Pepper Commission to Set Health Care Agenda in the 1990s

by Herbert P. Weiss, Guest Columnist

In the second session of the 101st Congress and beyond, congressional debate on access to health and long-term care services will, in large part, be shaped by the U.S. Bipartisan Commission on Comprehensive Health Care, renamed the Pepper Commission in honor of its first Chairman, the late Rep. Claude Pepper (D-FL).

In the final days before Christmas recess, elderly constituents, opposed to a special surtax on persons over 65, forced a reluctant Congress to repeal major provisions in the landmark Medicare Catastrophic Care Act of 1989, including the controversial financing mechanism. However, the establishment of the Pepper Commission, consisting of 12 members of Congress--from both parties and both houses and three White House appointees--survived the "congressional ax" and remained in place.

During a December 1989 meeting of the Pepper Commission, Senator John D. Rockefeller (D-WV), Chairman of the Pepper Commission, laid out his draft health care reform plan to the commission members, behind closed doors.

According to a draft copy of the Rockefeller plan summarized in a December 19, 1989 article in the *Los Angeles Times*, employers would be required to provide their workers with insurance coverage or pay a special tax to finance public funding of coverage. Small business and new companies would be paid a federal subsidy to help them cover the additional operating cost.

In addition, the draft plan would create a new insurance program to finance home health care and short stays in nursing homes for the severely disabled.

The draft plan addresses the needs of more than 31 million Americans who lack health care insurance, and nine million persons who pay for costly nursing home care.

While Congressional leaders wait for the 15-member Pepper Commission to release its report in March 1990, Capitol Hill supporters are hoping for comprehensive reform.

"In the Pepper Commission, we have a historic opportunity to plug the holes in the U.S. health care delivery system," says Congressman Edward R. Roybal, Chairman of the House Select Committee on Aging.

Roybal believes that financing costly long-term care and providing insurance to America's uninsured are two problems that must be linked together in any restructuring of the health care delivery system.

According to Senator David Pryor, Chairman of the Senate Select Committee on Aging, "paying for long-term care and health care insurance for the tens of millions without coverage is going to be costly."

Pryor states that Congress has learned its lesson with the "Catastrophic Coverage debacle." He states, "there is a growing awareness that Congress cannot single out one segment of the population to pay for or receive care.

With a growing federal budget deficit, Congress considers legislative proposals to mandate employers to offer health benefits to their uninsured workers, knowing that a tax increase would face an almost certain Presidential veto."

As the Pepper Commission struggles to reach a consensus on how to reform the health care delivery system, the important question facing public policy makers will be "whose pocket is picked to finance expansion of benefits, the employer or the taxpayer?"

*--**Herbert P. Weiss** is a member of the Editorial Advisory Board for the Journal of Long-Term Care Administration. He is an editor at St. Anthony Publishing, Inc., editing three newsletters addressing physician payment and hospital reimbursement issues. He is former Washington Correspondent for Contemporary Long-Term Care and former editor of Aging Network News.*

Pepper Commission Releases Its Report

by Herbert P. Weiss, Guest Columnist

After a year of work, the 15 member U.S. Bipartisan Commission on Comprehensive Health Care, (renamed the Pepper Commission in honor of the late Rep. Claude Pepper, D-FL), released its comprehensive blueprint for providing health care coverage for 31 million uninsured Americans and long-term care services for the elderly and disabled.

Failure to agree on a specific financing mechanism created a wedge between commission members. As a result, the part of the proposal on universal health care coverage was accepted on an 8-to-7 vote, while the financing of long-term care section was approved 11-to-4.

In addition, the Bush Administration's battle cry of "no new taxes" puts it at odds with the commission's endorsement of using progressive taxes to finance the expansion in healthcare coverage.

Conventional wisdom on Capitol Hill is to wait and see. "In 6 to 8 weeks, the Pepper proposal will either help shape the public policy debate on Capitol Hill or may be dead [after delivery]," says a House staffer, referring to the proposal's failure to identify specific federal revenue sources and its hefty $66 billion price tag.

