wanted to pass the legislation on the first day of full Senate consideration. Controversial amendments were limited through compromises before they were offered."

On May 28, Sen. John Heinz (R-Pa.), backed by Sen. John H. Chafee (R-R.I.), was prepared to call for a vote on an amendment during a Senate Finance Committee bill markup. Senator Heinz's amendment would have incorporated a comprehensive outpatient drug benefit into S. 1127. However, due to potential cost and perceived administrative difficulty, both Bentsen and Chairman George J. Mitchell (D-Me.) of the Subcommittee on Health requested that Senator Heinz not offer his amendment. In return, Heinz was assured of their support in introducing his amendment on the Senate floor to create an outpatient drug benefit provision to the Medicare program.

In order to increase the political odds that S. 1127 would be passed, the bill was reported out of the Senate Finance Committee on May 29 without an outpatient drug benefit provision. Instead, the bill included language recommending the implementation of a 12-month Institute of Medicine study to develop recommenda-

tions for developing an outpatient drug benefit package.

Bentsen asked Chairman Mitchell to hold a hearing pertaining to the outpatient drug benefit provision. The hearing was held in June and provided needed information on the topic.

Senators Heinz, Mitchell, Chafee and Thomas A. Daschle (D-S.D.) were the original sponsors of the amendment to cover the cost of prescription drugs under Medicare that was offered during full Senate consideration. During consideration on the Senate floor, Senators Edward M. Kennedy (D-Mass.), Donald W. Riegle, (D-Mich.), Paul Simon, (D-Ill.), Dave Durenberger (R-Minn.) and Howard M. Metzenbaum (D-Ohio) became co-sponsors of the amendment.

Negotiating with the White House. Numerous times, Senators Heinz, Mitchell, Chafee, Daschle and Durenberger met with representatives from the White House in order to reduce the administration's opposition to the outpatient prescription drug benefit amendment. At the conclusion of those negotiating sessions, many of the administration's concerns had been addressed.

As a result of the meetings between the White House and the senators who supported an outpatient drug benefit provision, the annual $1,700 cap on out-of-pocket spending on non-drug-related Medicare services was increased to $1,850. Revising the cap would provide additional revenue to finance the outpatient drug benefit proposal and reduce administration opposition in terms of cost.

The administration was also concerned about the indexing method to be used to keep income to the program in line with expenses. In order to accomplish this, deductible and premiums would be indexed to the increase in the cost of the program. The administration did not want future increases tied to the Consumer Price Index; however, a compromise was reached whereby deductible increases would be tied to the cost of the Medicare program.

Phased In. Finally, the drug package would be phased in over several years and would provide the Secretary of Health and Human Services with considerable discretion in taking steps to limit the scope of the program to contain costs.

David Scheulke, professional staff member on the Special Committee on Aging of the U.S. Senate, stated, "Bentsen deserves a great deal of credit for accepting amendments that facilitated the creation of an outpatient prescription drug benefit under Medicare." If Bentsen did not accept the negotiated compromises worked out between the senators who were proponents of the outpatient drug benefit amendment and the White House, the catastrophic care initiative in the Senate might have been derailed.

On September 22, it became clear that the Senate would pass a catastrophic care bill with a drug benefit provision. Then, on October 27, while Capitol Hill reeled from the "Black Monday" stock market crash, the Senate acted on S. 1127 and catastrophic care legislation moved one step closer to enactment.

The Passage. The Senate approved passage of S. 1127 and its outpatient drug benefit provision by an overwhelming vote of 86 to 11. This legislation would authorized the largest expansion of the Medicare program since its inception in 1965.

To finance S. 1127, each Medicare beneficiary would pay an additional $4 a month premium indexed to the cost of catastrophic care in addition to the current $17.90 premium. A small premium increase of 60 cents in 1990, $1.40 in 1991, $2.20 in 1992 and $3.80 in 1993 would also be added for outpatient drug benefit coverage.

> The drug package would be phased in over several years.

Additionally, S. 1127 would impose a surtax on Medicare beneficiaries with income tax liability exceeding $150. The maximum surtax would be $800 for an elderly couple in 1988, increasing to $1,000 by 1992.

In many ways S. 1127 is similar to H.R. 2470, the House-passed catastrophic care legislation. Both bills build on the existing Medicare benefit structure. Each bill:

- Provides for unlimited hospital inpatient stays for general acute care but not psychiatric care.
- Eliminates coinsurance payments for hospital stays.
- Extends the 210 days of coverage currently allowed for hospice stays to an unlimited number of days
- Extends the coverage of care in skilled nursing facilitites from 100 to 150 days.
- Institutes a "per year" instead of a "per spell of illness" basis for determining deductible costs for hospital inpatient care, SNF care and units of blood.
- Provides the greatest benefits to lower-income enrollees.
- Provides limited coverage for costly nursing home care.

However, there are several significant differences between the House and Senate bills.

The outpatient drug benefit provision is a major difference between the measures. Once fully implemented, S. 1127 would require Medicare to pay 80 percent of the charges for prescription drugs after the first $600 of expenses each year. The deductible would increase annually to keep pace with the program cost. This new benefit would not be fully implemented until 1993. Additionally, in this Senate version, the Medicare program would encourage the use of cheaper generic drugs.

The House bill would take effect in 1988. H.R. 2470 would require Medicare to pay 80 percent of the charges for prescription drugs after the first $500 of expenses each year.

Another difference in S. 1127 and H.R. 2470 lies in the area of cost containment. There are more cost-containment provisions in the Senate bill, and the legislation would allow the Secretary of Health and Human Services to spread cost containment beyond the Medicare beneficiary to pharmacists and the drug manufacturing industry.

Amendments on the Floor. The Senate approved 19 amendments, including:

- An amendment sponsored by Heinz and Mitchell to add a prescription drug benefit and to provide for Medicare cost-sharing under the Medicaid program.
- An amendment sponsored by Sen. Barbara A. Mikulski (D-Md.) to add Medicaid provisions to protect income and resources of couples for maintenance of a spouse in the community.
- An amendment by Lawton Chiles (D-Fla.) to establish a United States Bipartisan Commission on Comprehensive Health Care to make recommendations on how to promote access to health care and long-term care services.
- Several amendments from Chairman John Melcher (D-Mont.) of the Special Committee on Aging of the U.S. Senate which would: 1) provide authority to lower the deductible for covered outpatient drugs; 2) call on the Secretary of Health and Human Services to conduct a survey of adult day care (co-sponsored by Bill Bradley (D-N.J.); and 3) modify provisions in the long-term care studies.

Differences between S. 1127 and H.R. 2470 are expected to be resolved in conference committee. Even though the odds are good for passage of catastrophic care legislation during the 100th Congress, it still might not happen. A Senate staffer speculates, "If the conference committee agreement concerning the outpatient drug provision goes too far away from the Senate-passed provision, it is very likely that the administration will no longer support a catastrophic care bill." Administration opposition can equate to presidential veto, which would have to be overridden by the House and Senate.

Summary. The oldest member of the House of Representatives, Congressman

Claude Pepper (D-Fla.), a long-time proponent to catastrophic care legislation, has been closely following S. 1127. Pepper states, "S. 1127 has the same strengths and weaknesses as H.R. 2470 that was passed in July 1987. In other words, while it includes an outpatient prescription drug benefit and some other essential benefits, it fails to address the most important aspect of catastrophic coverage — long-term care."

Through skillful compromise on the controversial issue of the outpatient drug benefit provision and committed bi-partisan support in the Senate, S. 1127 was passed. It may well be time for congressmen and senators to turn their attention to the pressing problem of financing costly nursing home care. To many elderly, incrementalism may be hazardous to both their health and pocketbooks.

Correspondent's Note: For one and a half years, I have had the opportunity to write the "Inside Washington" column for *CLTC*. Due to new duties and challenges in publishing, I am resigning my position as Washington Correspondent as of Jan. 1, 1988.

It is my hope that my columns have provided you, the reader, with insight into the political process. Washington does impact on you, wherever you reside, and it is important to be aware of what is happening on Capitol Hill. I hope my columns have provided you with such awareness.

Finally, to follow issues in depth, I have relied heavily on staffers in both the House and Senate — individuals who have both the grasp and knowledge of how things work "Inside Washington." I would like to thank each and every one of them for their assistance and support in researching issues for this column over the years. **CLTC**

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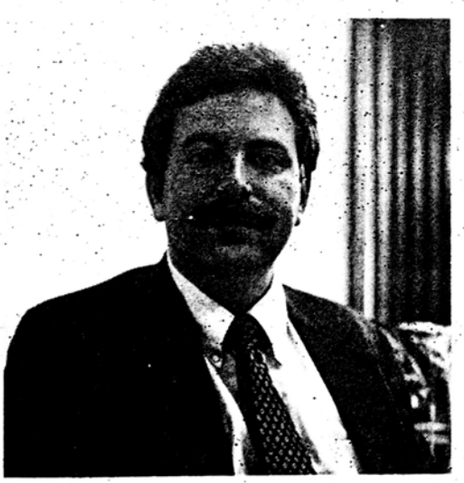
Covering the Cost of Long-term Care: Searching for Answers

Government, private studies seek options in private sector coverage.

by Herbert P. Weiss

In February 1986, President Reagan in his State of the Union Address placed the issue of catastrophic long-term care and its impact on the elderly on his Administration's agenda when he called for a major initiative on "...how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."

During his speech, President Reagan directed Secretary Otis Bowen, M.D., Secretary of the Department of Health and Human Services to provide him with recommendations as to how to provide affordable insurance to protect the life savings of the elderly which would be threatened by catastrophic illness. Secretary Bowen named James Balog, Chairman of the Private/Public Sector Advisory Committee on Catastrophic Illness and appointed a 13-member committee consisting of consumers, employers, insurers, financial experts, medical professionals and health providers.



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Through six public forums held throughout the country, hundreds of organizations and individuals provided testimony on catastrophic illness to the committee and its four staff members.

In August, this Blue Ribbon Committee presented its recommendations to Secretary Bowen. In the area of catastrophic long-term health care expenses, the report noted the following options deserved careful consideration: educating the public about long-term care protection with state and local governments taking a greater role in this public education; encouraging the development of private insurance policies for long-term care in skilled and intermediate care facilities; promoting tax-preferential IRA and other savings arrangements to stimulate purchase of long-term care insurance; improving data on cost and utilization for long-term care services; encouraging practical research and demonstration projects; removing legislative barriers to employers for providing long-term care insurance; and clarifying the appropriate scope of "skilled nursing services" and "home health services" under Medicare to include a broader range of nursing and other health services?

The findings of this report, supporting private sector long-term care initiatives with no recommendation for massive changes in the current way in which long-term care is financed, was presented by Secretary Bowen to President Reagan. Due to reported internal disagreements on what Secretary Bowen's final recommendations will be to the President, it is not clear whether he will discuss the issue of catastrophic financing during his 1987 State of the Union Address.

Congressional Initiatives

Congress has been active in exploring ways to finance costly catastrophic long-term care. The U.S. House Select Committee on Aging held a hearing on "America's Uninsured and Underinsured" in September to discuss the problems of lack of basic and catastrophic coverage for millions of Americans. When President Reagan announces his proposal on catastrophic insurance coverage, the Select Committee will hold a hearing to examine the President's catastrophic health care proposal as well as other congressional proposals.

Enacted legislation has also mandated detailed study of the issues surrounding catastrophic long-term care. In April, under a mandate of the Consolidated Omnibus Budget Reconciliations Act of 1986, the Task Force on Long-term Health Care Policies was established. Secretary Bowen selected Daniel P. Bourque, President of the National Committee for Health Care Policies to serve as chairman and appointed 18 individuals to form the ranks of the task force. A report and recommendations of the task force will be presented

(continued on page 72)

Cost *(continued from page 16)*

to Secretary Bowen and to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate by October 7, 1987.

Dennis L. Dewitt, executive director of the task force recognizes the controversy of the long-term care financing issue that will be studied by his task force. He said, "We're tip toeing into an area that has been reserved for the states [state insurance commissions] which ought to be reserved for the states." The recommendations from this task force will likely confront issues on consumer protection and identify ways in which to stimulate private sector long-term care inititives. There will be no recommendations for major federal government intervention to financing long-term care.

The 99th Congress was active in exploring ways to provide elderly with assistance in financing of long-term care services. Legislation was introduced to finance costly long-term catastrophic care through home equity conversion; medical expense deductions; special tax credits, deductions, and exemptions for caregivers; individual health savings accounts; improving coordination of the Medicare and Medicaid program; implementing Medicare and Medicaid demonstration projects; Medicare coverage expansion; and through the establishment of research, training, information and support programs.

Talk, But No Action

No legislation on long-term care financing was enacted during the 99th Congress. Geza Kadar, Assistant Washington Counsel of the Health Insurance Association of America said "the House Ways and Means Committee and the Senate Finance committee which have jurisdiction over changes in Medicare did not look seriously at any bill that would have added nursing home care to the Medicare benefit structure. If anything, they were struggling desperately to find ways that would be politically acceptable to reduce existing promises and benefits for Medicare."

A Republican administration in an era of fiscal scarcity and mandated budget cuts through Gramm-Rudman will influence the direction of the 100th Congress. Medicare benefits will be reduced rather than expanded. This will take place in either a Democratic or Republican controlled Senate.

The recommendations of the Private/Public Sector Advisory Committee on Catastrophic Illness and the Task Force on Long-term Care Policies will influence the Administration's response to financing of long-term care services...through private sector long-term care initiatives with the federal government's role being to help stimulate the market.

Relying on the private sector to protect the elderly from costly catastrophic long-term care is not viewed by some as the best way to attack the problem.

One House Committee staffer states that most currently offered long-term care insurance policies on the market can only be afforded by a small percentage of the population, leaving both the lower and middle class with the prospect of fiscal bankruptcy if nursing home care is required. Furthermore, there is concern that "the fascination with private long-term care options will serve as a smoke screen for what in the end is the public responsibility for financing long-term care services," the staffer said.

Brookings Study

Preliminary research findings from a study conducted at the Brookings Institution by Senior Fellow Joshua M. Wiener, Ph.D., to determine the effects of private long-term care insurance on Medicaid expenditures buttress the concern expressed on Capitol Hill that there will be individuals who will not be covered by private sector long-term care reforms.

Based on the assumption that a person would not purchase private long-term care insurance policies if the price of the policy exceeded five percent of their income and they had less than $10,000 in assets, estimates from the Brookings/LTC Financing model reveal that 20 percent of the elderly could afford to purchase a policy in the years 1986-1990. The average annual policy premium for those years would be $771. From the years 2016-2020, over 45 percent of the elderly could purchase a policy with an average annual policy premium price of $1,078. Even though the results from the model reveal a increasing market penetration of private long-term care insurance, estimated Medicaid expenditures for the period 2016-2020 are reduced by only five percent. This computer simulation may reveal that people who can afford to purchase long-term care insurance are not those individuals who end up as Medicaid recipients in nursing homes[3].

Denise Spence, Senior Research Analyst at the Brookings Institution remarks, "It seems pretty clear that private sector LTC insurance is not going to do the trick. There are no magic bullets, and the research indicates that they may not cover enough people at the lower end of the income distribution."

Long-term care options marketed by the insurance industry are considered by most in the insurance industry as a new frontier. It is the belief of many that in order to make the concept work, the American public, especially its younger members, will have to be educated to the facts of life that with old age comes a high probability of being inflicted with chronic diseases, increasing the need for costly long-term care services. Long-term care insurance marketed to corporations as new part of ongoing employee benefit and to a younger population who would be less at risk the most realistic way in which to lower the current high premiums.

At this time, the insurance industry is compiling data through experience to further broaden and market long-term care insurance. Susan Van Gelder, associate director for research policy and development of HIA, said, "It is our hope that future insurance products will reach a broader segment of the population with increased coverage and lower premiums." Currently, it is estimated that over 32 insurers offering policies and at least that many under development with over 130,000 elderly being covered by policies. Federal, state, local government and insurance companies will have to sell the concept to the public who do not believe they will age or need costly nursing home care.

Supporting private sector long-term care initiatives may be considered a politically acceptable solution to protect an aging population from costly long-term care services in the era of limited government spending. However, federal government intervention may become a necessity if it is determined private sector long-term care initiatives do not reach all levels of income. Protection against costly catastrophic insurance should not be gauged on socio-economic status, but as a right of old age.

Footnotes

[1] Statement of the Health Insurance Association of America on Long-term Care Insurance presented by Arthur Lifson, vice president of the Equitable Life Assurance Society of the United States before the Private/Public Sector Advisory Committee on Catastrophic Illness on July 30, 1986 at Chicago, Illinois.

[2] Report to the Secretary of Health and Human Services from the Private/Public Advisory Committee on Catastrophic Illness, August 19, 1986.

[3] Wiener, Joshua, Ph.D., "Modeling Long-term Care for the Elderly: The Case of Private Insurance." A paper presented at the American Sociological Association Annual Meetings, New York, New York, September 2, 1986. **CLTC**

Issues '89: Long-term Care and the 101st Congress

The federal budget deficit will have a decided impact on efforts by the 101st Congress to deal with long-term care.

One can look back at the 100th Congress and know that many aging issues were considered, but few legislative initiatives made it to the books. At a glimpse, a controversial catastrophic care bill was enacted; the Older American Act was reauthorized; the Omnibus Budget Reconciliation Act of 1987 was enacted which included nursing home and home health care reforms; and federal funding was increased for Alzheimer's research in an Health and Human Services appropriation bill. But many would agree that much more could have been done, especially in the area of financing long-term care.

From the Ashes. More than 30 long-term care financing bills were introduced during the last session of Congress. However, none of these bills was signed into law, not even the popular "Pepper bill," which was endorsed by over 100 national health care organizations and tens of thousands of elderly Americans across the country.

Although Rep. Claude Pepper's (D-Fla.) long-term home health care bill was soundly defeated last year due to fiscal cost and procedural concerns of the House Democratic leadership, it should stimulate interest in long-term care during the upcoming 101st Congress.

As one Pepper legislative aide told *CLTC*, "We may have lost this one battle but we'll win the war. This was the first vote in the history of Congress on long-term care. The national organizations that supported this bill will ensure that a meaningful long-term care bill will be considered in the next Congress."

As the 101st Congress begins, the debate will focus on financing long-term care. Some will come to this debate asking the question, "Where is the money going to come from?" Others expect a more prolonged debate to sort out a consensus on funding.

Musical Chairs. There will be several new players on Capitol Hill as the new Congress convenes. While Republican George Bush will be inaugurated as President this month, the Democrats have bolstered their majority in both the House of Representatives and the Senate. This could have the effect of making Congress somewhat unresponsive to the Bush agenda.

The important position of Secretary of the Department of Health and Human Services, which oversees the Medicare, Medicaid and Social Security programs, is up for grabs. Rep. Willis Gradison (R-Ohio), Social Security Commissioner Dorcas R. Hardy and Deborah Steelman, domestic policy advisor to the Bush presidential campaign, are considered to be frontrunners to replace HHS Secretary Otis R. Bowen, M.D. Also seen as a contender for the position is Sen. Orrin Hatch (R-Utah), ranking Republican on the Senate Labor and Human Resources Committee.

Some political observers speculate that William Roper, M.D., administrator of the Health Care Financing Administration, the agency which administers the Medicare and Medicaid programs, would like to be considered for an Assistant Secretary position in the Department of Health and Human Services. One House staffer observes, "HCFA is the most exciting position around, probably in the whole federal bureaucracy. The question one must ask is whether Bill Roper is ready to give up all this excitement."

Sen. George Mitchell (D-Maine), former chairman of the Senate's Finance Subcommittee on Health, will replace Sen. Robert C. Byrd (D-W.Va.) as Majority Leader of the Senate. During the 100th Congress, Mitchell introduced legislation that would have increased Medicare's responsibility for nursing home services while simultaneously stimulating the growth of long-term care insurance plans.

Because of the defeat of Sen. John Melcher (D-Mont.), there will be a new chairman of the Senate Special Committee on Aging during the 101st session. "Sen. David Pryor (D-Ark.) is expected to be the new chairman of this committee," states Bill Benson, staff director of the Subcommittee of Housing and Human Interests of the House Select Committee on Aging. "It will be greeted with enthusiasm by the people in the aging field. Not only does he have a solid track record on elderly issues, but Senator Pryor sits on three important authorization committees, especially the Senate Finance Committee."

Issues to be Addressed. The Administration and Congress must address other aging and health care issues besides the financing of long-term care during the 101st Congress. The debate is expected to focus on the following issues:

- **Catastrophic Care.** Congress will hear an outcry from elderly constituents regarding the newly enacted catastrophic care legislation once it hits their pocketbooks. Mid- to high-income elderly are concerned about the increased Medicare premium and surtax which will finance this new benefit. Attempts might be made to modify the financing of the catastrophic care measure. However, as one staff member of the House Select Committee on Aging notes, "Prospects for changing it are slim. There is no easy way to change it."
- **Social Security Benefits.** "Notch Baby" constituents will likely bombard their representatives with postcards asking for a correction in the Social Security benefit formula. In 1977, Congress mandated that a transitional formula be utilized to determine Social Security benefits for people born between 1917 and 1921. Because of this policy decision, the Social Security system has remained fiscally solvent.

Benefits were reduced much more than Congress had intended, however. Instead of a gradual reduction in benefits of six to 10 percent over a five-year period, in many cases benefits were reduced by 10-20 percent. Rep. Dan Rostenkowski (D-Ill.), chairman of the House Ways and Means Committee, and Rep. Andrew Jacobs (D-Ind.), chairman of the House Subcommittee on Social Security, were opposed to Notch reform legislation during the 100th Congress. They will continue to try to defeat any measures introduced during the 101st Congress that would jeopardize the fiscal solvency of the Social Security Trust Fund.

- **Housing Reform.** "There could be a real movement away from the Department of Housing and Urban Development's mentality that we do bricks and mortar only," states Dr. Don Redfoot, legislative representative for the American Association of Retired Persons. Sens. Alan Cranston (D-Calif.) and Alfonse D'Amato (R-N.Y.) released a bipartisan concept paper on housing reform at the end of last year.

The National Affordable Housing Act, which includes many of the paper's recommendations, will be introduced during the 101st Congress for debate, according to Redfoot. "One of the three major areas of this bill will be a supportive housing package which would integrate social services and housing for the frail elderly, disabled and homeless."

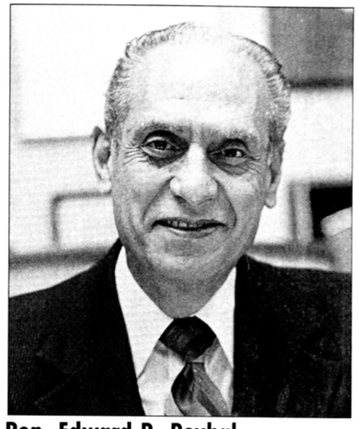
- **Social Security Trust Fund.** Congress is expected to seriously discuss the Social Security Trust Fund in relation to the federal budget deficit. Even though the Social Security program is considered off-budget, it is used to determine the Gramm-Rudman budget deficit targets. A House staffer states, "The Social Security Trust Fund has been used by both parties to mask the real size of the budget deficit." According to the National Committee to Preserve Social Security, "Including the 1988 Social Security surplus of $37 billion in the Gramm-Rudman deficit calculation creates the illusion of a $157 billion deficit, when the real deficit will be $195 billion in 1988."
- **Rural Hospitals.** Six hundred of the nation's 2,700 rural hospitals are "at risk of closure." The Prospective Payment System was established to give all hospitals an incentive to operate efficiently; however, this has not been the case. Since 1980, 161 rural community hospitals have shut their doors because of inadequate Medicare prospective payments and the inability to recruit physicians, nurses and allied health professionals. One-quarter of America's elderly population lives in rural areas, and since many have multiple chronic conditions, these individuals rely more heavily on rural hospitals.

"The bottom line is fairness or payment equity," says Amy J. Schultz, government affairs consultant for the National Rural Health Association. "There is enormous support among the members of the 101st Congress for giving rural hospitals a fair shake."

- **Medicare/Medicaid.** A Congressional Budget Office report projects Medicare and Medicaid costs will rise four times faster than inflation between 1988 and 1993. The federal budget deficit, along with the growth of Medicare and Medicaid programs, will put more pressure on Congress to contain the costs of these programs. A House Aging Committee staffer notes, "Physician reimbursement will be a hot item to look at. Reducing overpriced procedures will produce savings in Medicare Part B."

In the era of Gramm-Rudman, Congress will continue to debate aging and health care issues. Strategies for lobbying have changed to reflect the harsh fiscal realities of the time. Special interest groups no longer fight for larger pieces of the budgetary pie; they fight to hold their own. This might well sum up their legislative strategies in future years. Funding pilot programs and incrementally increasing existing programs may be more politically feasible during the 101st Congress than establishing new, large and untested programs and services.

Legislators' Views. *Contemporary Long-term Care* canvassed several leaders on Capitol Hill to obtain their views on long-term care policy during the first session of the 101st Congress. Following are their responses. (Note: As committee assignments had not been finalized at the time this article was compiled, there may be changes in various chairmanships and vice chairmanships when the 101st Congress convenes.)



Rep. Edward R. Roybal (D-California)
Chairman, House Select Committee on Aging

We have a long and difficult way to go before we complete our journey to a healthy and caring America. However, before we step forward, let's take a few moments to look back. While I had hoped that we would have seen major progress over the last eight years, nothing could be further from the truth.

Medicare/Medicaid Cuts. Just recently, we released a report prepared by the committee with the help of the General Accounting Office. This report, *An Assault on Medicare and Medicaid in the '80s: The Legacy of an Administration*, details the effort by the Reagan Administration to cripple Medicare and Medicaid. Year after year, this Administration attempted to make major cuts in Medicare and Medicaid. In 1987, they proposed a five-year cut in Medicare of over $54 billion and a five-year cut in Medicaid of over $18 billion. Congress rejected many of these cuts, but many cuts were made in both programs.

What was the result of these cuts, as well as the Administration's disinterest in helping elderly and poor Americans? Today, a smaller percentage of America's

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Editor's Note: This analysis was compiled by Herbert P. Weiss, a freelance writer based in Gaithersburg, Md., who frequently writes on national aging and health care issues. He is a former Washington correspondent for *Contemporary Long-Term Care* and former editor of *Aging Network News*.

poor are covered by Medicaid than in 1979. Even in 1979, only about half of the poor were covered by Medicaid. During the last eight years, America took another giant step backwards as the number of uninsured rose from an already unacceptable 28 million Americans in 1979 to a totally unacceptable 37 million Americans in 1987.

Progress Lost. For America's elderly, our recent journey has consisted of one step forward and several steps backward. By 1980, we had clearly made substantial progress in bringing down the proportion of elderly income going for health care. In that year, the elderly were spending just under 13 percent of their income on health care, according to our committee's study — down from the 15 percent level when Medicare and Medicaid began in 1966. Sadly, that progress was quickly lost.

Our latest committee study of out-of-pocket health costs shows that today's elderly are spending over 18 percent of their income on health care — nearly one and one-half times more than in 1980. This means that today's elderly are spending $21.9 billion more — $718 per person more — than if they were spending the same percentage of their income for health care as in 1980.

With respect to long-term care, another of our committee studies found that seven in 10 elderly living alone would find their income "spent down" to the federal poverty level after only 13 weeks in a nursing home.

The picture for couples is only somewhat less tragic. Also, it is only couples who would receive some limited protection under the Medicaid spousal impoverishment provisions of the catastrophic health insurance bill.

With that as history, let us turn to the journey ahead and to reforming and rebuilding a health and long-term care system that has yet to provide full protection for all Americans.

What's Ahead? While we did pass a catastrophic health insurance bill, we could have done better. My own catastrophic bill (H.R. 1930) would have taken several steps with respect to Medicare, including a lower catastrophic limit ($500), more respite care (10 days per year), more home health days (90 days plus extensions), a lower drug deductible ($300), and fairer financing (about one-third from increased cigarette taxes). With respect to Medicaid, it would have covered more children (all poor children up to age 18).

However, while the catastrophic legislation addressed important problems of America's elderly, it failed to significantly address what the elderly perceive to be their greatest problem — the cost of long-term care. The promise of a first major step toward long-term care protection — the long-term home care bill introduced by Rep. Claude Pepper (D-Fla.) and myself — was lost on the floor of the House last June. Even when confronted with our committee study documenting that long-term care induced impoverishment, Congressional turf and procedure won and the American people lost.

But long-term care is alive and well as an issue. In the past few months, we have seen a wave of new and comprehensive long-term care bills introduced, and we saw a Presidential candidate make long-term care a cornerstone of his campaign. Be assured that we will keep Congress and the Administration's feet to the fire when it comes to long-term care.

Comprehensive Package. In the 101st Congress, any long-term care legislation should build on the foundation of our long-term home care bill, but should also go further. Nursing home care as well as home- and community-based services must be part of a comprehensive long-term care package. Also, a complete long-term care package must protect people regardless of age, income or type of illness.

Finally, affordability will be a key, whether it be for the private sector or the public sector. With respect to the federal government, any long-term care plan must be self-financed and not increase the deficit. Any long-term care package not meeting these criteria is not likely to receive our support.

USHealth. Each of these many steps could help move us toward a comprehensive system of health and long-term care protection, but we still need a grand scheme if we are to complete our journey.

One such grand scheme goes by the name of USHealth (H.R. 200). When it is reintroduced in the 101st Congress, we will bring all of the individual bills outlined above and integrate them into the USHealth scheme.

What would it mean to have USHealth as the law of the land? First, all Americans — regardless of age, residence, income or illness — would have financial access to health care.

Second, health care quality would be assured for everyone without regard to who pays and to the setting in which they receive care.

Third, health care costs would be held in check at a level not to exceed 12 percent of our nation's gross national product — a level which is affordable to the nation and which would ensure both access and quality.

Finally, by building upon what the public and private sectors each do best, we would have completed a full system of health care access, quality and cost protection for all Americans.

Again, our journey to a healthy and caring America is a hard one and will take many steps. However, we must persevere. Many Americans are depending upon us to complete our journey and to do it as soon as possible. Thirty-seven million Americans are uninsured for health care and they need our help. Two hundred million Americans are underinsured for long-term care and they need our help as well.

Rep. Matthew J. Rinaldo (R-New Jersey)
Ranking Minority Member, House Select Committee on Aging

A consensus is emerging in Congress that any solution to the problem of financing long-term care must be a joint venture between federal and state governments and the private sector — a sort of three-legged stool. All three elements are necessary in order to ensure that, whatever the solution ultimately adopted, it will be balanced and capable of bearing up under the needs of increasing numbers of senior citizens. Given that current budget climate, it is not surprising that private-sector approaches to long-term care financing are receiving considerable attention.

LTC Insurance. Long-term care insurance in particular seems to hold tremendous potential for helping to meet the enormous costs of home health and nursing home care. However, before we can fully understand the potential contribution of long-term care insurance to meeting these costs and reducing public outlays, there are significant obstacles to be overcome.

We must clear away legislative and regulatory barriers to several logical and effective product designs. In addition, we must focus on ways to improve the affordability and coverage of products already on the market.

Risk Pooling. Many of the policies now on the market have been criticized as being too expensive for seniors to afford. Costs can be reduced if the market is encouraged to evolve in a direction that does a more efficient job of pooling risk through group plans or reinsurance arrangements.

Employer-sponsored group medical insurance, for example, almost always offers superior coverage at rates far below those of individual health insurance policies.

To their credit, several large employers have begun to recognize the value of long-term care insurance as an employee health benefit and have begun to incorporate these plans into their benefit packages.

In addition, many religious and fraternal organizations now offer participation in group long-term care insurance to their memberships, as do most organized retirement communities. Promoting the diffusion of these risk-pooling arrangements must be a top priority of federal long-term care policy.

Limitations and Restrictions. The second criticism of commercial long-term care insurance concerns the coverage limitations and underwriting restrictions that characterize many of the policies now on the market. For example, many policies contain clauses that exclude coverage for "organic illnesses," such as Alzheimer's or Lou Gehrig's disease.

These limitations are the natural response of a conservative industry entering a new and relatively unexplored market with little hard information to guide it. However, as more information has become available through ongoing federal long-term care surveys and industry claims experience, companies have begun to drop coverage restrictions from their policies.

The second and third generation long-term care policies now available, while not perfect, are a much better value for consumers than earlier products.

Older Americans Proposal. I have introduced legislation, H.R. 3501, the Older Americans Long Term Care Insurance Act, to encourage these long-term care policies. Reinsurance is a common practice in markets where risks are high and losses are likely to be substantial. In this instance, reinsurance is simply a federal financial guarantee wrapped around coverage provided by the private sector and is designed to protect both the company and the policyholder.

As vice chairman of the House Select Committee on Aging, I believe that this legislation offers the only pragmatic, affordable plan to reform the nation's long-term care "policy." In the face of our current budget deficit, asking those individuals who are able to do so to self-insure for their own long-term care needs is not inappropriate.

Financing Reform. There are also several steps the federal government must take to reform the long-term care financing system for the poor and near poor along more rational and equitable lines.

First, the federal regulatory environment must continue to support ongoing research and experimentation into new and innovative methods of long-term care management, financing and delivery strategies at the sub-federal level. States have had a significant role in financing long-term care and have been delegated much of the responsibility for the structure and implementation of long-term care programs.

In designing a new safety net for long-term care, we need to examine carefully the impact of federal directives upon the flexibility and responsiveness of these state systems.

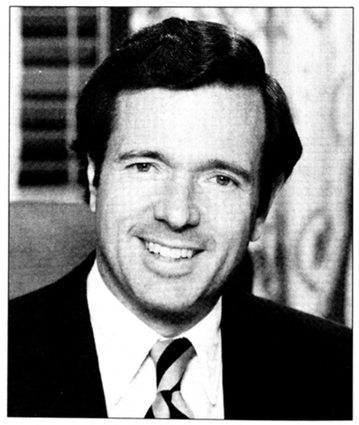
Second, we should take advantage of the valuable data and experience collected at the state and community levels by advocates, providers, administrators and other superintendents of delivery structures. Several state human services agencies have been experimenting with various combinations of public and private dollars to care not only for the elderly, but also for the mentally retarded, developmentally disabled and technology dependent populations of all ages. Such initiatives merit our interest and attention.

Reduce Fragmentation. Finally, we must pull long-term services out of other federal programs where they do not belong and where they contribute to the confusion and fragmentation of service delivery.

Some 80 programs currently provide long-term care services, including Medicare, Medicaid, Social Services Block programs and the Older Americans Act. These programs have different, but often overlapping eligibility criteria, reimbursement limits, target populations and funding sources.

This system needs to be shored up, defined and made more accessible to those in need. In particular, we need to stop haphazardly assigning services to whatever program happens to be the focus of Congress' attention. Flexibility is desirable, but not at the price of having programs scattered throughout the bureaucracy.

In short, we need a much more clearly articulated federal long-term care policy — one that draws upon the resources and expertise of all sectors.



Sen. John Heinz (R-Pennsylvania) Ranking Minority Member, Senate Special Committee on Aging

Six million families a year are confronted with the potentially devastating cost of a stay in a nursing

home or extended care at home. Half of the families, paying as much as an average of $25,000 a year for long-term care, will exhaust their resources and become eligible for Medicaid within a year. This financial vulnerability has become a growing problem for the elderly and their adult children, one which the Congress must now turn its attention.

The question is not whether we should have a program of public financing. Already, the government, through Medicaid, pays 42 percent of the cost of nursing home care.

In addition, Congress included in the recently enacted catastrophic insurance act additional long-term care benefits, including respite, home health and my own proposal for prescription drug coverage, and provided financial protection through Medicaid to the at-home spouse of a nursing home patient.

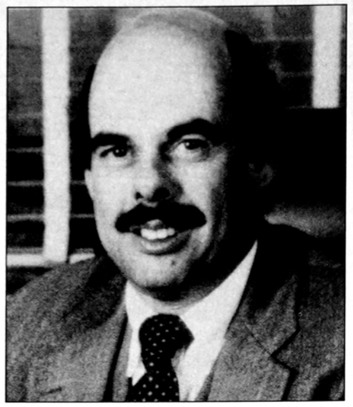
A Comprehensive Approach. The question we face today is how to structure a comprehensive approach to financing long-term care.

It should be comprehensive by covering both home health and nursing home care services, including an element of universal protection for families. It should draw on public financing as well as private insurance and individual responsibility. Furthermore, it should retain financial participation by the families and the elderly themselves.

Adequate financing by itself will not be enough if quality services are not available to meet the needs. We must encourage an expansion and improvement in the existing array of community-based services. Our focus must be on ensuring that a high standard of care is maintained. In addition, we must structure reimbursement to facilitate access to nursing homes for patients with a wide variety of needs.

LTC a Top Priority. As a newly appointed member of the U.S. Bipartisan Commission on Long Term Care and Comprehensive Health Care, the issue of long-term care will be a top legislative priority for me in the 101st Congress. Members will present recommendations for solving the long-term care financing problem to the Commission at the start of the new session.

I believe Congress can create a sound and workable solution to the long-term care financing problem — a solution that will once and for all ease the enormous financial and emotional burdens which long-term care costs place on families and on the elderly themselves.



Rep. Henry A. Waxman
(D-California)
Chairman, Subcommittee on Health and the Environment
House Committee on Energy and Commerce

It is time to come to grips with the long-term care financial crisis that threatens so many older Americans by establishing a comprehensive program under the Medicare statute that offers protection against the devastating costs of in-home and nursing home long-term care services.

A Growing Need for LTC. Today, more and more Americans are facing long-term care needs that threaten to force them out of their homes, eat up their savings and put tremendous financial burdens on their families. It will not be easy to fashion a balanced and comprehensive plan that offers protection to those most in need at a price that is affordable, but the elderly and their families cannot and should not wait any longer.

The growing need for long-term care affects us all. Those in need of care are our parents, our spouses and our friends. Most Americans have already had firsthand experience trying to find a nursing home and then arranging to pay for the care. They know long-term care is hard to secure and even harder to pay for. They know the average cost of nursing home care is now approaching $30,000 per year and they know they need help with these bills for themselves and their families. As legislators, we must face the facts, design the programs and secure the financing to bring real protection against these financial burdens to the American people.

Elder-Care Proposal. The Elder-Care Long Term Care Assistance legislation (H.R. 5320) that I introduced last fall along with my colleagues, Reps. Doug Walgren (D-Pa.) and Edward J. Markey (D-Mass.), is designed to begin to address these problems. It provides much needed assistance to severely impaired elderly and disabled Medicare beneficiaries with two or more limitations in activities of daily living or comparable cognitive impairments. It covers both home care and nursing home services and fills the financial void that now confronts most families when the need for long-term care strikes.

The legislation does not address every need or every concern, but it makes a fair start. It provides personal care, in-home assistance and day care services for the severely impaired elderly and disabled who live at home. For those who can no longer cope at home, Elder-Care covers nursing home care. It will help pay the nursing home bills of the nation's one and a half million nursing home residents, over half of whom are today without assistance from either Medicaid or private insurance. It asks beneficiaries to shoulder some of the responsibility by continuing to pay part of the cost but provides Medicaid assistance with cost-sharing for those with low incomes.

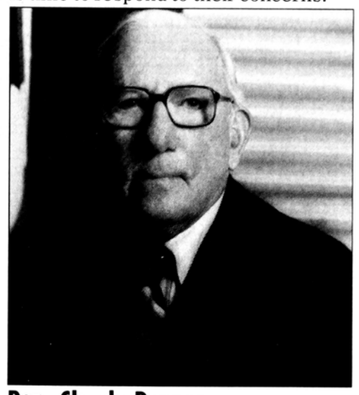
The program cost could exceed $50 billion in the first full year of implementation, but the legislation provides for revenue sources to help meet the cost without adding to the deficit.

Common Ground. I look forward to working with my colleagues in the 101st Congress to explore this approach and examine other alternatives. The bills introduced in the last session offer assistance in the home as well as in nursing homes for the frail elderly. Although the bills differed in scope of benefits and costs, all shared a common ground in the determination of eligibility, the use of cost-sharing coupled with low-income protections, and the recognition that revenues must be raised to cover program costs. Most importantly, these bills all signal a growing recognition that long-term care is a serious and expensive problem that Congress must soon address.

Long-term care will be a priority on our legislative agenda in 1989 as we work to develop a bill that offers genuine protection but is fiscally responsible.

We know that long-term care reform will not be easy and it will not be cheap. It will take enormous resources combined with federal leadership and grassroots support. But, we also know that Americans want long-term care reform to protect themselves and their

children from the devastation of illness and disability, and they tell us that they are willing to pay for such protection. It is time to respond to their concerns.