Sen. Jay Rockefeller, Chairman of the Pepper Commission, responds to his critics' opposition to the proposal's cost and lack of identified federal revenue sources, "The question is not whether America can afford the Pepper Commission proposals," he says, "the question is whether America can continue to do nothing."

Towards Universal Coverage

The Pepper proposal lays out a series of steps to strengthen private and public health insurance systems over a five year period. At the onset, this plan assures health care coverage for every pregnant woman and child in America. By the fifth year of implementation, every American would be covered by health insurance.

Because 85 percent of private insurance is provided by employers and 85 percent of the uninsured are members of working families, the Pepper Commission recommends providing health insurance through the employer. Since 65 percent of the working uninsured are employed by small businesses, special efforts would be made to help these firms provide health insurance coverage.

With more than 9 million severely disabled and frail individuals requiring long-term care services, the commission recommends both public and private sector financing of long-term care services, including the development of a social insurance program to pay for home care services and for the first three months of nursing home care.

As the country moves into the final decade of the 20th century, congressional debates will center on how to restructure a fragmented health care delivery system. Hopefully, the Pepper Report will not collect dust on too many legislator's bookshelves.

Note: A copy of the Pepper Commission's Recommendations to Congress can be obtained from ACHCA's Education Department for $10 to cover copying and postage.

*--**Herbert P. Weiss** is a member of the Editorial Advisory Board for the Journal of Long-Term Care Administration. He is also Assistant Vice President for Communications for the American Osteopathic Hospital Association. He is former editor at St. Anthony Publishing, Inc., and former editor of Aging Network News.*

Pepper Commmision Recommends the Following:

- Businesses with 100 or fewer employees would be encouraged to provide health insurance for employees and non-working dependents. Tax credits for some small employers would be available.
- Businesses with more than 100 employees would provide public health insurance (for a specified benefit package) or contribute to a public plan for all employees and non-working dependents.
- The public plan would cover employees and dependents that contribute and non-working individuals who buy in or are subsidized. The plan would replace Medicaid for the specified services and pays providers according to Medicare rules.
- The minimum benefit package would include primary and preventive care, physician and hospital care, and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.
- The plan would establish a Nursing Home Program (NHP) for nursing home care to provide financial protection and ensure that no one faces impoverishment. The federal and state governments would share in financing the NHP.
- Nursing home residents would be entitled to social insurance for the first three months of nursing home care. This "front-end" insurance would allow people who have short stays to return home with resources intact.
- Severely disabled persons would be eligible for social insurance for home and community-based care. The federal government would finance the home and community-based care program and the three-month "front-end" nursing home care.
- Private long-term care insurance would fill the gaps not covered by the plan, subject to government oversight.

Source: U.S. Bipartisan Commission on Comprehensive Health Care

SPECIAL MAILING

On April 1, 1990, a special mailing was sent to the ACHCA membership covering the following subjects:

- Proposed ACHCA Bylaws Amendments to be voted on at the Opening Business Session on Sunday, May 20, at the Convocation in Toronto.
- ACHCA Strategic Plan--Covering FY 1989-90 thru 1993-94. Revised by the Long-Range Planning Committee and approved by the Board of Governors in February 1990.
- Audited Financials for FY 1988-89 and Treasurer's Explanatory Statement.

Supreme Court Decision Erodes Patients' Rights of Self-Determination

Nursing Groups Disagree With Cruzan Decision

The American Association of Nurse Attorneys (TAANA) and the American Nurses Association (ANA) strongly disagree with the Supreme Court ruling in the case of *Cruzan v. Director, Missouri Department of Health*. TAANA and ANA believe that the wishes of an incompetent patient will most likely be effectuated by the family in collaboration with the health care team.

They state that in the *Cruzan* case, "the State has no interest, and no right to intervene in the decision-making process other than to establish procedural safeguards to be followed."

Furthermore, the TAANA and the ANA believe the decision forces nurses to violate the ANA Code for Nurses, which states, "Since clients themselves are primary decision-makers in matters concerning their own health, treatment and well-being, the goal of nursing actions is to support and enhance the client's responsibility and self-determination to the greatest extent possible."