Rep. Claude Pepper
(D-Florida)
Chairman, Subcommittee on Health and Long Term Care
House Select Committee on Aging

Without question, long-term care for Americans of all ages will be a focal point of the 101st Congress. The results of several national polls on this issue and the flurry of bills introduced on the subject by key House and Senate members last year suggest that the people and the Congress are standing on the same square — both want action on this pressing matter. In fact, in releasing survey data supporting a federal plan for long-term care, pollster Lou Harris told my subcommittee that he had not seen such strong public consensus on an issue since the early 1960s, when his polls revealed Americans' nearly unanimous support for the type of program which was to become Medicare.

Why Long-term Care? The focus will be on long-term care because it appears to be the leading health concern for Americans young and old. An estimated one million of our citizens annually become impoverished trying to meet the costs of Alzheimer's disease, Parkinson's disease, cancer, stroke and other illnesses which, under current law, only Medicaid will cover.

Long-term care costs today are staggering. Care in a nursing home averages over $24,000 per year and can cost as much as $60,000. Home health care costs an average of $15,000 a year. Long-term care accounts for 80 percent of all catastrophic illness spending, and yet the Medicare Catastrophic Protection Act, signed into law last year, overlooks that aspect of catastrophic illness. Clearly, much remains to be done.

Last June, H.R. 3436, my bill to provide long-term home care under Medicare to children, disabled persons and the elderly, came to the House for a vote. Although it was defeated, the bill did have the distinction of being the first long-term care legislation to be voted on in the history of Congress.

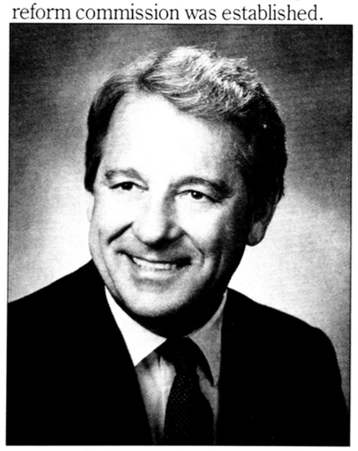
Over 140 national organizations supported the measure, which I plan to reintroduce as soon as Congress reconvenes. Thanks to the work of this extraordinary coalition of children's groups, elderly groups, disease-specific groups, unions and even educational organizations, as well as other interested citizens and legislators, public awareness of this home care proposal is growing. I am optimistic about its passage in the 101st Congress.

Bipartisan Commission. Another eagerly anticipated event in 1989 is the convening of the United States Bipartisan

Commission on Long-Term Care and Comprehensive Health Care. This 15-member group, composed of six senators, six congressmen and three Presidential appointees, was created when a bill of mine was added as an amendment to the Medicare Catastrophic Protection Act.

Not at all an "ivory tower" group, the commission is designed to be practical and make suggestions that could be implemented and funded in the real world. Its ambitious agenda is to take six months to develop a way of financing and administering a program of long-term health care for all Americans, and to take another six months to devise a comprehensive health care program for our citizens.

The creation of this bipartisan commission represents an historic step forward on the part of the Congress to come to grips with several serious health policy questions facing the nation, including the provision of health care for the chronically ill, the uninsured and the underinsured of America. The commission will force the Congress to reach a political consensus on these critical issues, just as we were forced to do back in 1982 and 1983 with Social Security, when a comparable reform commission was established.



Rep. Ralph Regula
(R-Ohio)
Ranking Minority Member,
Subcommittee on Health and Long Term Care
House Select Committee on Aging

It is tragic that in our nation of wealth there looms the frightening prospect of destitution, poverty and lack of adequate health care in our older years. The cost of a prolonged hospital or nursing home stay can pauperize even the most well-prepared families. Most of us have experienced that sense of dread for ourselves or a loved one.

Last year, we passed the catastrophic care legislation which has eliminated part of this threat, but it has done nothing to protect against the costs of long-term care or encourage the proper use of home and institutionalized care. Furthermore, it does not even acknowledge the 37 million Americans who have no public or private health insurance. It is important that we approach these issues seriously and consider alternatives which will structure a system that makes the best possible use of existing resources.

Change Reforms' Focus. Congress has taken action to slow the rate of growth of Medicare outlays through the use of the Prospective Payment System (PPS) and other reimbursement devices. The efforts have decreased costs in the hospital setting and caused many institutions to become more efficient. However, they have also resulted in problems with access and premature discharges from care.

Moreover, some of the savings are illusory in that the cost is being passed on to other third-party payors. As private insurers and the states tighten their reimbursement plans, care givers are confronted with lower revenues and the possibility of rationed care or decreased services.

Every effort must be taken to reduce the rampant increases in cost, but this cannot be achieved simply by lowering reimbursement rates. Instead, both Congress and the states must look at ways to actually improve the cost-efficiency of health care, ranging from manpower issues and case management techniques to preventive health care. We must also strongly support basic science research from which tomorrow's treatments will originate.

PPS has begun to make the industry more efficient, but its success is limited by the actual costs of providing care. As private payors tighten reimbursement, hospitals are being put in a situation where greater savings are difficult because productivity savings have been largely achieved and alternative revenue sources are increasingly limited. Setting caps on costs for certain procedures under Medicare is a necessary element in controlling expenditures; however, only when this blunt approach is coupled with efforts to actually improve the delivery of health care can we expect long-term control over its cost.

Recently, I was successful in expanding Medicare coverage to include influenza vaccinations under a trial program. The reform could result in savings of $63 million annually. This is the type of program change that can reduce outlays while improving the system.

Better Protection for Elderly. The cost of long-term care can be devastating to an elderly couple. The average annual cost of home health care alone is $15,000 as compared to $27,000 for care provided in an institutional setting. We need to protect the elderly by offering them protection from the unbelievable strain and burden associated with long-term care. The number of people needing such care is increasing as the population of older Americans continues to grow.

The age group of 65 and older is the fastest growing segment of society and is projected to continue growing into the next century. Over one million people are in need of long-term care now, and this number is surely going to expand.

Obviously, most people prefer to remain in their homes to receive care, yet our system promotes institutionalization even when the alternatives are less costly and more humane. At the same time, there are situations when home care is not feasible and nursing home care should be provided. The system must be changed to foster delivery of the most appropriate care.

It is my judgment that the best solution to the problem would incorporate a blend of public and private options ranging from using IRAs to purchasing certified long-term care policies to a limited public expansion of Medicare. Also, we must be very careful not to open Medicare to all ages or merge it into a new, broader program, ultimately hurting the intended beneficiaries. This would pose problems of financing, access to care and quality of services.

Employers' Responsibilities. The issue of employer provision of health insurance is inextricably locked with the dilemma of the medically indigent. The goal of making affordable health care available to every American cannot be achieved without some sort of step in this direction. Of those Americans who currently lack health insurance, more than half (19.5 million) are either employed or are dependents of a worker.

Not having health insurance often results in not receiving the proper health care. For example, the uninsured, who

are generally in poorer health than those with insurance, receive 27 percent fewer physician services and 19 percent less hospital care. In 1986 one million individuals who sought health care were turned away for financial reasons and another 14 million did not seek care because they could not afford it.

Mandating that employers provide health care will not solve this problem, and the potential impact upon the economy could further exacerbate the budget deficit. Instead, we must work to provide incentives for the development of industry-sponsored packages. These could range from deductions for employer contributions to favorable treatment of prefunded qualified long-term care insurance. The focus is to provide encouragement to business for coverage of retirees, as well as part-time employees, while ensuring the viability of these new plans.

Congress must be especially careful not to hurt the many small businesses that are an integral part of our economy. Some protection must be given to these companies so that they can provide the needed coverage to their employees and retirees without a major burden.

In conclusion, it will be difficult for Congress to pass such major health reforms after the changes enacted in 1988. However, I am hopeful that a reasonable schedule may be set forth to act promptly on these problems.

Rep. Tom Tauke
(R-Iowa)
Ranking Minority Member,
Subcommittee on Retirement
Income and Employment
House Select Committee on Aging

With nursing home costs now averaging $23,000 per patient annually, an aging population creating a rapidly growing need for home and nursing home care, and the movement of women — the traditional care givers for the elderly — into the work force, long-term care has moved to the front burner in Congress.

The debate has moved from the question of whether or not there is a federal role in financing long-term care for the elderly to the question of what that role should be.

As a nation, we have reached a consensus, I believe, that every individual should have access to basic health care services, regardless of income. We are uncomfortable with a system which forces individuals into poverty before Medicaid will pay for nursing home care. We realize that the elderly would prefer to receive care in their homes and communities, yet home health care coverage is very limited under federal and private-sector health care coverage.

No Easy Answers. The question of the appropriate federal role in financing

(continued on page 71)

ISSUES *(continued from page 38)*

long-term care has no easy answers. Complicating the debate is the growing pressure on Congress to address not only the long-term care needs of the elderly, but also the fact that 37 million Americans have no health insurance coverage. As the federal government and the private sector have instituted cost containment policies to stem the spiraling increase in health care costs, the "fat" in the health care system that once absorbed and concealed the cost of care for the indigent and uninsured is vanishing.

Medicaid, originally designed to be the health care safety net for the poor, now provides coverage for only about 40 percent of our nation's poor. Also, an increasingly larger share of Medicaid dollars is being consumed by nursing home costs for the elderly, limiting the ability to expand coverage for the non-elderly population.

Budget Deficit. Overshadowing the debate over financing long-term care is the budget deficit. The nation is now spending about $38 billion a year on nursing home care, triple what we spent a decade ago. With no change in current policy, that bill is expected to triple again over the next 30 years. The cost of several proposals introduced in the last Congress to expand federal financing for nursing home services was estimated, conservatively, at $18 billion annually.

Providing home care coverage is also expensive. The Health Care Financing Administration estimated the cost of a proposal introduced in the last Congress to provide federally financed home care services at $6.8 billion in 1989, rising to $21.6 billion by 1992.

Private-Sector Involvement. The ability of private insurance alone to address the need for long-term care coverage is limited. Insurance works on the principle of spreading the risk, but most younger persons do not see the need for long-term care coverage, although there is a risk that they or their children will need such care. While more insurers are entering the long-term care market, the policies they are offering are expensive and, due to the unpredictability of the cost of care in the future, may provide a very limited benefit when they are actually needed.

Yet a private-sector approach holds the most promise for addressing the long-term care problem and should be explored. History has taught us, or should have taught us, that expanding the role

of the federal government as the direct purchaser of health care services invites inflation and abuse and requires an ever-heavier hand of regulation to attempt to ensure quality of care and access to care.

A private-sector approach, with the federal government providing assistance to individuals, based on income, for the purchase of qualified private plans, would act to restrain costs through competition and capitated payments. Competition for plan members would foster quality of care, and plans would have incentives to offer home health care services to prevent more costly institutional care and to give individuals what they prefer — home care.

Tax Incentives. The federal government could stimulate this market by acting as reinsurer for the most costly cases and by providing incentives through the tax system for individuals to plan for long-term care, for insurers to develop long-term care policies, and for employers to include long-term care coverage in their benefit plans.

A private-sector approach also offers individuals a range of choices and requires that individuals take responsibility for their choices.

There are no easy — or cheap — answers to long-term care coverage. But it is clear that Congress must begin now, in partnership with the private sector, to meet today's and tomorrow's needs.

Rep. Olympia J. Snowe
(R-Maine)
Ranking Minority Member,
Subcommittee on Human Services
House Select Committee on Aging

As individuals live longer, they have a correspondingly greater need for long-term care services, including home health, nursing home and respite care. Yet, at present, there are few protections against the financially devastating costs associated with chronic illness.

Thus, while the 100th Congress focused on the acute health care needs of the aging population, the 101st Congress will face the task of revamping the chronic long-term care system.

Family Care. An essential element of the current long-term care system is the family. Indeed, 80-90 percent of the care of the chronically ill is provided by family care givers, usually wives and daughters. Without the efforts of these care givers, the strain on the health and social service systems would be great and many older persons would have to go without care entirely.

Family care is one of the most critical factors in preventing or delaying the need for nursing home care and, as such, deserves serious consideration when we undertake long-term care reform. Yet, families alone cannot bear the full burden of multiple generations and numerous family members who suffer chronic illnesses.

A Public/Private Partnership. We also must strengthen the public/private partnership by assuring access to adequately funded employee benefits, including health insurance, long-term care insurance and pension benefits in retirement. These, in conjunction with a secure Social Security system, will help to provide many protections in old age.

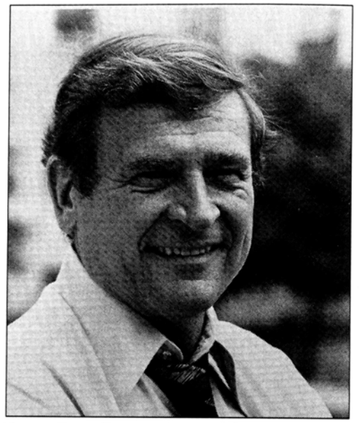
There is no question that it will also be necessary to provide public support for a more coordinated system of home- and community-based care. To that extent, Congress must press health and social services to assist both chronically ill individuals and their families.

The proposals that were offered for long-term care reform in the last Congress only provide starting points for what must be a full debate of the issues. Not only must we examine the mix of services and benefits, but we must also find realistic ways to pay for the services without further burdening older persons.

Broadening LTC's Scope. While addressing the long-term care issue, we must remember that the needs of our citizens for home health, respite and nursing home care are equaled by their need to have their personal rights and autonomy protected and respected.

In that vein, Congress must broaden its current notion of long-term care. For example, we must include guardianship reform in any long-term care package. Individuals who have been adjudicated incompetent and placed under court guardianship programs are the most vulnerable individuals, often unseen and unheard. While guardianships can protect the well-being of those incapable of caring for themselves, the current fragmented system provides few safeguards to assure that only those most in need of guardianships are affected, and then only to the extent of their need.

The next Congress will challenge our creativity as we attack very serious questions of concern to all citizens. I, for one, look forward to the challenge.



Rep. Dan Rostenkowski
(D-Illinois)
Chairman, House Committee on Ways and Means

President-elect George Bush and the next Congress will have to face two of the more troubling legacies of the Reagan presidency: a national debt that will exceed $2 trillion and a social safety net that will have endured eight years of neglect.

Economic-Social Conflict. Whether by accident or design, the fiscal policy of the Reagan era, with its huge federal debt, has created a natural conflict between economic responsibility and social responsibility. The 101st Congress will have to meet the competing goals of continued deficit reduction and satisfying the pent-up demand for needed social spending.

How this conflict is resolved will affect more than just health care proposals. It will influence the debate about all public policies — defense spending, education, child care, public works, farm programs, housing and welfare — all government spending will be examined in the light of our federal deficit.

The experience of the past eight years gives us some indication of how the deficit will shape the public policy debate. Existing programs will face constant scrutiny, if not outright assaults. New spending programs, no matter how justifiable, will have to overcome a deep-seated, institutional resistance. And, any legislation containing new spending will have to contain spending cuts or tax increases to match the new spending.

Past Experience. I learned a few things in the legislative battles of the past eight years. One, is the power of the Presidency and the importance of working with the President to accomplish as much as possible. The major legislation enacted since 1981 has either been supported by the President or it has made only minor, if any, improvements in the safety net.

In cases where the President supported the bills — Tax Reform, the Social Security Act Amendments of 1983 and 1987's Medicare Catastrophic Health Insurance bill — we took the President's willingness to work with us and made the bills better. In those areas where he fought us, it was trench warfare, making progress a foot at a time.

Consensus Hard to Achieve. The second thing I learned was that political consensus is very difficult to achieve in an era of limited resources. It's easy to identify social needs. Balancing those needs, deciding on priorities, is another story. It is a mistake to think that the end of the Reagan Presidency means the end of this difficult task. Although we won't have to contend with his personal popularity, we will have to contend with his legacy of federal debt.

So it is against this background that the 101st Congress will confront the issue of health care. There is certainly no shortage of health care issues that must be addressed. These include improved health insurance coverage for the 37 million uninsured Americans, long-term care, physician payment reform and further refinement of the hospital DRG payment system.

Medicare. There will also be continued pressure to reduce Medicare spending, either as part of a deficit reduction effort or to help finance other health-related initiatives. Medicare is an attractive target for both budget cutters and spenders. In recent years we have been able to limit reductions largely to provider reimbursements rather than cuts directly affecting beneficiaries. I think this will continue to be the trend in the Committee, but we have to be careful not to reduce the quality of the care being provided.

We will continue to monitor the DRG system, making adjustments to improve its efficiency and fairness. Of particular concern to me is the need to protect inner-city hospitals with large numbers of uninsured patients.

Physician Payment Reform. The next logical step in improving the Medicare reimbursement system is physician payment reform. There is a great deal of interest on the Committee in assuring that equitable fees are paid for primary care. This means that the current reimbursements for surgeons and other specialists will be carefully scrutinized. Any significant change in physician reimbursements will be controversial. Our task will be to get the most care for the Medicare dollar without jeopardizing the quality of the care.

In addition to these important adjustments to the current Medicare system,

the Committee will be in the middle of the debate over new health programs. The recent debate over the Pepper bill focused attention on the growing need for long-term care. And the latest estimate of Americans with no health insurance is a startling 37 million. Each of these issues poses tough questions about the appropriate role for government in providing health care.

Home Care, Nursing Homes. The long-term care issue raises questions about home care versus nursing home care. Which is more important? What is the appropriate mix of private insurance, government spending and out-of-pocket costs to pay for this care? Who will provide the care?

The alarming number of uninsured Americans raises similar questions. Who will pay? What amount of care should be assured? Who should provide the care?

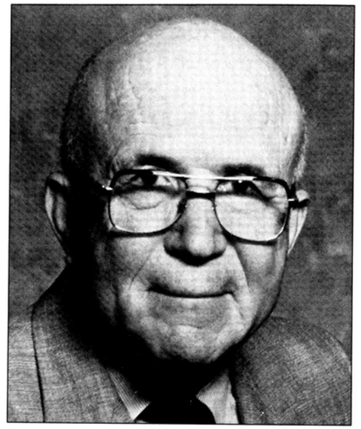
I think the federal government has a role to play in both of these areas. And both will be at the top of our health agenda. Addressing these issues will be technically difficult, politically controversial and very expensive.

A Question of Balance. I don't believe the legislative process can address both at the same time, nor do I think we'll develop the political consensus about where to get the money for both. So which do we do first? I don't know the answer to that question. I'm not sure that a consensus has been reached among all of the interested parties to the debate — beneficiaries, health care providers, insurers, business and labor.

And, wholly apart from the questions of how much to spend in health care and where to spend it, how are we going to balance health care needs against the need for housing, for education, for AFDC benefits?

I don't have the answers to these questions either. But I do know that the next President will have a major role in sorting out these different priorities. The President's agenda may not always be followed, but it starts the debate and it is a powerful influence on the process of establishing our national priorities.

I think that my role in this process, and the role of the House Committee on Ways and Means, is straightforward. I want to develop legislation that the Congress will pass and that the President will sign. I'm a legislator and a pragmatist. I don't view the legislative process as an opportunity to score political points — I want to use the process to make good law. That means compromising. It means working with the President. It means giving up some things I want and accepting some things I don't want. And more than anything else, I think it means accepting that incremental progress is preferable to no progress at all.



Rep. Augustus Hawkins (D-California) Chairman, House Committee on Education and Labor

As the nation's demographics change and the work force grows older, the kinds of benefits provided by employers are beginning to change. Traditionally, employee benefits often included health insurance, a pension plan and some kind of paid annual vacation.

New Concerns. But today, workers increasingly are concerned about things that do not fall into the traditional benefit plan, such as child care and caring for elderly or ill parents. The huge growth of women with young children in the marketplace, for example, has forced employers to build day care centers on the job site, consider offering parental leave as a benefit and establish flexible work hours to accommodate working mothers. Young workers who have the responsibility for caring for their aging parents have also been pushing for a government and business response to their needs.

In addition, many workers are also thinking of their own future beyond retirement and beyond pensions to a time when long-term care may be needed for themselves or their spouses. The big question is, how do we pay for the care? The most costly long-term care option and the one most often chosen — a nursing home or similar kind of institutional setting — averages about $25,000 per year.

Cost for all long-term care services exceeded $50 billion last year. More than 50 percent of that tab was paid by nursing home residents or their families. Private insurance paid less than one percent. For the elderly living in poverty, obtaining and paying for quality long-term care are nearly impossible. The number of older Americans fitting into this category is increasing steadily.

Currently, about 15 percent of individuals 65 or older live in poverty — only among children is poverty more prevalent. The situation for the middle class is not much better, with a large share of the financial burden resting on relatives or children who may be in the midst of raising families of their own.

Possible Solutions. One proposal which seeks to provide answers to these troubling circumstances is legislation providing for long-term care protection for Americans of all ages and incomes. This is an issue that will be addressed by the 101st Congress.

While we must weigh the cost to the federal government and its impact on the deficit, we must also be mindful of the benefits to be received by protecting those facing the burden of both nursing home care and other unmet health care needs. The Congress must also look to the private sector and encourage the development of employee benefit plans that help address the problem of paying for long-term care.

LTC Coverage as a Benefit. Many unions already are considering including long-term care as part of collective bargaining agreements for their members. And, professionals and other white collar workers are examining the possibility of obtaining long-term care protection as a fringe benefit.

Employee benefit plans are a life support system for all workers. More than 140 million people have job-related health insurance protection, for example. This network of protection has helped alleviate the fear of working people and their families that illness would mean loss of job and poverty.

Today many workers now fear the pos-

sibility of impoverishment because of the high cost of long-term care in the way their parents feared the high cost of medical care.

The Congress should be examining life support benefits and finding ways to expand them as an important part of our nation's commitment to a decent standard of living for all citizens. Our intent is to promote programs that provide for the well-being of all of the American people.

The use of employee benefits to provide long-term health care has strong political opposition and will therefore not happen overnight. But, this is an issue that the House Education and Labor Committee is committed to pursue in the 101st Congress and in years to come. We cannot afford to be a nation without a national long-term health care policy.

Sen. James M. Jeffords (R-Vermont)
Former Ranking Minority Member, House Committee on Education and Labor

A fact of life on Capitol Hill that is never easy to accept is that some pressing issues are never resolved before one Congress adjourns and a new one convenes. Unfortunately, that was the case with long-term health care during the 100th Congress.

Catastrophic Bill. We did make significant progress. Passage of the catastrophic health insurance bill, which the President signed into law last July, expanded Medicare to provide coverage of catastrophic hospital stays and capped the amount that Medicare recipients have to pay out of their own pockets for covered services during any one year.

The importance of the catastrophic health care bill cannot be understated. It offers tremendous relief to a great many elderly Americans who have feared that hospital stays and out-of-pocket expenses related to catastrophic illness would financially devastate them.

National LTC Policy Needed. Catastrophic care, however, is one of two critical health areas affecting our senior population. The other is long-term health care, both institutional care and home care, and that area was not resolved before the 100th Congress adjourned last October.

I have confidence that the 101st Congress that convenes this month will tackle this issue anew and will be able to craft a national policy on long-term health care. Certainly, that will be a priority of mine.

Whatever policy emerges, however, it must take into account both institutional and home health care needs, since most Americans will experience both in some form during their lifetime. Although only about five percent of the elderly reside in nursing homes at any given time, it is estimated that the chances of a person needing nursing home care at some point in his or her life is between 25 and 45 percent.

Financing Sources. What a national policy also must address is how long-term health care is to be financed, and by whom. Health care costs, as everybody well knows, are high and climbing higher.

The cost of nursing home care alone now runs between $20,000 and $30,000 annually, depending on such factors as severity of illness and area wages. Moreover, we will soon experience a dramatic shift in the pool of workers available to help finance such human service programs.

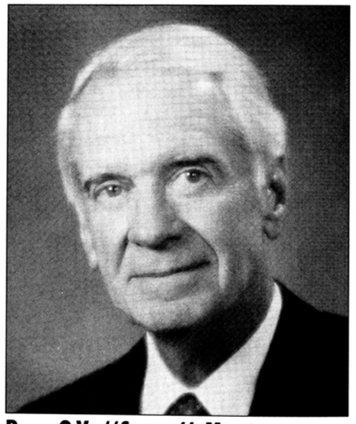
Currently, we rely heavily on our large, working-age baby boom generation to pay the tab for many of these human service programs. But soon those baby boomers themselves will be heading toward retirement, to become consumers rather than providers of human services, and the number of working-age Americans left to financially support those services will be considerably less. If we do not plan ahead, we will simply overwhelm the generations that follow the baby boomers. We have already heaped over $2.5 trillion in public debt onto today's workers and those to follow. We cannot compound that staggering burden further.

What we need, then, is a national long-term health care policy that addresses the needs of both institutional and long-term care, and spreads the costs for such care over a number of sources, so that no one source is overwhelmed. Ideally, we should have national policy geared at ensuring that each generation pays for its own long-term health needs.

One Proposal. Before the 100th Congress adjourned last year, I outlined a proposal for such a balanced, comprehensive policy. It would finance long-term care through a number of funding sources, both public and private, and would offer tax incentives to encourage expanded availability of affordable private long-term health care insurance policies.

In addition, it would address institutional and home health care, including expanded Medicare benefits for both. After an initial two-year exclusionary period, for instance, Medicare would pay for 70 percent of all nursing home costs. (The current Medicare skilled nursing benefit for hospital discharges would not be subject to that exclusionary period.) It also would provide respite care for those tending chronically ill relatives at home.

These and other features of the proposal are ones that we need to address in creating sound, comprehensive and affordable public long-term health care policy — a policy the 101st Congress hopefully will establish.



Rep. G.V. "Sonny" Montgomery (D-Mississippi)
Chairman, House Committee on Veterans' Affairs

The Veterans Administration, particularly its medical care delivery capabilities, has suffered in recent years due to inadequate budgets.

Staffing, Funding Shortages. This summer, Veterans' Affairs Committee staff visited 16 VA hospitals and discovered that 1,700 hospital beds had been closed because of staffing shortages.

A follow-up survey of the VA's 172 hospitals revealed that more than 13,000 beds nationwide had been taken out of service, 31 percent of which were closed due to staffing and funding shortages. As of June 30, 1988, VA hospitals were experiencing a $221 million medical funding shortfall and the VA has since projected a $635 million shortfall for fiscal 1989.

The committee survey further discovered that there were approximately 7,000 medical professional personnel vacancies in VA hospitals nationwide due to recruiting problems, i.e. money to compete with private-sector salaries and benefits. The bottom line: Some veterans are being turned away from VA medical facilities due to a lack of resources, and new and replacement equipment is not being brought on line as needed, which could have an adverse impact on quality of care. VA managers have diverted hundreds of millions of dollars in equipment funds to cover other operating costs. Certainly, each of these findings affects the manner in which the Congress and the VA will address long-term care concerns.

And while Rome burns . . . the White House Office of Management and Budget remains consistent, pushing for potentially devastating reductions in the health care capabilities of the VA and opposing construction of urgently needed VA nursing homes. This, despite the fact that the older veteran population is growing at a faster pace than the older population in general.

The Situation. Nationwide, the number of veterans age 65 and older is expected to increase from approximately six million today to a peak of almost nine million by the turn of the century. Veterans age 75 and older will more than triple by the year 2005.

Obviously, the need for increased medical resources — particularly long-term care resources — will grow. The dilemma lies in providing these urgently needed resources while meeting the demands of deficit reduction.

Over the past 12 years, the VA medical budget has remained essentially a straight line, rising only slightly from $4.4 billion in 1977 to $5 billion in 1989 (in inflation-adjusted dollars). During this same period, the number of inpatients treated in VA hospitals has risen seven percent, outpatient visits have risen by more than 25 percent, and the number of patients receiving nursing home care at the VA's expense has doubled.

In 1984, the Veterans Administration published *Caring for the Older Veteran*, which presented an extensive analysis of the resources which the VA might require to meet the needs of older veterans. This analysis concluded that the VA should be operating 19,000 nursing home beds by 1990 and between 30,000 and 41,000 beds by the year 2000 — realistic projections that are currently being addressed with unrealistic policies.

VA's Planning Strategy. Shortly after the publication of these numbers, the VA announced a change in its planning strategy which called for a decreased emphasis on VA-owned and -operated nursing home beds in favor of increased reliance on privately operated community nursing home beds and beds operated by the various states through the VA-assisted state home program. Under the state home program, the VA picks up approximately two-thirds of the construction cost and pays part of the cost of care for each patient.

The current VA strategy for meeting

the needs of veterans who require nursing home care is to place 30 percent in VA beds, 30 percent in state home beds and 40 percent in community beds. For three basic reasons, the VA will be unable to meet this policy objective:

The VA is not converting unused hospital beds to nursing beds at an adequate pace; the VA has not requested adequate funding to either build and operate its own beds or to support the cost of care in community facilities; and while funding for state nursing homes has increased slightly, there are dozens of unfunded projects.

Even if all of the state projects were funded, there would still be a sizable shortfall in state nursing home beds. To encourage greater participation in the state program, the Congress recently raised from $17.05 to $20.35 the per diem rates paid by the VA to the state for each nursing home patient.

In fiscal year 1987, over 51 percent of the veterans who received nursing home care to which the VA made some contribution were cared for in community nursing home beds. Since the VA has little control over the number and availability of these beds, expanded reliance on community resources exposes many veterans to the risk of being denied needed care.

Moreover, the VA has implemented a new policy that shortens the length of time it will pay for nursing home care for veterans discharged from VA hospitals. As for VA-operated units, not only are occupancy rates very high, there are waiting lists at many nursing home care units.

Changes Needed. Therefore, the VA must end its unrealistic policy of a static number of VA-operated nursing home care beds and the policy of increasing reliance on community nursing home beds. Community facilities generally cannot meet current demands, much less the future requirements of the veteran population.

The VA should continue to utilize community resources to complement its nursing care program, but the key is increased VA resources. Further, there must be expanded emphasis on the non-institutional long-term care capacity of the VA, particularly programs of outpatient care, hospital-based home care, adult day health care and geriatric research, education and clinical care.

Recently, legislation has been enacted which will have a profound impact on budget and health care policies under VA jurisdiction. The 100th Congress passed overwhelmingly and the President signed a bill that upgrades the VA from an independent agency to the nation's 14th Cabinet department.

This is a tremendous step forward for veterans. They no longer have to go through the back door of the White House just to deal with some mid-level OMB staffer for attention.

Their representative will now be at the Cabinet table, fighting to protect our budget and stressing the importance of veterans' benefits and medical programs. Veterans will have their opinions and concerns considered in the highest councils of government, and this includes their requests for adequate health care resource funding.

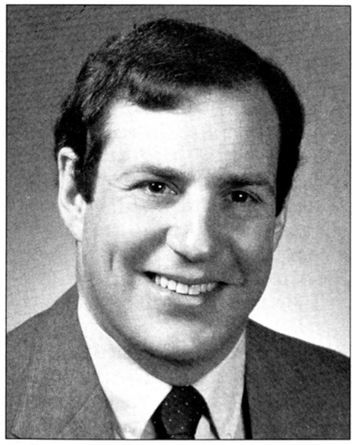
Proper health care funding and the challenge of an ever-increasing need for long-term care services will be top priority for the Veterans' Affairs Committee during not only the 101st Congress, but through the turn of the century. **CLTC**

VIEWS *(continued from page 40)*

While provider and consumer representatives will offer essential input as federal and state officials develop rules governing nurse aide training, nurse staffing increases, abuse registries and sanctions, AHCA will seek to ensure that the cost of the increased requirements are recognized in Medicaid payment levels. Adequate funding must be guaranteed if the new regulations are to be implemented successfully.

Undoubtedly, 1989 will be an interesting and exciting year for those of us involved in the long-term care debate. Most encouraging were the comments of Sen. Robert Dole (R-Kan.), who in a brief post-election interview last November identified the two most crucial issues facing the new Congress and the Administration: reducing the deficit and dealing with long-term care.

Certainly, reaching agreement on the most critical long-term care issues will require the cooperation and commitment of policymakers, consumers and providers. And while our efforts in this regard are bound to tax our energies, it is truly inspiring to envision the possibilities.



Sheldon L. Goldberg
President, American Association of Homes for the Aging

As the new Administration takes office and the 101st Congress convenes, the American Association of Homes for the Aging will be aggressively pursuing a full slate of policy issues affecting nonprofit homes and the elderly they serve. Among the issues of immediate concern to AAHA are:

- Implementation of nursing home reform.
- Reimbursement-related issues.
- Long-term care financing policy.
- Housing reform.
- Nonprofit tax issues.

Nursing Home Reform. In December 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987, the most significant nursing home legislation since Medicare and Medicaid began. Although the law is to be implemented over a four-year period, crucial deadlines are ahead for new requirements for nurse aide training, facility administration, preadmission screening of residents, monitoring of state waivers of licensed nursing requirements and alternative sanctions.

The Health Care Financing Administration has shared with AAHA drafts of various guidelines to implement the new requirements, but many questions remain. HCFA has not followed an orderly implementation plan, nor has it given states adequate guidance for meeting their obligations under OBRA.

AAHA will continue to work with HCFA, Congress, industry groups and consumer interests on the implementation of nursing home reform measures. Our objective is to enhance quality of care and to see that facilities are compensated adequately for the additional costs they will incur.

Central to nursing home reform are improved staffing and training levels; yet, in a larger context, the labor shortage in nursing homes continues to pose grave staffing problems for providers. Many facilities face high turnover rates and a shrinking labor pool of nurses, nurse aides and other essential employees. AAHA will continue to explore avenues and strategies for recruiting and retaining these vital personnel.

Reimbursement. OBRA '87 requires states to provide an "appropriate adjustment" in nursing home rates for those facilities meeting the law's requirements.

Additional funds are to be available for preadmission screening and assessment, nurse aide training and competency evaluation, and state survey and certification activities. However, HCFA has yet to provide guidance to states on how to determine an "appropriate" rate adjustment.

Providers will bear significantly increased costs in meeting the OBRA '87 requirements, and the federal government must respond with the additional funds promised for this purpose.

The association will continue to press for adequate compensation of facilities. We will also be tracking the development of case mix reimbursement systems across the country, as well as HCFA's demonstration programs. Although AAHA has been receptive to case mix patient assessment systems, we believe the reimbursement changes that accompany such systems must keep pace with the cost of providing services.

LTC Financing Policy. AAHA is committed to fostering the adoption of a comprehensive public policy on long-term care for the elderly and has been working with Congress on legislation to address this need. Several major bills were introduced in the last session of Congress, and many more are expected in the new Congress.

AAHA believes a national long-term care policy must include complementary roles for both the public and private sectors. For example, tax incentives to insurers, employers and consumers would make private long-term care insurance a more attractive, affordable option for workers and recent retirees.

AAHA has been working aggressively to develop facility-based plans, in which an insurer contracts with a provider to afford protection to its residents. Such plans hold great promise and demonstrate the private sector's commitment to find workable solutions to long-term care financing needs.

Government's role must not be minimized, however, by private efforts. AAHA will continue to advocate public-sponsored protection and assistance to low-income elderly to help defray the cost of coverage.

Long-term care benefits, AAHA believes, must include a variety of services within a continuum of care. Care should be available in the most appropriate setting, whether a private home, nursing home, day care center or elsewhere.

In 1989, AAHA will work through its members, and with other national organizations and federal policymakers, to focus public attention on the need for a national policy to meet critical long-term care financing objectives.

Housing Reform. In 1989, AAHA will be working alongside the new Administration and Congress to restore the federal government's vital role in providing suitable, affordable housing for older persons.

Nonprofit sponsors, government and other sectors must be strong partners in this effort.

AAHA will work toward enactment of the National Affordable Housing Act to

bring about fundamental changes in the development of Section 202 housing and supportive housing for special populations, including the elderly. The association believes the nation, while being sensitive to the federal deficit, must seek cost-effective ways to restore adequate funding to much-needed housing programs.

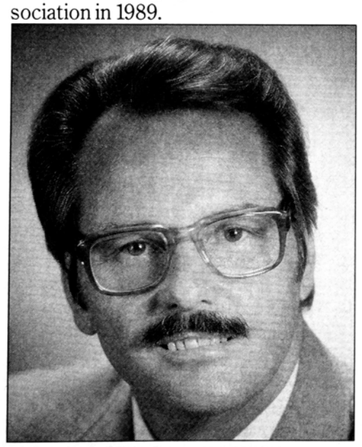
AAHA will also work with Congress in 1989 to ensure continuity in affordable housing for the low-income residents or facilities whose Section 8 subsidy contracts are due to expire soon.

Tax Issues. Finally, AAHA will be in the forefront of the continuing debate on taxation, championing the tax-exempt status of nonprofit organizations.

The loss of any exemption from state and local income, property, sales or other taxes, and restrictions placed on tax-exempt financing are serious threats to the nonprofit sector's ability to meet community needs.

AAHA will move aggressively to educate policymakers about the rich history of nonprofit organizations and the many public benefits derived as those organizations engage in health, housing, charitable, educational and religious activities. The histories and sense of trust that nonprofit organizations share with their local communities must be maintained.

This educational effort and the preservation of our members' nonprofit tax status will be high priorities for the association in 1989.



Richard L. Thorpe, CFACHCA
Executive Vice President,
American College of Health Care Administrators

As professional long-term care administrators, our legislative and regulatory plates will indeed be full in the year to come. Perhaps even more significant than the already established legislative edicts of OBRA '87 will be the impact of both the Bush Administration and the newly constituted 101st Congress.

Consumer Involvement. We can look forward to increased consumer involvement in the year ahead, evidenced by the recent release of the HCFA consumer guide. We must approach the year proud of the fine care we provide and invite the public into our facilities to observe, firsthand, evidence of that quality care.

In an effort to continue to improve the quality of life for nursing home residents, we must also continue to form alliances with the consumers of our services. We must expect consumers to ask questions, and we must be prepared to respond.

Without fail, Congress must provide solutions to the financing riddle. Long-term health care providers can no longer be subjected to the scrutiny resulting from legislation that demands the highest standards of quality care but ignores its financial correlation.

It is my hope that with the appointment of Sen. George Mitchell (D-Maine) as Senate Majority Leader, Congress will aggressively address the funding issue. Senator Mitchell has a history of sensitivity to long-term care issues that I trust he will carry with him to his new position.

Anticipating the early 1989 release of the newest version of the Conditions of Participation, we find ourselves redefining and rearranging our policy and procedures manuals in an effort to accommodate this new wave of regulatory definition. We can look with assurance to our professional society (ACHCA) and our respective trade associations (AAHA and AHCA) for training and leadership in this important arena.

Nurse Recruitment. The nursing shortage, which has become pandemic in the health care industry, will continue to haunt us, and we will have to look for even more creative mechanisms to recruit and retain nurses.

First among these initiatives must be the passage of legislation that allows pass-through cost reimbursement for labor costs related to direct patient care. We must be able to compete in the marketplace with other health care providers for available nursing personnel. We must then work with their concerned groups to ensure a more adequate labor pool of professional nurses.

A promising move in this direction is the recently negotiated management agreement between the American College of Health Care Administrators and the American Medical Directors Association (AMDA), whereby the College will supply support services and administrative management to AMDA.

It is anticipated that this agreement will strengthen both organizations and result in an even more unified effort toward solving some of the clinical and nursing issues faced by the three key professionals in our industry: the administrator, the medical director and the director of nursing.

Implementing OBRA. The coming year will find us continuing to struggle with the nursing home provisions of the historic 1987 OBRA legislation.

While it was just a year ago that this legislation was passed, it will take the next five years for the struggle to play itself out. I anticipate considerable difficulty as we wade through the implementation of just the mental health and mental retardation screening, as well as the provisions for nurse aide training.

Again, the administrators of this nation can look to their professional society for assistance in meeting the demands of OBRA '87.

The College has been, and will continue to be, involved in consensus group review and recommendations to HCFA regarding regulatory interpretation of this law. The American College of Health Care Administrators' involvement in committees and review boards enables the College to have an impact on considerations as they relate to the administrator's task and gives the individual professional administrator representation in matters that may ultimately affect his or her career.

In the new year, I would hope that long-term care professionals take pride in being the best qualified, trained and prepared to do their vital task: Administer to the needs of individuals in their care. ACHCA, through its Standards of Practice, Code of Ethics, credentialing programs, educational offerings and other valuable member services, advances the profession and contributes to the individual's core of knowledge so that administrators can address these challenges more effectively.

Now, more than ever before, the professional administrator needs his or her professional society. We at ACHCA wish President-Elect Bush, the 101st Congress and the entire long-term care industry a rewarding and productive year.

Barbara Jameson, Ph.D.
Executive Director, National Association of Residential Care Facilities

Since its formation in 1984, the National Association of Residential Care Facilities has worked to increase the support and understanding of non-medical protective environments for the frail elderly and mentally and physically disabled persons. Although there are more than 40,000 such facilities licensed by state agencies across the country, they have been generally ignored in national health care, housing and long-term care planning.