TAANA and ANA strongly support the concept of the Patient Self-Determination Act, currently in committee before the House and Senate. They also feel it is imperative to educate people about advance directives.

New Office Systems Manager

Steven Malone became the Manager of Office Systems at ACHCA in May. He is responsible for overseeing the purchase, installation, and smooth functioning of an upgraded computer system.

Steven comes to ACHCA with a wealth of experience in computer systems. For ten years he was the Chief Service Technician at Diebold, Inc., in Rockville, Maryland, where he worked with mini-computers, data communications, automatic teller machines and security equipment. He is completing a Bachelor of Computer Science degree at the University of Maryland.

Families Encouraged to Prepare Advance Directives

by Herbert P. Weiss, guest columnist

Before its recess, the Supreme Court handed down a major ruling on the emotionally charged "right-to-die" issue. States may require clear and convincing evidence that a permanently unconscious patient wishes to end life-sustaining procedures before family members can make such a decision, says a 5 to 4 ruling.

"In the absence of strong evidence, states may not recognize the incompetent patient's wishes or that of the family," says Chief Justice **William H. Rehnquist**, in writing for the majority.

"For the first time, the court recognizes the constitutional rights of competent patients to refuse life support," says **Shirley Neitlich**, spokesperson for Concern for Dying and Society for the Right to Die.

Also significant, "The court finds no difference between artificially administered nutrition and hydration and other life-sustaining measures," says Neitlich.

The Supreme Court upholds Missouri's interest to preserve the life of **Nancy Cruzan**, a 32-year old comatose patient, residing in a Missouri state hospital.

Without a court order, hospital employees refused to honor Cruzan's parent's requests to end artificial nutrition and hydration procedures. A state trial authorized the termination, while the Supreme Court of Missouri reversed the decision.

Advance Directives Crucial

Because of the *Cruzan* decision, **"Now it becomes even more critical to use advance directives, such as living wills and durable power of attorney documents,"** says **Charles Sabatino**, Assistant Director of the American Bar Association's Commission on Legal Problems of the Elderly.

Forty-one states and the District of Columbia have living will laws, while 28 states and the District of Columbia have enacted durable power of attorney legislations, Sabatino says.

"Living wills do not wash in Maryland," says **Sandra Wood**, administrator of the 100-bed Fernwood Retirement and Nursing Center in Bethesda, Maryland, noting that the document's language excludes the withdrawing and withholding of artificial nutrition and hydration procedures.

"Being located between the District of Columbia and Virginia creates a problem," Wood says, referring to the fact that living will legislation varies from state to state.

"For two years, we've done everything to encourage patients to sign durable power of attorney documents," she says. "Durable power of attorney gives our patients more opportunity to specify their personal wishes."

"The fact that we have these two advance directives is a quirk of history, rather than a result of reason," adds Sabatino. "There's no reason why we can't combine these two documents into one in the future."

Battle Lines Drawn

Like abortion, the *Cruzan* decision places the right-to-die issue firmly on the political agenda of state legislatures. To comply with this ruling, states will be forced to examine their existing living will legislation or enact new laws.

"It's too early to see the impact at the state level," says **Ann MacKay**, President of the Maryland Association of Non-Profit Homes for the Aging. "It's wait and see," MacKay says.

But simply put, the Supreme Court's message is clear. Nursing home administrators must educate families of the importance of filling out advance directives, especially if the patient is competent.

*NOTE: For a copy of the Cruzan v. Director, Missouri Dept. of Health case, send $5 check to ACHCA National Office, Attn: **Jan Lamoglia**.*

*--**Herbert P. Weiss** is a freelance writer, who specializes in health care and aging topics.*

Federal Agency Protects AIDS Patients' Right to Nursing Home Care

by ***Herbert P. Weiss****, guest columnist*

In 1989, the Office of Civil Rights (OCR) of the Health and Human Service Department cited Baltimore-based Seton Hill Manor for AIDS discrimination. The agency questioned the facility's practice of segregating AIDS patients, by diagnosis, in a special care unit.