Legislative Initiative. NARCF is working on a 1989 legislative initiative which seeks additional monies through the federal SSI funding program for persons living in protective environments, including residential care facilities and those receiving in-home health care. This bill would provide reimbursement to individuals for social and recreational activities, for special dietary and chronic condition supports, clothing and other personal care needs.

The current federal policy of restricting federal expenditures to non-medical residential care facilities (i.e., Title XX Social Services grant programs, Food Stamps, etc.) has resulted in disincentives for improvement in the quality and quantity of non-medical protective living arrangements by the public and private sectors.

SSI Mechanism. As a step toward removing these barriers, increasing the options and service alternatives available to a diverse population and expanding the long-term care system, NARCF feels that the SSI mechanism which is already in place is the best channel for enhancing the preventive methods of controlling physical and mental deterioration experienced by residents.

This approach can also increase the flexibility and economic efficiency of the long-term care system.

The need for national initiatives to supplement state efforts through the SSI mechanism was reinforced by the conclusions of research conducted by the Center for the Study of Social Policy (1988). That study recommends that the SSI program be explored as a resource for meeting "the needs for non-medical residential and supervisory care of hundreds of thousands of low-income elderly and disabled who are too impaired to live independently, but not 'sick' enough to justify medical model institutionalization."

The study further recommends an individualized case management approach, whereby the financing gap between available services to cover a person's assessed needs and those services that are needed but not financed is met by a federally funded source.

NARCF's proposal for legislation would place the choice of setting for obtaining such services in the hands of recipients in order to increase their choices and encourage some control over their lives. Currently, too many of the housing options are either without supportive services or inappropriately institutional.

Finding a solution for funding low income populations has reached a critical stage. Not only is that population growing, but providers are finding it increasingly impossible to charge private-pay individuals enough to cover the loss for care of low-income residents or service recipients.

The evolving two-tier system (low income and more affluent) creates problems in financing, regulatory and societal responsibilities.

Manpower Issues. Other legislative activity on the priority list for NARCF in 1989 includes manpower issues ranging from economic viability to quality of staff. This labor-intensive industry is concerned about an increase in the minimum wage, especially in marginally profitable facilities.

Recent Labor Department actions in interpretation of wage and hours laws, with focus on sleep-time pay, are having a devastating effect on small homes where the owners are not the principal care givers.

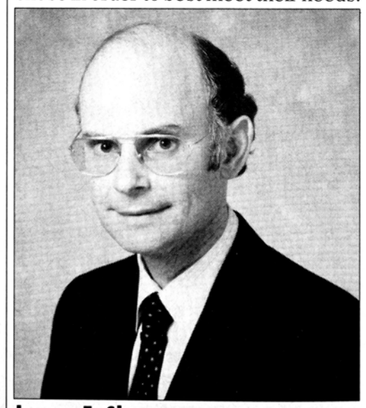
NARCF's effort to enhance the skills of facility managers is seeing positive results, with more than 500 members enrolled in course work in its Administrator Certification Program. Several states do, or plan to require such training for residential care operators. NARCF is also planning increased staff training opportunities.

Better Role Definition. Probably the most important task in 1989 for those concerned with long-term care is to begin a serious dialogue and research process to better define the role of non-medical protective living environments in both the national long-term care system and the housing system.

Because such facilities have been state licensed or non-licensed (i.e., foster homes, retirement communities, etc.), they have been the victims of a funding source-driven care system, and generally ignored by national policy planning.

The changing medical approaches to many chronic conditions make feasible the care of many persons in non-nursing home settings. A better understanding of the benefits of social model interventions, which emphasize independent functioning and appropriate utilization of complimentary community-based services, makes residential care facilities more appropriate for many people.

At the same time, our system for the care of the acutely or severely ill is putting greater demands on nursing homes. In 1989 the vestiges of adversarial relations should be set aside and real efforts made to define a long-term care system in which those requiring services have a range of good options from which to chose in order to best meet their needs.



James F. Sherman
President, National Association for Senior Living Industries

As an association with a diverse membership of many organizations that serve the nation's older citizens, the National Association for Senior Living Industries is affected by

the multitude of complex issues facing the long-term care industry.

Distilling these issues to a common core, however, results in the realization that the most important issue facing the long-term care field is providing quality care for our elderly population, within the limitations imposed by the constraints of diminished resources.

Though simply stated, the issues could not be more complex. The inadequacies of our current system — or non-system, to be more accurate — have been well documented. Providers blame payors, payors blame the government and the government blames the consumer.

Little doubt exists that financing long-term care is a complex policy issue, but it is one which must be resolved, if for no other reason than we have a "date with demographic destiny." The challenge is for all of us, as industry professionals and as citizens, to work together to develop a solution.

Concerted Effort. The National Association for Senior Living Industries and similar organizations must be at the forefront of these changes. In partnership with all the players in the health care system, we must work to address the problems that plague our long-term care delivery system.

We must understand that governments have a financial responsibility to balance budgets; governments must, in turn, recognize the need to provide for a standard of care and quality of life that is more than merely marginal. Innovative and creative solutions must be sought and implemented.

We also must focus on the positive. There are many exemplary facilities and programs providing a high level of care, despite the mounting challenges. There are foundations and private initiatives that are providing much needed capital and research money to develop new and needed services. Each day, the large majority of care givers provide humane, caring services to residents. These programs and people must be recognized and rewarded.

Educating the Public. Finally, our agenda must include education. The public must understand the challenges facing the long-term care industry and understand that they, through their governmental representation, have the ability to choose leaders who will work to provide a system of which we can be proud.

For too long, an unknowing public has believed that the current system is adequate. We know now that this is not always the case. NASLI expects to play a leadership role in this educational process, highlighting the good — and the bad — of the current long-term care delivery system.

The time for finger pointing is long past. What is needed now is for the best and the brightest from all sectors of the industry — providers, payors, policymakers and the public — to come together and work toward providing a coherent and comprehensive public policy on long-term care for the elderly.

In one of his speeches, the late Sen. Hubert H. Humphrey said, "The moral test of a nation is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life — the sick, the needy and the handicapped."

NASLI looks forward to participating in the efforts to make our long-term care system pass this important test.

Robert C. Atchley
President, American Society on Aging

The number of older Americans who need long-term care is substantial now and will increase dramatically in the near future. Recent projections by Suzanne Kunkel and Robert Applebaum of the Scripps Gerontology Center at Miami University of Ohio indicate that the population of severely disabled older people will increase from 2.5 million in 1986 to 3.5 million by the year 2000 and to 5.3 million by the year 2020. Much of this increase will occur among the very old. For example, Kunkel and Applebaum found that at age 70 about six percent older people are severely disabled, but at age 85 about 12 percent of men and 17 percent of women are severely disabled. These findings indicate two important things. First, a very large amount of care is currently being provided to older people who are not living in institutions. Second, the population in need of care is growing faster than we can build long-term care facilities. As a result, long-term care facilities will increasingly be caring for only the most serious cases.

Rationing of long-term care space is being done now on ability to pay. In the future, we may be forced to provide nursing home space only to those who are the most severely impaired. Personal care homes and home care programs can be expected to increase in number as both Medicaid and private long-term care insurance provide mandates and incentives to use care alternatives less expensive than the nursing home.

Financing. Long-term care insurance is evolving quickly. Policies are coming on line that avoid prior hospitalization requirements, have minimal prior illness exclusions and provide home care benefits. Interestingly, many older consumers are willing to self-insure for home care and see nursing home care as the major financial loss that needs to be insured against.

Congress will again grapple with government policy on the financing of long-term care. Social insurance is the most practical method suggested thus far for insuring moderate- and low-income families against the financial burdens of long-term care. The insurance industry acknowledges that no more than 20 percent of the need can be met by the private market. This means that we will continue to struggle with Medicaid or we will enact some sort of broad-based social insurance for long-term care.

As we think about how to finance public long-term care benefits, we need to be mindful that a third of all older Americans still have incomes near or below the poverty level and among the population most in need of long-term care (very old women), the proportion with poverty-level incomes nears 50 percent.

Networking. It is human nature to think that one's own profession is special and perhaps superior to other professions. But this kind of thinking will not help us meet the challenge of providing long-term care to an aging society. We cannot be specialists in everything, but we can involve ourselves in networks of specialists from a variety of professions vital to quality long-term care.

Organizations such as the American Society on Aging provide opportunities for multi-professional approaches to information gathering, training, planning and problem solving. Communication among various types of long-term care providers will continue to be one of our highest priorities. **CLTC**

Surveying the survey

Could report lead to tougher inspections? Only time will tell

DON'T EXPECT TO SEE HCFA'S FINAL report to Congress on the nursing home survey and enforcement process this year, but at press time the agency said it would soon issue a "good faith" interim report elaborating on its research methods and goals.

"We expect to release it within the next few weeks," said HCFA project officer Marvin Feuerberg on September 10. The interim report will update Congress on progress to date but won't outline preliminary findings.

Former HCFA Administrator Bruce Vladeck has commented in the past on his dissatisfaction with most nursing homes' performance on the new survey, saying that preliminary survey data indicate that the agency may have to crack down harder to bring noncompliant homes into compliance. No previews of data from the pending report to Congress have been released yet, however. In fact, much of the basic research is still under way.

Congress originally asked HCFA to submit the report by July 1, 1997. But according to Feuerberg, that deadline was never realistic for the "extremely complex" study.

The scope of the research is broad. In addition to assessing the effectiveness of the current nursing home survey and enforcement process, it will evaluate the viability of deemed status, by which private organizations could certify providers for participation in Medicare and Medicaid. A third, smaller aspect of the study will assess regulatory and nonregulatory incentives for improving care.

Abt Associates Inc. of Cambridge, Massachusetts, has contracted with HCFA to evaluate deemed status as an alternate way of accrediting long term care providers. Abt researchers are wrapping up telephone surveys with a sample of 700 providers and will submit their report to HCFA by November 1.

HCFA is handling internally most of the research on the effectiveness of the survey process.

Though all the necessary research is under way, HCFA has so far projected only the date by which its full report will be submitted for review by Health and Human Services: December 31, 1997. How long that review will take—and when the full report will find its way to Congress—is still up in the air, says Feuerberg.

Another unknown is how new HCFA Administrator Nancy-Ann Min DeParle will choose to interpret the study's findings. Notes Feuerberg: "As far as the real impact of this report goes, we'll just have to wait and see." BY YVONNE PARSONS

A matter of influence

Industry leader subpoenaed in campaign finance probe

THE LONG TERM CARE INDUSTRY HASN'T escaped scrutiny by the U.S. Senate panel probing matters of campaign finance. Responding to an August 6 subpoena, Alan D. Solomont has turned over about 4,000 pages of documents amid allegations that his fund-raising efforts on behalf of the Democratic National Committee (DNC) gave him pull with top federal officials in charge of nursing home standards, says a staffer with the panel, the Senate Committee on Governmental Affairs. Solomont is founder of A•D•S Group, Inc., a Newton, Massachusetts-based long term care chain.

Solomont's role in fund-raising is of particular interest because since February 1997 he has served as national chairman of the Democratic National Committee. Earlier, he served as national chairman of the Democratic Business Council, a fund-raising committee of the DNC.

"We're cooperating fully with the committee," said Solomont when asked by *Contemporary* about the subpoena.

More than 190 individuals, companies, and organizations have been subpoenaed in the Senate investigation so far, according to Paul Hendrie of the Center for Responsive Politics, a nonpartisan research group that tracks money in politics. Since commencing its investigation on July 8, the Senate panel has shifted its focus from foreign campaign contributions to allegations of *quid pro quo* donations. "The probe demonstrates the inherent conflict of interest where policymakers are raising money from the very people they regulate, who want policy changes," says Hendrie.

At the heart of the matter as it relates to long term care is the question of the industry's influence on nursing home regulation.

According to the Center for Responsive Politics, Solomont and A•D•S Group have contributed $276,360 to the Democratic party, federal candidates including President Clinton,

ILLUSTRATION BY RUSS McMULLIN

and various political action committees. Reports in *Time* magazine estimate that Solomont helped raise $1.1 million from nursing home executives.

As the campaign finance abuse issue heated up last February, published reports surfaced about Solomont. In response, he talked to a *Boston Globe* reporter for a February 3 article, in which he denied any connection between Democratic donations and access to key federal officials.

"My efforts to give voice to the concerns of nursing home providers had nothing to do with what I was doing in fund-raising," he told the reporter. "It's a real distortion to suggest that I had access to people in government because of the money I was raising as opposed to the content of what I had to say and the values I represented and the bridge that I was trying to create between government officials and constituents."

But Elma Holder, founder of the National Citizens' Coalition of Nursing Home Reform, questions that statement. "We are not surprised that nursing home industry donations are now subject to a Senate investigation," says Holder, who reports seeing "very informal and overly responsive" letters about policy issues written by key federal regulators to representatives of AHCA.

"These letters reek of special influence," says Holder, noting that if consumer groups get their concerns answered at all by a key regulator, it often takes months before they get a reply. BY HERBERT P. WEISS

TIME FOR A CHANGE

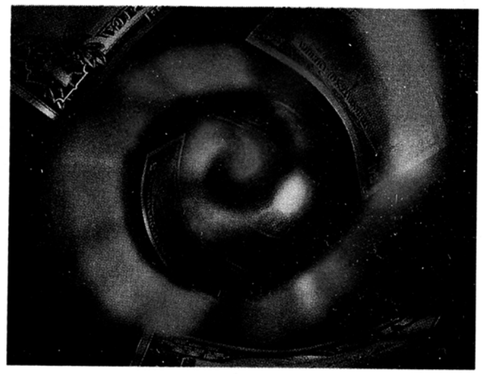
"In Medicaid, I think it's about time for the baby-boomers to buy long-term-care insurance, so that Medicaid is primarily reserved as a program for children and the disabled."

—House Budget Committee Chairman and potential presidential candidate John Kasich in an interview with Smart Money *magazine (September 1997)*

The lesser of the two

Dual eligibles change may cut into providers' reimbursement

STATES RECEIVED NEW DIRECTION FROM Washington recently regarding a long-standing reimbursement dispute centering on dual eligibles—a change that could reduce payments to providers. The Balanced Budget Act of 1997 approved in August contains a provision allowing states to limit their cost-sharing to the state Medicaid rates, which are typically lower than the Medicare copayment normally paid by beneficiaries.



PHOTOGRAPH BY WILLIAM WHITEHURST/THE STOCK MARKET

Federal law requires states to pick up some of the Medicare costs for dual eligibles—beneficiaries who qualify for both Medicare and Medicaid—including premiums, coinsurance, and deductibles. In question until now was whether a state had to pay full Medicare Part B costs or could use the typically lower Medicaid rate as a ceiling in covering the 20 percent Medicare copayment.

According to the Budget Act provision, providers must accept the limited cost sharing as payment in full.

States are still exploring the Act's implications. In Montana, for example, the Montana Medical Association recently filed a class-action lawsuit against the state Medicaid administrator and the U.S. Secretary of Health and Human Services charging that the state fails to pay full Part B costs for dual eligibles.

The Montana lawsuit claims that the state is shortchanging providers by paying the 20 percent coinsurance based on the lower state Medicaid rates. The class-action suit seeks past and future reimbursement of dual eligibles' copayment and deductibles based on the higher Medicare rate.

To date, four federal appeals courts governing 14 states have upheld states' obligation to cover the full 20 percent copayment. Whether the new law will affect these decisions and put an end to the Montana lawsuit is uncertain.

"The most accurate answer is that we don't know," says Robert McCann, partner with Green, Stewart, Farber & Anderson, PC, a law firm in Washington, D.C., and counsel to the American Medical Association.

"The legislation purports to eliminate prospective and retrospective lawsuits," McCann confirms. "Yet we have a real question about whether any court is going to enforce the new law to the extent that it takes away suits for retrospective payment.

"If Congress thought it was going to pass a law and save money, it may be sorely mistaken," McCann adds. He predicts some "interesting legislation" in the wake of the new provision.

One concern is that limiting reimbursement may affect beneficiaries' access to health care. G. Brian Zins, executive vice president of the Montana Medical Association, characterizes the cost-sharing shortfall as one that could lead to "the erosion of access to health services for a vulnerable population."

A May 1997 study by the Kaiser Commission on the Future of Medicaid supports Zins' assertion. The study, *Medicare/Medicaid Dual Eligibles: Fiscal and Social Responsibility for Vulnerable Populations,* claims that "when [the state's cost sharing] contributions are limited by Medicaid fees, dual eligibles become more like Medicaid than Medicare beneficiaries in seeking access to medical care." The study also notes that dual eligibles are one-third less likely than Medicare beneficiaries to be very satisfied with their health care. They are also considerably less likely than their Medicare-only counterparts to receive specific types of preventive and follow-up care. BY KAREN LUSKY

A double standard?

Hospice care in nursing homes not up to par, report says

THE MEDICARE PROGRAM IS PAYING NURSing home-based hospice agencies too much for the level of service they are rendering and should either cut payments or ratchet up requirements for nursing facilities that serve the terminally ill.

Those are the findings and recommendations of a report issued in October by the U.S. Department of Health and Human Services (HHS) that has raised concerns from the nation's hospice care providers.

The report, which was prepared by HHS's Office of Inspector General, found considerable differences between the level of service hospice patients typically get in nursing facilities and at home.

According to the report, nursing home hospice patients typically receive just under half (46 percent) as much assistance from nurses and nursing assistants employed by the hospice program as hospice patients living at home. Many of these services are delivered by nursing facility personnel instead because hospice employees are not present, the report said.

Despite the differences in services, Medicare typically pays hospices the same amount for their nursing home patients as it does for home-bound cases, the report said. Hospice providers are usually paid a per-diem rate linked to a regional wage index and based on the level of service delivered to patients.

Nursing homes are viewed by hospices as an effective means of expansion, so those payments are growing. Medicare expenditures for hospice care doubled to $1.8 billion in 1995 from $77 million in 1986, when the benefit was first established (figures not adjusted for inflation).

The 1990 repeal by Medicare of a 210-day limit on hospice care also helped fuel the growth in nursing home hospice enrollment, although some estimates show that typically only 5 percent of all nursing home patients qualify for the hospice benefit. But recent initiatives, the most recent of them provisions in the Balanced Budget Act of 1997, have tried to slow indiscriminate growth by imposing more frequent recertifications and tougher claims submission requirements on providers.

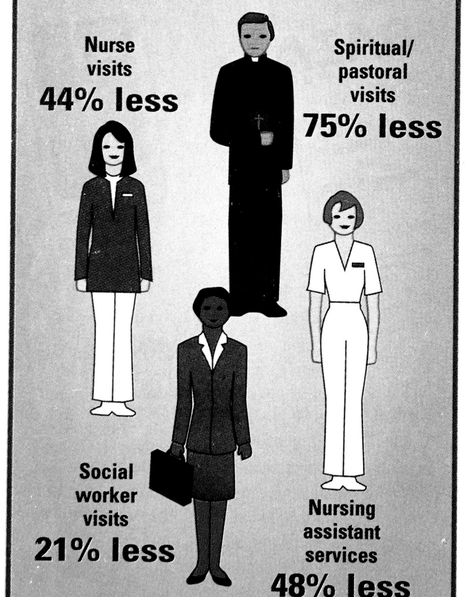
The hospice industry gave the government's report a mixed reception. Some agreed with the findings. "The recommendation to reduce payments is perhaps valid," says Diane H. Jones, executive director of the Washington, DC-based Hospice Association of America. The group supports efforts to develop a payment formula that properly reflects nursing home hospice costs.

But Judith Eighmy, an administrator with Hospice of the Pacific in Los Angeles, calls the report "shortsighted and misguided." Average lengths of stay for terminally ill hospice patients vary depending on age and condition, but they typically fall well below six months, Eighmy says. But "instead of looking at a broader picture of nursing home patients, the government admitted that it looked at the exceptions, patients who exceeded the average length of stay," says Eighmy.

BY HOWARD KIM

Don't leave home?

Hospice patients in nursing homes receive significantly less specialized care than those in private homes, according to the HHS study. Here's how nursing home hospice patients fare compared with their counterparts at home:



Source: Department of Health and Human Services, Office of Inspector General

CHART BY SARAH EDGAR

Fight fraud ... or else

Confirmation vote for new HCFA chief delayed

BIPARTISAN SUPPORT AT A SEPTEMBER CONfirmation hearing didn't clear the way for Clinton nominee Nancy-Ann Min DeParle to slide into a post as HCFA's new chief, replacing Bruce Vladeck. Instead, amidst claims that HCFA is not doing enough to fight fraud, the confirmation process stalled.

Using a procedural maneuver, Senator Tom Harkin (D-Iowa) put a "hold" on the Senate floor confirmation vote of DeParle, vowing to hold firm on his objection unless the Clinton White House steps up efforts to combat Medicare fraud, waste, and abuse. Harkin admitted his role in holding up the confirmation hearings in a September 30 letter to U.S. Health and Human Services Secretary Donna E. Shalala in which he called the administration's efforts outside of the home health initiatives to combat Medicare fraud, waste and abuse "woefully inadequate." The senator called on HCFA to use at least $50 million of its program management funds to increase Medicare audits, double the number of Medicare audits to be implemented next year, and address fraud and abuse in ambulance payments.

Observers say the ploy doesn't seem related to the qualifications of DeParle, formerly associate director for health and personnel for the federal Office of Management and Budget.

"The HCFA nomination is being blocked for political gamesmanship," says Robert Greenwood, manager of public affairs for the American Association of Homes and Services for the Aging. "This concerns us because HCFA has a lot on its plate right now." Among other tasks, the agency must implement certain provisions of the recently enacted Balanced Budget Act and is the midst of a reorganization.

BY HERBERT P. WEISS

All systems no

Testimony links computer problems to program fraud and abuse

HCFA'S FAILED ATTEMPT TO MODERNIZE THE way it processes Medicare claims triggered heated Congressional testimony on September 29 at a hearing of the House Subcommittee on Oversight and Investigations, with experts linking the agency's outdated computer systems to a flawed ability to fight program fraud, waste, and abuse.

Plagued by schedule delays, cost overruns, and the lack of effective management and oversight, HCFA was forced to abandon its costly Medicare Transaction Systems (MTS) project, testified Joel C. Willemssen, director of information resources management for the General Accounting Office. As a result, he said, 72 contractors, using at least 10 computer systems with a wide variation of software, will continue to review and pay more than 800 million Medicare claims annually.

HCFA announced in September that it had abandoned plans to proceed with the MTS, a project to consolidate Medicare claims processing by updating and unifying its outdated and disparate computer systems.

According to Willemssen, the cost of MTS had quadrupled from an original estimate of $19 million in 1994 to $80 million for software development and internal costs. By the time the contract was canceled, Baltimore-based contractor GTE had incurred costs of about $45 million.

In addition to costs, poor management by HCFA may have doomed the project. Sources at GTE, for example, report that the agency underestimated the complexity of the project when they hired the firm in 1994.

During the hearing, Subcommittee Chairman Joe Barton (R-Texas) chided HCFA for not acting on a 1991 federal report that called for adapting commercially available software for Medicare's use, to prevent overpayment to physicians. Barton noted that a 1995 GAO report had estimated that following the earlier report's recommendations could have saved more than $600 million annually by preventing Medicare overpayments.

Bruce Merlin Fried, director of HCFA's Center for Health Plans and

Washington watch

Providers, says that, in hindsight, HCFA should have built MTS in increments, testing and validating each step. In addition, the agency should have used a matrix to measure the performance of GTE, Fried says.

Moving forward, HCFA plans to move gradually to standardize computer information systems in Medicare's Part A and Part B programs. Separately, GTE will continue working on the development of an information system to process the agency's managed care claims.

According to Fried, the agency is also in the final stages of filling a vacant position: senior level chief information officer to oversee the agency's technology initiatives. BY HERBERT P. WEISS

Two shots in the arm

Residents, caregivers both need vaccines

Not everyone in long term care is getting her proper vaccinations, says a report released in October 2 from the federal Centers for Disease Control and Prevention in Atlanta. And that caution applies equally to residents and health care workers, who can easily expose their frail elderly charges to potentially deadly strains of flu and pneumonia.

According to the CDC, 58 percent of Americans aged 65 and older received the flu shot in 1995, an 8 percent increase over 1993, the first year that Medicare paid for the shot.

But there's still room for improvement. Just 39 percent of elderly African-Americans got their shots in 1995. The rate was also relatively low for the nation's older Hispanics (50 percent). Even fewer older adults are vaccinated for pneumonia.

And troubles don't stop there. A vital factor in efforts to reduce the risk of death from the diseases is the immunization of health care workers, who are often lax in getting their vaccines. Researchers at the Mayo Clinic in Rochester, Minnesota, note that only about 30 percent of doctors, nurses, and attendants get flu shots every year. About 25 percent are infected. Unimmunized caregivers put patients at risk, especially the frail elderly, says Mayo Clinic researcher Gregory Poland, MD. The flu is easily transmitted among the aged and often progresses to pneumonia, he explains. About 10 percent of older patients who develop pneumonia die.

Caregivers also play a role in spreading the word. "Everyone who comes in contact with senior citizens ... should take the opportunity to remind them that flu shots are important, and free," says U.S. Health and Human Services Secretary Donna Shalala in an October 2 news release announcing the CDC's research.

For information about shots covered by Medicare, call 800-638-6833. Caregivers should check with their physician or local immunization program. BY YVONNE PARSONS

STATE NEWS

North Carolina eases moratorium

Assisted living providers in North Carolina made some progress in their fight against the state's proposed 18-month moratorium on new assisted living facilities, reports Jerry Cooper, executive director of the North Carolina Assisted Living Association. In the final version of the proposal, state legislators reduced the ban on new construction and development to 12 months and excluded plans submitted for approval before May 18, 1997. Exceptions may also be available to some providers who submitted plans subsequent to the May 18 cutoff.

The state has imposed the moratorium while conducting an in-depth study on vacancy rates in adult care homes, the category under which assisted living facilities are licensed. BY YVONNE PARSONS

Idaho takes on "double dipping"

An Idaho judge recently denied a preliminary injunction sought by nursing homes to stop a 7.5 percent Medicaid rate cut. The payment cut, which was set to go into effect this fiscal year, is based on the state's contention that providers are "double dipping," or receiving payments from both Medicare and Medicaid for the same costs.

The Idaho Health Care Association (IHCA) estimates that the reimbursement change will decrease Medicaid rates by about $7 a day, trimming $5.6 million off industry profit margins, which are now about 4 percent.

IHCA executive director Scott Spears notes that "double dip" label triggers the suspicions of legislators who don't have the time or interest to hear providers' detailed explanations about Medicaid cost reporting. "The near-fraud and abuse allegations have offended providers who have been simply using the state's methodology and forms in reporting Medicaid costs," says Spears.

Before the new Medicaid methodology, the state had offset nursing homes' Medicare Part B billing for Medicaid residents. The new formula tries to comb out every penny that could be related to Medicare, including laundry and other indirect costs.

Ross Mason, spokesman for the Idaho Department of Health and Welfare, says that the rate change was needed because of the growing gap between higher-paying Medicare and Medicaid reimbursement.

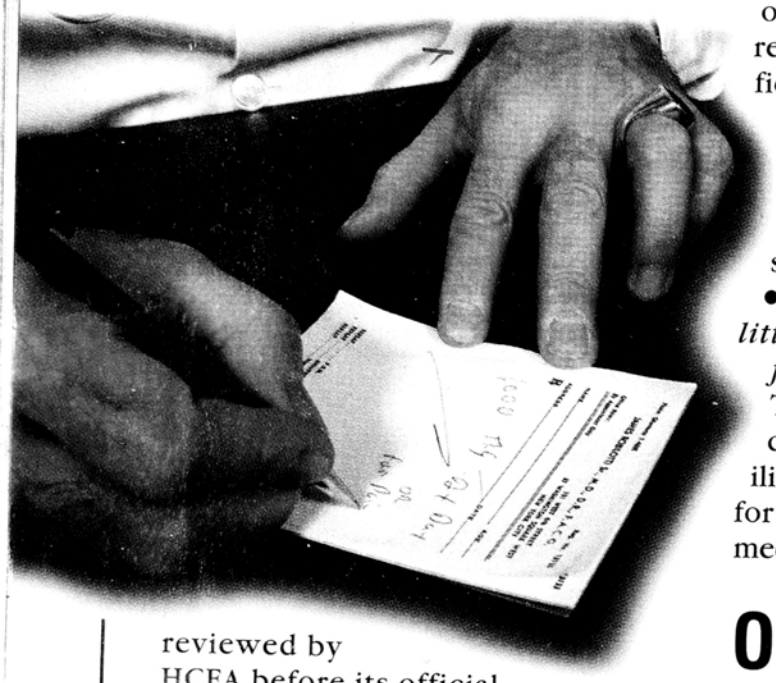
"It used to be that Medicare and Medicaid paid approximately the same rates, so the state Medicaid program had nursing homes send in annual cost reports that combined Medicare and Medicaid costs," Mason explains. BY KAREN LUSKY CLTC

Prescription for problems

Draft report criticizes medication use in nursing homes

DELIRIUM, DEPRESSION, AND FALLS ARE among the adverse drug effects caused by inappropriate drug use and monitoring in the nation's nursing facilities, says a new draft report prepared by the HHS Office of the Inspector General.

The draft report, which is being



reviewed by HCFA before its official release, details the findings of a random, statistically valid sample of consultant pharmacists at 17,000 nursing facilities.

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

Inappropriate use of antipsychotics, anxiolytics, and sedative/hypnotics still plague some nursing facilities, the report suggests. Of those surveyed, more than one-quarter reported some patients receiving medically inappropriate prescriptions for such drugs. More than 15 percent said that some physicians prescribe medically inappropriate antidepressants.

Findings also include the following:

- *Administrative errors are an obstacle to safe drug use at some facilities.* Errors include the absence of specific usage directions, incomplete orders, failure to update medication administration records with dosage or schedule changes, and physician signing orders that are not current or correct.
- *Serious shortcomings in the quality and thoroughness of monthly medication reviews also put residents at risk.* More than half the reviews do not even consider the resident assessment (65 percent) or plan of care (56 percent). One-third of 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 medication aides. BY HERBERT P. WEISS

OIG takes aim

1998 work plan outlines priorities

PHYSICIANS AND MEDICAL EQUIPMENT SUPPLIERS working with nursing homes are among those targeted in a report released in October by the HHS Office of the Inspector General (OIG). The 58-page Fiscal 1998 Work Plan calls for 140 audits, evaluations, and investigations to be performed in nursing homes, hospitals, and home health agencies. It is indended to outline strategies to counter Medicare fraud, waste, and abuse.

"This plan is just a working document for the OIG," says Judy Holtz, OIG public relations specialist. The document can be altered to reflect the priorities of Congress and the investigative activities or studies of other federal agencies, Holtz notes.

Tentative audits for nursing facilities include the following:

- *OIG investigators will use computer screening to identify physicians with abnormal billing patterns for visits to patients in SNFs.* On the agency's hit list: excessive number of visits in a given day and excessive visits to the same beneficiary. The OIG will investigate individuals with the most egregious billing patterns.
- *The agency will audit claims submitted for Medicare beneficiaries in nursing homes that have been purchased, either partially or wholly, by durable medical equipment supplier chains or physician groups.* An audit of such claims will identify any aberrant billing patterns for services and supplies.
- *The OIG will target abusive and unallowable or fraudulent use of certain revenue codes* by nursing facilities in Florida and select other states.
- *A series of OIG reviews will evaluate therapy services provided in skilled nursing facilities to Medicare patients* in terms of reasonableness of cost, payment arrangements, and medical necessity.
- *An audit of Illinois nursing facilities* will determine if payments for SNF stays meet Medicare's requirement that a patient's nursing home stay must be preceded by a hospital stay of three days of longer.
- *The agency will follow up on a 1996 finding challenging the medical necessity of some mental health services in skilled nursing facilities.* The latest initiative will determine whether mental health services in SNFs continue to be inappropriately billed. BY HERBERT P. WEISS

They want their DRGs

Hospitals seek repeal of patient transfer provision

THE AMERICAN HOSPITAL ASSOCIATION (AHA), the nation's largest hospital group, has taken aim at the 1997 Balanced Budget Act's patient transfer provision, set for implementation on October 1, 1998. The provision prevents hospitals from receiving the full Medicare prospective payment when patients who fall within select diagnosis-related groups (DRGs) are discharged early to SNFs and other traditionally PPS-exempt postacute settings.

And they're off ...

The new national Medicare commission gets off to a rough start

THE FUTURE ALREADY LOOKS CLOUDY for the highly touted National Bipartisan Commission on the Future of Medicare. Partisan wrangling began even before all the appointees were named, and at press time, a chairman had yet to be named—more than a week after the December 1 deadline for squaring away the lineup.

Established under the Balanced Budget Act, the commission is charged with examining ways to meet the increased financial needs of Medicare as the baby boomers retire. Recommendations from the 17-member group must be approved by an 11-member majority and are due March 1, 1999.

"It is a commission that has some very strong-minded diverse opinions and pretty strong partisan individuals, which will only make a difficult job more difficult because a simple majority is inadequate," notes Gail Wilensky, chair of the Medicare Payment Advisory Commission and senior fellow at Project HOPE, an international health care education foundation. "But frankly, the time is unfortunate, first because the Balanced Budget Act has bought 10 to 12 years [for Medicare] and second, the report comes out March 1999 and it's hard to imagine a more partisan time than gearing up for a Presidential election."

U.S. Representative William M. Thomas

Partisan politics limited the scope of the group's options even before its first meeting: House Speaker Newt Gingrich required all his appointees to pledge that they would not consider tax increases as a way to shore up Medicare. BY DIANA REESE

THE APPOINTEES

Who will serve?

As of press time the Medicare commission lacked a chairman, but the other 16 appointees had all been named.

Appointed by President Clinton:

- *Stuart Altman*, professor of national health policy at Brandeis University and former chair of the Congressional Prospective Payment Assessment Commission.
- *Laura D'Andrea Tyson*, professor of economics and business administration at the University of California at Berkeley and former National Economic Advisor and chair of the National Economic Council during President Clinton's first term.
- *Bruce Vladeck*, professor of health policy at the Mount Sinai School of Medicine, former HCFA administrator, and author of *Unloving Care: The Nursing Home Tragedy*.
- *Anthony L. Watson*, chairman and CEO of the Health Insurance Plan of Greater New York, one of the country's oldest HMOs.

Appointed by Senate Majority Leader Trent Lott:

- *Senator Bill Frist* (R-Tennessee), a heart surgeon and chairman of the Labor and Human Resources public health subcommittee.
- *Senator Phil Gramm* (R-Texas), chairman of the Finance health subcommittee.
- *Ilene Gordon*, an employee of Lott's Mississippi office who handles constituents' Medicare cases.
- *Deborah Steelman*, a Social Security adviser to President Bush and a Washington, DC, attorney specializing in health care.

Appointed by Senate Minority Leader Tom Daschle:

- *Senator Bob Kerrey* (D-Nevada), member of the Finance committee.
- *Senator Jay Rockefeller* (D-West Virginia), member of the Finance committee.

Appointed by House Speaker Newt Gingrich:

- *Representative Michael Bilirakis* (R-Florida), chairman of the Commerce Committee's subcommittee on health and environment.
- *Representative Greg Ganske* (R-Iowa), a physician and member of the subcommittee on health and environment.
- *Representative William M. Thomas* (R-California), chairman of the Ways and Means Committee's subcommittee on health.
- *Samuel H. Howard*, chairman, president and CEO of Phoenix Healthcare Corporation in Tennessee.

Appointed by House Minority Leader Richard Gephardt:

- *Representative John Dingell* (D-Michigan), member of the Commerce Committee.
- *Representative Jim McDermott* (D-Washington), member of the Ways and Means Committee.

Moving in on Medicaid

HCFA names work group to sort out post-Boren concerns

IN THE POST-BOREN ERA, HCFA AND STATE Medicaid agencies are moving to redefine themselves. No longer do they consider themselves just payors processing Medicaid checks, but prudent purchasers of health care services.

A joint effort of the executive committee of the National Association of State Medicaid Directors and HCFA has led to the creation of a work group. Its purpose is to create a Medicaid quality strategy that includes a "tool box" of outcome measures and quality indicators for use by state Medicaid agencies. It is also charged with developing a purchasing strategy based on those measures, according to a HCFA official.

WORK GROUP

HCFA's Five-by-Five

State Medicaid Directors

- *Peggy Bartels*, director, Wisconsin Bureau of Health Care Financing.
- *Ray Hanley*, director, Division of Medical Services, Arkansas Department of Human Services.
- *Ann Kohler*, director, Office of Medicaid Management, New York State Department of Health.
- *Rick Potter* deputy director, Arizona Health Care Cost Containment System.
- *Linda Wertz* (co-chair), Medicaid director, Texas Health and Human Services Commission.

HCFA officials

- *Rachel Block*, director, Data Systems Group Center for Medicaid and State Operations.
- *Steve Jencks*, MD, director, Priority Management Group Office of Clinical Standards and Quality.
- *Jeff Kang*, MD, PhD, Chief Medical Officer Center for Health Plans and Providers.
- *Trish MacTaggart* (co-chair), director, Officer Quality and Performance Management Group.
- *Regina McPhillips*, director, Planning and Analysis Group Center for Beneficiary Services.

The work group is officially called the Value-Based, Beneficiary Centered, Quality-Focused Medicaid Purchased Strategy Working Group. Composed of five HCFA officials and five state Medicaid directors, it has been nicknamed "the Five-by-Five group."

It will not modify Medicaid reimbursement, Medicaid regulations, or Medicaid benefits. Nor will it issue any reports. Instead, the group's primary goal is to develop better purchasing strategies aimed at improving the quality of services and health of Medicaid beneficiaries. "It is no longer good enough to just pay bills. You need to know what you are getting for your dollar and hold people accountable for getting that bang for your buck," says the HCFA official.

At its initial August meeting, the Five-by-Five members backed off from a jam-packed agenda, choosing to limit the number of issues it plans to address and scheduling a two-day meeting in December to tackle the topic of immunizations.

Next, the group plans to move on to the area of special needs populations. BY HERBERT P. WEISS

Guidelines get the go-ahead

HCFA is to act on salary equivalencies this month

"BETTER LATE THAN NEVER" MAY BE THE federal government's stand on publishing the long-delayed final Medicare salary equivalencies (SEs) for rehabilitation therapies provided in nursing homes under arrangement by outside therapy providers. Long term care and therapy provider groups learned of HCFA's intention to publish the salary equivalencies at an October 29 meeting with agency representatives on Part B payment issues. And in December, a HCFA staffer confirmed for *Contemporary* that the agency plans to issue the rates in January, with implementation set for March or April.

The guidelines will update salaries for physical therapy and respiratory therapy and provide first-time salary equivalencies for speech therapy and occupational therapy. Intermediaries have been paying ST and OT based on varying applications of the "prudent buyer" principle, creating a wake of disputed claims and litigation.

Provider response to the informal announcement ranged from skepticism to bewilderment over HCFA's plans to publish the salary equivalencies a few months before the cost-based methodology will become obsolete under new reimbursement systems.

On July 1, 1998, HCFA is set to implement a prospective system for Part A patients that will pay an all-inclusive, case-mix adjusted rate for services, including therapies. On that date, nursing homes will also be required to begin billing Medicare directly for therapies provided to Part B residents.

As of July 1, 1998, Part B therapies must be billed directly to Medicare and will be paid on a fee basis.

Peter Clendenin, executive vice president of the National Association for the Support of Long Term Care, says NASL members wish HCFA had stuck to its earlier publication date of September for the salary equivalencies. "Now providers will have to deal with three different reimbursement systems in 1998," he points out. The payment brew includes cost-based reimbursement with the new salary equivalencies, the Medicare PPS, and the new Part B payment formula.

HCFA officials may have had a legal motive in publishing the salary equivalencies, calculating that getting something finalized will help stem the tide of future disputes and litigation over prudent buyer applications for speech and occupational therapy costs.

The equivalencies could serve at least one useful purpose for providers as well, some speculate. Clendenin believes they may be used by HCFA to help establish a fee schedule for Part B therapies.

A HCFA staffer would not confirm that the agency intends to use the equivalencies for this purpose, but provider groups continue to work with the agency on the fee schedule for Part B therapies.

"The SEs won't really impact the fee schedule [for Part B therapies] except that the information and data that went into their development, especially the market basket, could be considered," says Laurence Lane, vice president of regulatory affairs for NovaCare and past NASL president. BY KAREN LUSKY

of consolidation. "However," the report warns, "overdevelopment may occur, which will no doubt influence the market." Schless already sees "pockets of overbuilding" in some assisted living markets. But, he notes, "you're not seeing that in existing stabilized properties."