"I thought their discrimination charge was absolutely ludicrous," says Lorraine Raffel, president of Raffel Healthcare Group. "We created the special care unit because of AIDS patient input. They wanted their own environment."

The agency later dropped charges when Seton Hill Manor agreed to admit patients with other blood-born diseases, (i.e., hepatitis), into the special care unit.

With AIDS patients now surviving up to two years, many will require nursing home care. Expect OCR to closely monitor nursing home admissions for discrimination against AIDS patients or individuals testing HIV positive.

Failure to comply with federal law (see box below) may result in sanctions, including the suspension or termination of federal financial assistance.

In 1990, one OCR regional office received anecdotal complaints that nursing homes may be denying admissions on the basis of AIDS or HIV infection. **Sanford V. Teplitzky**, partner in the Baltimore law firm Ober, Kaler, Grimes and Shriver tells ACHCA, "The office believes this practice violates federal law."

"The regional office plans to conduct compliance reviews to determine if nursing homes are discriminating in their admission policies," Teplitzky says. If information is shared nationwide, compliance reviews may be implemented by other OCR regional offices.

Teplitzky provides the following tips to nursing home administrators for maintaining OCR compliance:

- A facility's decision to admit or deny admission to individuals with HIV infection should be made by applying the same criteria used to consider individuals who are not infected with HIV.
- When admission of any individual with a communicable disease is complicated, the facility may wish to notify the appropriate state licensing agency. If denial is considered, it should be made with licensing agency guidance.
- If admitted, care should be provided to individuals with AIDS and HIV infection of the same caliber, and on the same basis, as care provided to non-infected individuals.
- It is important that facility staff be educated about caring for patients with AIDS or HIV infection and that universal infection control precautions be taught and strictly enforced.

Source: Sanford Teplitzky, (301) 685-1120.

*--**Herbert P. Weiss** is a Washington, D.C. based freelance writer who specializes in health care and aging topics.*

FEDERAL STATUTES PROHIBITING DISCRIMINATION AGAINST ADMITTING AIDS PATIENTS

Federal law prohibits denial of nursing home admission solely on the fact that an applicant has AIDS, or has a positive HIV test.

- **Section 504 of the Rehabilitation Act of 1973.** Programs receiving federal funds cannot discriminate on the basis of handicap. Case law has established that AIDS patients or individuals with HIV infection are handicapped.

Individuals who qualify for nursing home admission may not be turned away because of their HIV infection. The act prohibits facilities from denying services or from offering services that are not equal to or as effective as those provided to non-infected residents.

This act also forbids a facility from offering services to AIDS or HIV infected individuals which are different or separate from services provided to others, unless such differences are necessary to provide effective services.

Facilities must not limit an AIDS patient or HIV infected individual's enjoyment of any right, privilege or advantage enjoyed by non-infected residents receiving the facilities' services.

- **Medicare.** Facilities must comply with other Health and Human Service Department regulations including those related to nondiscrimination on the basis of handicap.

- **Hill-Burton.** Facilities receiving "Hill-Burton" funds may not discriminate in the delivery of services on any ground unrelated to an individual's need for service. Noncompliance could result in an action against the facility for specific performance of the requirement or an order to develop an affirmative action plan.

- **Americans with Disabilities Act of 1990.** Under this act, AIDS and HIV infections are considered disabilities. As "public accommodations," nursing homes must comply with the ADA's requirements effective 18 months from July 1990.

Facilities may not impose eligibility criteria to screen out an individual or class of individuals with disabilities. In addition, the ADA requires reasonable modifications to be made in policies, practices, or procedures as are necessary to make services available to disabled individuals. Steps must be taken to assure that these individuals are not excluded, denied services, segregated or treated differently.

Facilities may be excused from these requirements if they can demonstrate that the modifications necessary to accommodate disabled individuals would fundamentally alter the nature of service or result in an undue burden.

Violation of ADA requirements could result in civil fines of $50,000 for the first violation and $100,000 for any subsequent violations.