As for the nursing home industry, more long term care companies are forming partnerships with investment firms to consolidate business. "This offers more capital and reduces competition for acquisitions," the report explains. "There's a stability there in terms of the players, the companies," Schless notes.

In all three sectors, the report finds "revitalization, increased consolidation, and clear-cut leaders emerging."

To order a copy of the report, phone Julie Whitehead at 202-974-2338 (cost: free for ASHA members, $25 for non-ASHA members). BY DOUG BRUNK

Stating the case

Illinois challenges HCFA's survey and certification process

IN A DECEMBER 5 APPEAL, ILLINOIS NURSING home providers challenged key provisions of HCFA's survey, certification, and enforcement rule.

The legal challenge was filed by Illinois Council of Long-Term Care (ICLTC), representing 180 nursing homes, in the 7th Circuit Court of Appeals. It charged that the procedures used by the federal government to enforce the survey and certification process and the state operations manual used to implement the rule were not published and promulgated through the federal administrative rule-making process. "We alleged that the state operations manual implementing the survey and certification process is an illegal rule," notes Charles Sheets, ICLTC's legal counsel and a partner at the Chicago-based legal firm of Winston & Strawn.

Illinois' suit follows on the heels of similar legal complaints filed by the Michigan Association of Homes and Services for the Aging (MAHSA) before federal district court and the U.S. Court of Appeals. Like ICLTC, MAHSA had alleged that the survey and certification process was unconstitutionally vague and violated nursing facilities' right to contest government findings and regulations, as set forth in the Medicare Act and the Administration Procedures Act.

The appeals court dismissed MAHSA's complaints on procedural grounds. Under the Medicare Act, the court noted, all HHS administrative remedies must be exhausted before they are brought into federal court. The court also declined to hear MAHSA's claims under the Medicaid Act, which does not impose judicial review provisions.

In May 1996, ICLTC filed its suit with the U.S. District Court for the Northern District of Illinois. That court ultimately ruled against the association, citing the same jurisdictional problems.

Taking stock of the MAHSA ruling, Sheets and his legal team amended their law suit, filing on August 6, 1997, on behalf of ICLTC's Medicaid-only nursing homes.

"What this case will undoubtedly do is to clarify when providers can go to court and make a challenge to a Medicare and Medicaid statute," Sheets predicts.

As of press time, the appeals court was drafting its decision, which Sheets was hopeful of getting by March. If the court rules against ICLTC, Sheets plans to ask for permission to argue the issue before the U.S. Supreme Court. BY HERBERT WEISS

Facts and Trends: The Assisted Living Sourcebook (The National Center for Assisted Living). This publication contains data on assisted living residents, including functional levels and needs for assistance with activities of daily living; operational matters such as staffing. licensure, and service plans; money matters such as financial profiles, payment methods, and supply and demand; and an appendix that provides a state-by-state summary of regulations as well as facts about the top 25 assisted living chains. Data is based on surveys of 303 facilities in 46 states conducted by NCAL, which is a branch of the American Health Care Association.

To order, call 800-321-0343 (cost: $29.95 for AHCA members, $69.95 for non-members).

National Clinicians' Post-Exposure Prophylaxis Hotline (PEPline) (Department of Health and Human Services). This toll-free service provides clinicians with information, counseling, and treatment recommendations for workers with needle-stick injuries or other serious occupational exposures to bloodborne microorganisms that lead to such serious diseases as HIV or hepatitis. The number is 888-448-4911 (cost: free).

Volunteer Energy Resource Catalog (Energize Inc.) Updated each year by a training, consulting, and publishing firm specializing in volunteerism, this catalog contains more than 60 volunteerism books, training materials, and software from a variety of sources. To order, call 800-395-9800 (cost: free).

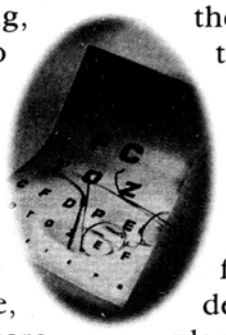
Making the Moments Count: Leisure Activities for Caregiving Relationships (The Johns Hopkins University Press). Author Joanne Ardolf Decker providers caregivers with practical suggestions for spending leisure time with people of all ages who need care, whether they are recovering from an illness, facing a terminal disease, or growing older and more dependent on outside help. To order, call 800-537-5487 (cost: $29.95 for hardcover, $14.95 for paperback).

Planning, Design and Construction of Health Care Environments (The Joint Commission on Accreditation of Healthcare Organizations). Written by health care architecture experts, this book covers issues that can affect decisions in planning, creating programs, designing, and constructing a facility. To order, call 630-792-5000 (cost: $45).

A freeze on the freebies

Medicare HMOs ratchet down their costs

THE GROUND IS SHIFTING UNDER MEDICARE managed care plans. These popular alternatives to traditional Medicare coverage are ratcheting down costs and cutting back on free drug, dental, and vision benefits to enrollees.



Recent reports that Aetna and some Blue Cross health plans have raised premiums and started to eliminate such benefits, which are not covered by traditional fee-for-service Medicare, surprised many in the health care industry. HMOs have used these freebies to attract seniors and build healthy enrollments. But they've begun to reassess the strategy due to rising costs and funding cuts enacted in the federal Balanced Budget Act of 1997.

The cost crunch has hit others as well. In December, the American Association of Retired Persons raised premiums on its Medicare supplemental insurance program by 13 percent, following two earlier rate hikes.

Some long term care providers worry that the HMO cutbacks might signal a slowdown in Medicare managed care and a halt to the small but growing trend toward skilled nursing contracts with facilities.

No such thing, say industry analysts. The HMOs are still a better deal for the elderly than conventional Medicare, they say, so enrollment will continue to soar. Enrollment in Medicare HMOs has been growing at the rate of about 100,000 members per month.

In fact, the trend may foreshadow greater opportunities for long term care. "What these developments say is that senior plans are looking for ways to save dollars," says Ellen Altman Milhiser, an independent Medicare analyst in Gaithersburg, Maryland. And in the long run, she explains, cutting back on hospital stays and offering more lower-cost long term care will become a better cost-cutting strategy than reducing benefits.

That's because "plans can't cut benefits too far or they'll cease to be a competitive force," explains Patricia Newman, director of Medicare policy at the Henry J. Kaiser Family Foundation, a Washington, D.C.-based health care think tank. BY HOWARD KIM

WHAT STANDARDS?

In a recent HHS probe of durable medical equipment suppliers that receive Medicare payments,

41% failed

to meet at least one of the government's 11 standards. HCFA is tightening controls on the DME program.

Medicaid memo

HCFA outlines rules for states setting new rates

THE POST-BOREN ERA OFFICIALLY BEGAN ON December 10, 1997, with HCFA's first memorandum on Medicaid rate setting. In a memo to state Medicaid directors, the agency interpreted Medicaid rate setting provisions outlined in the Balanced Budget Act of 1997.

According to HCFA's five-page memo, no public notification process is required if states are not proposing any modifications in their payment methodology or changing their Medicaid rates.

States are required, however, to publish all proposed and final rate changes, methodologies underlying the rates, and justifications for the changes. Interested parties must be given a reasonable opportunity for a review and comment during the public rate-setting process. To satisfy that requirement, states may choose any of a number of options outlined in the agency's memo, including public hearings, public commission meetings, or a published notice in the newspaper.

HCFA's interpretation of compliance is a reasonable and sensible approach, says James M. Verdier, Director of State Health Policy for Mathematic Policy Research Inc., a Washington, DC-based social policy research firm. "The options for making the rates public that HCFA outlines would certainly achieve the purpose of informing the nursing home industry of what they need to know about rate setting methodology and rates," he says.

But industry spokesmen disagree. When Congress eliminated the Boren amendment, it intended that information

RELATED NEWS

No playing favorites

AARP says it has no plans to endorse Medicare HMOs

BATTERED BY NEGATIVE CRITICISM, THE American Association of Retired Persons denied claims that it had planned to publicly endorse certain Medicare health maintenance organizations.

The powerful senior citizens' group told *Contemporary Long Term Care* in January that it is moving ahead with an initiative to assess the senior health plan industry. But the group has dropped a project involving nine HMOs with Medicare contracts, according to AARP spokeswoman Lisa Davis. Davis left unclear AARP's specific involvement with the plans, but underscored that product endorsement was "not part of any deal with any health plan."

The group came under heavy criticism by HCFA and the managed care industry last year. Criticism was centered on allegations that AARP was about to endorse certain Medicare HMOs and charge the plans a $20 fee for every new AARP member they enrolled. Although the group frequently endorses products and services, it confines these to hotels and vacation travel services, Davis says.

"Our efforts are aimed [solely] at looking at positive ways to make an impact on managed care for our members in order to broaden the array of choices for them," Davis says. BY HOWARD KIM

about changes in long term care rates be broadly disseminated, says Tom Burke, director of community relations for the American Health Care Association. "The HCFA memo undermines the legislative intent of the Balanced Budget Act," asserts Burke, who fears that the methods of dissemination approved by the agency will keep providers from learning about rate-setting actions. BY HERBERT P. WEISS

For the record

National data bank to track offenses by licensed professionals

CRIMINAL AND CIVIL RECORDS RELATED TO health care offenses by long term care administrators, nurses, social workers, therapists, and other professionals will soon be stored in a central national data bank. As part of the Department of Health and Human Services' arsenal against fraud and abuse in the Medicare and Medicaid programs, the Healthcare Integrity and Protection Data Bank (HIPDB), a federally managed data bank authorized by the Health Insurance Portability and Accountability Act of 1996, will keep track of certain criminal and civil records for health care suppliers or providers who are licensed or certified by the state.

Federal and state agencies and health plans will be required to report certain final adverse actions, including criminal convictions and civil judgments related to health care, exclusion from federal programs, and adjudicated actions. To ensure confidentiality, HIPDB data will be provided only to federal and state government agencies and to health plans. In addition, anyone who is the subject of a report will be able to obtain a copy of his own record.

"HIPDB creates a one-stop-shopping mechanism for peer reviewers and those conducting licensing, credentialing or for those who make certain contracting decisions," says Vivian Chen, the policy team leader implementing the federal legislation.

The program is scheduled to be up and running by March, assuming the federal regulations can be published and the database developed in time. BY HERBERT P. WEISS

Guiding HCFA

Measures in Congress would affect Medicare, Medicaid

SEVERAL BILLS WITH BEARING ON LONG TERM care stand a fair chance of winning Congressional approval, say industry officials.

The first (H.R. 4046), introduced by Jim Davis (D-Fla.) and Michael Bilirakis (R-Fla.) in June, would protect the rights of certain residents to stay in nursing homes that choose to leave the Medicaid program. Under the bill, HCFA would grant facilities seeking decertification a "date certain" for leaving the program; all residents in the home on and before that date would be able to remain, even if they were on Medicaid or later became Medicaid-eligible. An identical bill is expected to be introduced in the Senate soon after press time, replacing a bill sponsored in May by Senator Bob Graham (D-Fla.). The earlier bill would have protected any resident who became Medicaid eligible, regardless of their date of admission, explains Michael Hogan, director of legislative affairs for the American Health Care Association.

Bob Graham

"We are all pushing for [the updated bill] and for getting additional members to sign on," says Hogan. "We don't support what Vencor did. A nursing facility is someone's home, and residents should have a security that they can stay there."

In light of Congress' busy, appropriation bill-filled agenda, Hogan says the long term care bill's best chances for approval would come from being attached to a weightier piece of legislation. "We have to find a vehicle that is actually moving," he says. "On its own, the bill might not be granted sufficient priority."

At the same time, the Senate is considering a bill (S. 2222) introduced by Senator Charles Grassley (R-Ia.) to repeal the $1,500 cap on outpatient rehabilitation therapy, which includes services provided in skilled nursing facilities. The cap was called for in the 1997 Balanced Budget Act. At press time, the American Health Care Association planned to urge the bill's passage at a hearing before the Ways and Means Committee scheduled for July 16. BY YVONNE PARSONS

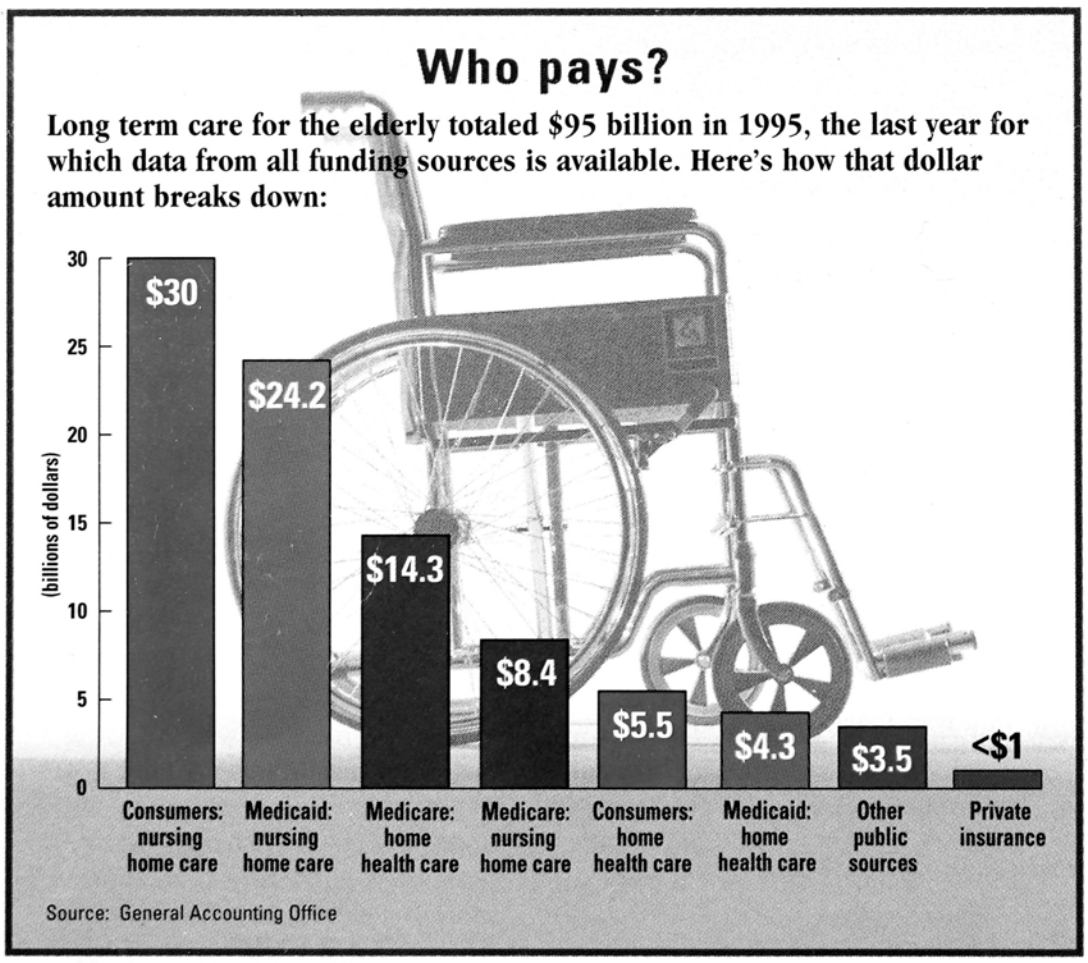


CHART BY SARAH EDGAR

Surveyors' summit

HCFA sponsors regional conference on urinary incontinence

HOW TO HELP NURSING HOME RESIDENTS with urinary incontinence was the subject of an unusual meeting in Worcester, Massachusetts, on June 18 and 19. Called by HCFA, the session was attended by more than 125 federal and state surveyors and providers from the New England states, New York, and New Jersey.

"It's the first meeting ever held that brings surveyors and providers together to discuss clinical issues surrounding urinary incontinence," says Nancy Barsamian, a nurse consultant in HCFA Region 1.

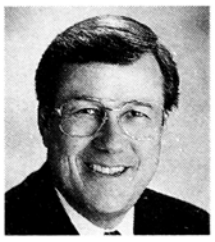
Diane Ordin, MD, medical officer for the division of clinical standards and quality in HCFA Region 1, counts the conference as an important step in bettering care as it relates to the frequently reversible problem of incontinence. "We think that there is a growing opportunity to improve assessment and management of [the condition] in a way that might greatly improve the health and well-being of many nursing home residents," she says.

The training session covered a number of topics including using MDS for assessment of urinary incontinence, best practice interventions, and using continuous quality improvement to manage and assess incontinence. The fact that many cases of incontinence can be treated was a constant theme at the meeting.

Following the conference, training will be given to providers in the six New England states in HCFA Region 1. In addition, HCFA has begun to work closely with peer review organizations in Connecticut, Vermont, and Maine on a quality improvement project designed to teach providers how to better assess and manage urinary incontinence. Results are expected sometime in 1999. BY HERBERT P. WEISS

Committee Chairman Bill Thomas (R-Calif.) directed HCFA to submit a plan to address the problem by this month.

Some testifying at the hearing also challenged the basic soundness of the PPS for skilled nursing facilities. Testifying on behalf of AHCA, Mary Ousley, senior vice president of government and regulatory affairs for Integrated Health Services, testified that the facility-specific portion of the rates will not cover many facilities' costs today. The rates, which are based on 1995 Medicare charges, don't take into account the fact that many facilities today are accepting more medically complex patients, she pointed out. In addition, AHCA says, exempting many facilities from the PPS that didn't have Medicare experience in 1995 by calling them "new" SNFs is unfair. Ousley proposed that HCFA broaden the definition of "new" to include facilities that can "adequately demonstrate a significant change in the type and volume of services provided since 1995."



Thomas

Proposed caps on outpatient rehabilitation therapy provided in SNFs were also addressed at the hearing. HCFA and the General Accounting Office answered differently when asked whether the cap would become effective on January 1, 1999, as required by the BBA: The GAO said the deadline couldn't be met, while HCFA said the provision was on schedule.

The cap would limit annual SNF outpatient physical and speech therapy reimbursement to $1,500 and occupational therapy to an additional annual $1,500. "Anything that delays the provision is good," says Gay, who adds that the provision should be repealed. "The provision is arbitrary and done solely for budget reasons."

The American Health Care Association is a strong backer of legislation known as the Reinstatement of the Medicare Rehabilitation Benefit Act of 1998 (HR 3835 and S 2222), which would repeal the cap. The legislation would force HCFA to implement a new payment scheme for outpatient therapy by January 1, 2000, that is based on diagnosis, functional status, and a beneficiary's prior use of service. BY KIM LAWSON

Comments, please

Long term care groups weigh in on PPS

SEPTEMBER 11 MARKS THE END OF THE extended period for comments on HCFA's interim final rule on prospective payment for skilled nursing facilities. As of press time in early August, long term care groups were already voicing their concerns loud and clear. High on the list: more specifics on payment for nontherapy ancillary costs.

"In our initial reaction, AHCA sees a need for HCFA to provide further technical details," says Tom Burke, senior director of public relations for the American Health Care Association.

Michael Rodgers, senior vice president of government affairs for the American Association of Homes and Services for the Aging, says the resource utilization group (RUG) categories used to determine rates don't reflect the costs of nontherapy ancillary services.

One solution suggested to HCFA was a budget-neutral pass-through of certain nontherapy ancillaries until more research is conducted on how the costs should be handled. Another was to develop an alternate payment system for patients who require high-cost medications, supplies, or services.

Provider groups are also seeking an appeal mechanism for adjusting rates.

The American Society of Consultant Pharmacists plans to address the concern that the PPS will erode beneficiaries' access to appropriate medication therapies, says Leigh Davitian, ASCP director of governmental affairs. Specifically, the group will call on HCFA to maintain the current Medicare pass-through for medications under PPS until Section U of the minimum data set is implemented nationally and data is available for quality measures. The group will also call for research into the relationship between RUG classification and the cost of medication therapy for diseases and conditions common in the Medicare population.

The American Medical Directors Association is concerned that the case-mix system "adjusts for activities of daily living and depression in very limited ways for some comorbidities," says Susan Petty, director of federal affairs at AMDA.

An overriding concern for providers is that prospective payment and consolidated billing changes will take substantially more dollars out of the health care system than was originally required by last year's Balanced Budget Act. Says AAHSA's Rodgers: "As a matter of fact, we think, when fully implemented, there will be some $12.8 billion over the next five years instead of the $9.5 that had been originally suggested." BY HERBERT P. WEISS

RELATED NEWS

pps.com

A new section of HCFA's Web site delivers the goods

PROSPECTIVE PAYMENT SYSTEM INFO-SEEKERS will want to check out HCFA's latest addition to its Web site: a special section devoted exclusively to the PPS. The section went up in July and posts information on key components of PPS, including question-and-answer sections on topics such as the MDS and the now-postponed consolidated billing system.

While there is some lag time between when information is published and when it is posted on the site, "it is useful because sometimes you get lost and don't know what to look for [on the main HCFA site]," says Dianne Wolman, reimbursement policy specialist for the American Association of Homes and Services for the Aging. The page acts as a bulletin board for copies of program memoranda sent to fiscal intermediaries and for lengthy documents such as the payment rate and case mix numbers for urban and rural areas.

"What we'd really like to see up there is the background data sets that HCFA used to construct the federal PPS rates," says Wolman.

Visit the site at <www.hcfa.gov/medicare/snfpps.htm>. A link to the site is also available from AAHSA's member's page at <www.aahsa.org>. BY BRIDGET DEMOUY

Ready, set, go

HCFA moves quickly on Clinton reform goals

HCFA HAS DEVELOPED A TIMETABLE FOR actions to implement President Clinton's 14-point plan to reform the nation's nursing homes. The internal working schedule outlines a series of steps monthly through May 1999, although the agency says the target dates could change.

The agency intended to redefine the "list and methodology" for choosing the worst nursing homes last month and to start "enhanced monitoring" of those homes this month.

Suzanne M. Weiss, vice president and counsel for public policy of the American Association of Homes and Services for the Aging, says an "informal consensus" about who the worst performers are had already arisen from recent meetings between industry leaders and HCFA officials and the July hearings before the Senate Special Committee on Aging. She notes that when committee chair Charles E. Grassley (R-Iowa) asked state survey agency personnel directly if they could identify the worst-performing facilities in their states, they acknowledged that they probably could. "I think HCFA is looking at those criteria," Weiss says.

HCFA also intended to meet last month with the Department of Justice and the Inspector General of the Department of Health and Human Services "to develop an interagency plan for appropriate identification, referral, investigation, and where necessary prosecution of egregious violations"—a step Weiss links to a plan by HCFA to step up application of the False Claims Act to nursing homes. The government already has used the anti-fraud measure against three long term care facilities in Pennsylvania, which agreed to pay $500,000 in fines for providing inadequate care to residents and then charging Medicare or Medicaid for their care.

The larger issue, Weiss contends, is "Who is going to run the survey system?" HCFA, she maintains, "has every single tool in place to stop instances like those from happening. To say, 'Okay, if it gets bad, we'll call in the IG's office,' is not a solution. The solution is more consistent and persistent monitoring. These situations don't happen overnight."

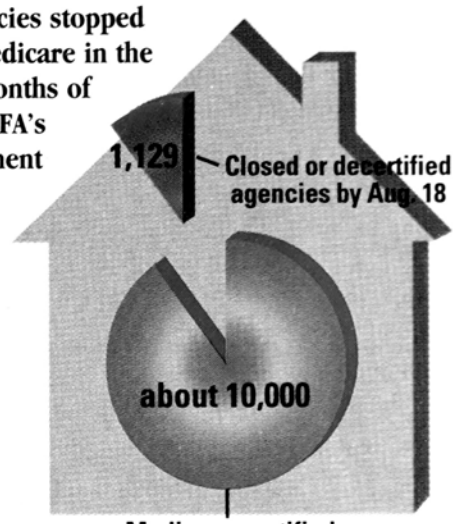
Overall, Weiss adds, HCFA's timetable is "pretty aggressive." She questions whether the agency can meet its schedule for all activities, including publishing final regulations in December for permitting states to impose a civil monetary penalty for each instance of serious or chronic violations harming residents. It would be unusual to produce a final rule in such a short period of time, says Weiss. "Even clearing the internal review process in that time frame could be challenging for them," she contends.

Also on HCFA's schedule: finalizing plans in December to use the Internet as a repository of best practice guidelines for caring for residents at risk of weight loss and dehydration, and, in April, targeting problems related to nutrition, dehydration, and bed sores.

BY ALAN DESSOFF

Home health as we knew it

A survey of the National Association for Home Care's state affiliates shows that more than 1 in 10 agencies stopped accepting Medicare in the first eight months of this year. HCFA's interim payment system for home health agencies is largely to blame, say NAHC officials.



Source: National Association for Home Care

CHART BY BARTEK MALYSA

RELATED NEWS

Surveys in cyberspace

HCFA to publish survey data on the Internet

BY THE TIME YOU READ THIS, CONSUMERS cruising the Internet should be able to review the survey findings of individual nursing homes, including violation records, on HCFA's new Web page, <www.medicare.gov>. But industry leaders wonder if the public will know what to make of the technical data.

The American Association of Homes and Services for the Aging is concerned that health safety waivers will be interpreted as deficiencies, says Susan Weiss, AAHSA's vice president and counsel for public policy. "In our minds that makes nursing homes look like fire traps, and that's not true," she says.

AAHSA is also unhappy that not all surveys posted will be current, with some dating as far back as 1996. "HCFA has told us that this is because states have not submitted more recent information," says Weiss, adding that the Web site data won't indicate whether deficiencies have been appealed or overturned.

AAHSA has called on HCFA to assign a technical support person to the Web site. "Consumers have got to have a way to contact the agency, because we are not going to answer all the questions that are raised by the data," warns Weiss.

The National Citizens' Coalition for Nursing Home Reform applauds HCFA's effort to disseminate the data, but it too questions how effective it will be. "Only a small percentage of older consumers will have access to computers," says Sarah Burger, NCCNHR's executive director.

The group is also concerned about what data is published, reports Burger. The group has called on HCFA to publish cost data as well as basic information about the facility owner. "Who is the owner? Is the person really responsible? These two questions are really important to the consumer," she says.

BY HERBERT P. WEISS

STATE NEWS

Rhode Island rights

With a new law approved this summer, Rhode Island joins a handful of states to codify goals and values that must be embraced by all long term care providers.

Passed by unanimous vote in the state's General Assembly and signed into law on June 30, the provision calls for all long term care programs and services provided by a state agency to promote residents' independence, enhance quality of life, and provide care in the least restrictive environment.

Under the law, consumers must be treated with dignity, actively participate in all care decisions, and be supplied information to support informed choices about long term care. In addition, the state's long term care system must now support family and other informal caregivers, control costs for the consumers, and offer quality of care in all service settings.

The new law should help policymakers set spending priorities for long term care programs or services, says Democratic Senator Charles Fogarty, chairman of the state's Long Term Care Coordinating Committee.

The long term care community supports the law, notes Sheila Sousa, executive director of the Rhode Island Association of Homes and Services for the Aging. She warns, however, "The values won't mean a thing if they are left on the books."

BY HERBERT P. WEISS

Florida's alternative

Florida health officials and nursing home providers are promoting a new way to get poor-performing facilities back on track. The plan would serve as an alternative to surveyors' current system, which levies sanctions against errant facilities ranging from civil monetary penalties to expulsion from the Medicare and Medicaid programs.

The plan, which has broad support from the state administration, providers, and the legislature, is based on the premise that "you can't punish your way to a better system," says Ed Towey, spokesperson for the Florida Health Care Association. "It's an attractive argument to set standards which a facility either meets or it's [out of the program]. But if you keep shutting down facilities, you have to transfer patients, and it creates all kinds of problems."

Modeled on a successful program in Oregon, the Florida proposal would earmark chronically poor-performing facilities for voluntary participation. "The state and trade associations would work with these facilities in a consultative manner to help them come back into compliance," Towey explains. "Meanwhile, the enforcement procedures would be suspended." Participating facilities would, however, be put on a short leash by the state.

"Facilities that did not progress to compliance would be subject to the original enforcement options," adds Towey.

The goal would be to find solutions for chronic problems, in part by identifying their roots. "The cause could, in some cases, be a funding issue, especially for a very old facility with a high Medicaid census and low family involvement," Towey says.

Other potential causes include staffing and training problems, the nature of residents' needs, administrative problems, and the commitment of the ownership to quality care.

Although the details have to be worked out, the proposal has "broad acceptance by the state and legislature," says Towey, who believes that the program has a strong chance of implementation in the near future.

BY KAREN LUSKY

California heats up

In the aftermath of this summer's blockbuster GAO report on poor-performing nursing homes in California, the state's provider groups are busy running damage control.

The California Association of Health Facilities, while supportive of the agency's effort to combat abuse and neglect in nursing homes, continues to question the validity of the report, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight.*

"We take issue with the fact that a study on death certificates of patients who died in 1993 is being used to determine whether or not there are care problems in 1998—five years later," says CAHF's written response to the GAO report.

As CAHF spokesperson Kelley Queale explains: "We found the method of the report questionable in that researchers visited three nursing facilities and did an evaluation of some of the records to make a determination [applied to the industry]."

The group is also publicizing the stringency of the state survey process. "California is a leader in the severity of surveys and [interpretation] of the regulations, so more problems are going to be identified in surveys as a result," says Queale. The most recent data from HCFA showed that only 3 percent of California nursing facilities are deficiency free, compared with 23 percent of facilities nationwide.

The industry has also initiated a best practices program to identify exemplary practices in facilities that can be replicated by other providers.

BY KAREN LUSKY

States of disarray

New study takes stock of survey practices

MOST STATES ARE FAILING IN THE ENFORCEMENT of federal nursing home standards, and HCFA isn't helping matters. That's the conclusion of a report released in October from the National Senior Citizens Law Center in Washington, D.C.

The 150-page report, *What Happened to Enforcement? The Experiences in Five States*, is part two of a study that examines the survey and enforcement practices in Georgia, Michigan, New York, Texas, and Washington. The study aims to identify factors that promote or inhibit the effective enforcement of federal quality standards for nursing homes.

The report recommends that states be given the primary responsibility for enforcement but that the federal government assure that states are using their authority correctly and also take action when states fail. "It makes no sense for the federal government to simply rubber stamp whatever states recommend," says Toby Edelman, NSCLC staff attorney and report author.

In fact, she says, HCFA's guidance has undermined the enforcement practices of Georgia and other states that implemented their own enforcement procedures prior to the 1995 enactment of the federal rule. "Between 1989 and 1995, Georgia implemented the enforcement requirements of federal law and imposed significant remedies. Since 1995, using the federal system, the state has imposed very few remedies," Edelman notes.

The report also criticizes the fact that federal officials have scrutinized states—particularly Michigan—that have identified deficiencies and more strictly imposed remedies. "This action sent a clear signal to other states that taking enforcement action and imposing remedies would create controversy," she says.

Edelman calls on the federal government to rewrite HCFA's State Operations Manual to assure swift and effective imposition of the full range of remedies mandated by federal law.

Last February, NSCLC released part one of the study, which analyzed federal enforcement of the nursing home reform law. For a free copy of the new report, write to NSCLC, 1101 14th St., N.W., Suite 400, Washington, D.C. 20005. BY HERBERT P. WEISS

Who you gonna call?

Federal agencies call meeting of fraud busters

OFFICIALS FROM FEDERAL, STATE, AND LOCAL government offices met in Herndon, Virginia, on October 21 for the first-ever national conference on nursing home fraud and abuse.

At the two day conference, cosponsored by the U.S. Department of Justice (DOJ) and the Department of Health and Human Services, more than 150 attendees were briefed on the current regulatory and nursing home payment system, federal enforcement efforts to attack health care fraud, and data collection and investigative challenges.

In his opening remarks, DOJ Deputy Attorney General Eric H. Holder Jr. called health care fraud a top priority for his agency. Citing a recent DOJ report, he said that there has been a sharp increase of allegations of fraud and abuse in nursing homes. According to the report, the number of nursing home fraud investigations increased more than 10-fold between 1994 and 1997, from 5 cases to 54.

Holder called for the development of an "action plan" to improve coordination between federal and state officials. HCFA Administrator Nancy Ann Min DeParle urged attendees to "make the best use of local, state, and federal laws, civil and criminal penalties, and the False Claims Act, to protect our most vulnerable citizens." No release date has been set for the action plan, says a DOJ spokesperson. BY HERBERT P. WEISS

The $1,500 question

HCFA clarifies therapy caps

HCFA TRANSMITTAL AB-98-63 HAS LANDED THE annual outpatient rehab cap in the provider's court, leaving skilled nursing facilities responsible for tracking the $1,500 limit on services starting January 1.

The Balanced Budget Act of 1997 requires a $1,500 annual limit for each beneficiary's outpatient physical therapy services, including speech and language pathology services. A separate $1,500 limit applies to occupational therapy. The limit does not apply to services furnished directly or under arrangement by a hospital to an outpatient, or to an inpatient who is not in a covered Part-A stay.

HCFA views the more limited implementation as a "transitional measure" toward the full beneficiary limit. Non-hospital providers will be "held accountable for each beneficiary to assure they do not bill Medicare for patients who have met the annual $1,500 limitation at their facility for each separate limitation," according to the transmittal.

For SNFs this means that the facility itself is responsible for the billing of all outpatient rehabilitation services and the tracking of the incurred expenses for those services when furnished to a SNF resident not in a covered Part-A stay and nonresidents receiving outpatient rehabilitation services at the SNF regardless of whether the services are furnished by the SNF itself or by an outside therapist.

"Some people are saying that this is an improvement over what the statute called for," comments Elise Smith, senior director of finance and managed care for the American Health Care Association. "It may be an improvement, but the cap remains totally inappropriate with no clinical foundation." BY KAREN LUSKY

STATE NEWS

Equal opportunity in Oregon

Vocal opponents to assisted suicide, including some physicians, recently protested a change in the state's Medicaid plan that added physician-assisted suicide to the list of covered services, claiming it would give suicide candidates unrestricted coverage of pain medications while limiting all other Medicaid patients. The change was effective December 1, a year after Oregon legalized physician-assisted suicide.

The Medicaid program ranks medical services and funds them in order of priority. This year, assisted suicide was placed on the same level as hospice care. The plan also lists dosing restrictions for certain pain medications, a practice critics say can hamper pain-relief efforts.

Opponents claim the dosing restrictions and assisted suicide coverage puts economic pressure on poor patients to opt for suicide. Susan Tolle, director of the Center for Ethics in Health Care at Oregon Health Sciences University refutes that claim: "Patients are getting a good package of benefits under [the program]—better than most private health plans. For patients with terminal illnesses, there are no limits on medication, no dosage limits, no drug-specific limits."

Margaret Carley, deputy director and legal counsel at the Oregon Health Care Association, adds that of the 12 reported cases where the physician-assisted suicide option was requested, none were in nursing facilities. BY ANITA PELTONEN

Going for the ratings in Michigan

A Michigan state senator, vowing to counter the state's "nursing home crisis," has reintroduced a bill that would create a consumer-rating index for Michigan's 450 nursing homes.

"The recent disclosures about nursing home abuse of patients [in the *Detroit Free Press*] may be just what we need to get this legislation passed," says Senator George Hart (D-Dearborn), referring to the newspaper's October series, which focused largely on unfavorable HCFA survey data released in September. "This latest news proves what I've been saying. We have a crisis on our hands, and the legislature needs to step in and protect our seniors."

Introduced on November 5, the bill would require the state Department of Community Health to work with the Michigan Long-Term Care Ombudsman to develop a consumer-rating index that provides information on infection control, psychotropic drug use, skin care, staffing levels, and other measures of care.

Nursing facilities would also be required to conduct an annual satisfaction survey and to notify residents and family of any financial interests and relationships they have with service providers, such as pharmacy services and medical suppliers. Finally, facilities would be required to provide itemized monthly statements of all charges to nursing home residents and their families.

At press time in mid-November, the Hart proposal had been referred to the Senate Health Policy and Senior Citizens Committee. The legislative session ends December 10. BY HERBERT P. WEISS CLTC

PLANNER

January 18-20
The Congress on Managed Medicaid & Medicare, produced by the National Managed Health Care Congress, in Washington, D.C. Call 888-882-2500.

19-20
Investing in Assisted Living '99, produced by AiC Worldwide, in Scottsdale, Arizona. Call 800-409-4242.

20-22
Rehab Services '99, produced by the National Association for the Support of Long-Term Care and Infocast, in Las Vegas. Call 512-918-2188.

FYI

Prospective Payment for Long-Term Care by Judith J. Baker (Aspen Publishers). This 428-page book is the first in a planned series of annual guides to Medicare's new prospective payment system. Weighing in at more than 28 chapters, the book gets to the nitty-gritty on rate calculations, operations, management, and billing concerns. To order, call 800-638-8437 (cost: $69).

National Center for Assisted Living Web site (NCAL). The National Center for Assisted Living, the assisted living arm of the American Health Care Association, now has a home on the Internet. The site includes resident and facility profiles from NCAL's surveys and a review of regulatory information in each state. Visit the site at <www.ncal.org>.

Chronic Pain in Geriatrics: Assessment and Management (Geriatric Video Productions). This set of videos—one on assessment, the other on management—is designed to help caregivers assess and treat chronic pain in elderly persons. The videos and accompanying written guides can be used for continuing education credits. To order, call 800-621-9181 (cost: $285 each).

Alzheimer's Education and Training Resource Catalog (Geriatric Resources). More than 150 publications and videos on Alzheimer's disease and its management are featured in this catalog. Included are a caregiving training video, educational workshop information, and a series on improving the quality of care and life for people with Alzheimer's. To order, call 800-359-0390 (cost: free).

Dealing with drugs

National forum aims to improve pharmaceutical care

IMPROVING PHARMACEUTICAL CARE IN long term care was the goal at a recent two-day gathering of physicians, nurses, pharmacists, and nursing home administrators.

Hosted by the National Forum on Quality Pharmaceutical Care Advisory Committee, a group established earlier this year by the American Medical Directors Association (AMDA), the consensus conference was held November 5 to 7 in Leesburg, Virginia. It brought together 46 participants from an array of health care groups, including AMDA, the American Society of Consultant Pharmacists, the National Association of Directors of Nursing in Long-Term Care and the American Health Care Association. Also in attendance were HCFA officials and representatives of the pharmaceutical industry.

Participants agreed that drug therapy in nursing homes must involve medical directors, attending physicians, nurses, and other practitioners. In addition, they cited communication among practitioners, caregivers, family, and administrators as essential to good care. Attendees also called for research that would identify ways to reliably measure outcomes.

HCFA official Sam Kidder, PharmD, calls the event successful but notes that the recommendations must now be put into practice. BY HERBERT P. WEISS

Robin Storey, RN, a National Forum team leader, shares insights from her work group on the ideal medication utilization process.

HOT LINKS

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Supply and demand

Study says assisted living construction lags behind need

CONCERNS ABOUT OVERSUPPLY CAUSED assisted living stock to take a dive last summer, and only recently has the sector fought its way back. But a new report refutes the conventional wisdom that there's too much assisted living product out there.

While conceding that Maryland may be overbuilt for its implied supply needs in the year 2000, and that a handful of states are worth monitoring for oversupply in the coming years, the report from St. Petersburg, Florida-based securities firm Raymond James & Associates concludes that overcapacity is generally not a concern and shouldn't be for some time.

In fact, the firm foresees a shortfall in construction. The brisk pace of senior housing construction over the past two years has not kept up with projected growth in the sector, according to the report: "Current construction trends imply an assisted living penetration rate of only 1.5 percent of its target by 2000. At the market's current penetration rate of 7.9 percent, the industry will be able to sustain supply of between 100,000 and 200,000 new units for each of the next two years."

The analysts, who contend that the demand for assisted living will only increase, project that by the year 2020, potential market penetration could be as high as 33 percent.

Sunrise Assisted Living Chairman and CEO Paul Klaassen praised the study. "They point out rightly that we're in the very beginning of maturation of assisted living and that the oversupply fears—which never had any basis in fact and are not reflected in occupancy rates—are unfounded," says Klaassen. Sunrise stock took a significant downward turn late last spring following an announcement that the company was experiencing a slower than anticipated fill-up rate in one of its Atlanta facilities.

The study does address differences from state to state. "To just give a national average tells you nothing about where the pockets of competitiveness are," says analyst James Kumpel. The study concludes, for example, that Maryland already has more supply than it will require for its year 2000 needs.

The report also notes that Connecticut, South Carolina, and Nevada have much higher construction rates than other states relative to need. Although the study does not measure supply on a city-by-city basis, hot markets such as Houston; Dallas; Charlotte, North Carolina; Atlanta; and Chesapeake County, Maryland, should also be on investors' watch lists, according to the report. BY SAM ADLER