Source: Ober, Kaler, Grimes & Shriver.

Providers Gear Up For OBRA Surveys

*by **Herbert P. Weiss**, guest columnist*

Providers find themselves in a precarious situation after sweeping nursing home reforms became effective October 1. While nursing facilities are required to comply with reforms (see box) in the Omnibus Budget Reconciliation Act of 1987, HCFA failed to publish regulatory guidance for compliance.

As a result, nursing facilities may be put in financial jeopardy if they violate any of the law's provisions. **Facilities are subject to civil penalties, enacted by state governments, of up to $10,000 a day if they violate patient's rights or other federal requirements relating to the provision of services.**

States are caught in a Catch 22 situation -- they must enforce the requirements of the new law, yet they can't codify OBRA's requirements until final regulations are issued.

States Balk at OBRA's Cost

As of September 28, HCFA had approved 36 state Medicaid plans which "take into account the cost of complying" with OBRA; eight were still pending, five had been rejected and two had not yet been submitted.

Although states have expressed on paper that they will pay OBRA costs, Pennsylvania, Wisconsin, Nevada, and New York say they will not make adequate resources available.

California refused to implement the new law and requested an exemption, claiming they already are in "substantial compliance" and full implementation of OBRA would cost $500 million. (HCFA responded by withholding $1.2 million -- 25 percent of California's federal money -- to punish the state for failing to comply with the law.)

Inadequate reimbursement is no excuse for nursing facilities not meeting OBRA's standards. **However, providers can either file suit based on OBRA's requirement for adequacy of reimbursement in a Boren Amendment suit.**

Group Files Petition

The American Health Care Association (AHCA) petitioned Health and Human Services Secretary **Louis Sullivan** to issue regulatory guidance concerning implementation of the nursing facility provisions in OBRA.

AHCA requested that the Secretary: (1) develop regulations to bring states whose Medicaid funding plans have not been approved into compliance with the law; (2) monitor the willingness of states to actually reimburse providers for the costs associated with OBRA; and (3) delineate substantive criteria for determining the adequacy of Medicaid rate adjustments being made under these state plans.

Citing the fact that a significant number of nursing homes, particularly in rural areas, are experiencing a nursing shortage, ACHA also supports a technical amendment which, under certain circumstances, would allow current licensed practical nurses to be deemed to substitute for the registered nurse requirement.

Surviving Without Final Rules

According to AHCA, providers will be surveyed for compliance with the new rules or with statutory language where no rules exist.

All facilities are expected to comply with the "Medicaid and Medicare Requirements of Participation for Long-Term Care Facilities" as published in the Federal Register on February 2, 1989, even though these requirements are still undergoing revision. All surveys conducted on or after October 1 will be based on these requirements.

February 2 rule revisions are expected to be published and implemented later this year. But until then, facilities will be held accountable for these rules.

*--**Herbert P. Weiss** is a Washington, D.C. based writer who specializes in health care and aging topics.*

OBRA AT A GLANCE

Effective October 1, OBRA regulations require nursing homes to:

- Provide quality of care and quality of life to nursing home residents.
- Comply with residents' rights, ranging from protections against Medicaid discrimination to wrongful transfer and discharge.
- Give ombudsman full access to the nursing facility.
- Establish mandatory nurse aide training and competency evaluations.
- Provide 24-hour nursing care, with an RN on staff every day. Waivers may be obtained under special situations.
- A new level of care, nursing facilities, replaces skilled nursing facilities and intermediate care facilities.
- Employ a full-time social worker if the facility has more than 120 beds. Social services must be provided for each resident as needed.
- Perform a comprehensive needs assessment and care plan for each resident.
- Review, prior to admission and annually after admission, all mentally ill or retarded residents to assure than are appropriately place.
- Establish a Quality Assurance Committee in each facility to assure quality of care.
- To be surveyed by staggered, unannounced inspections which focus on the actual care provided rather than on paperwork.

In addition:

- State agencies can increase staffing to monitor nursing home complaints and have more enforcement options to use against facilities not meeting OBRA standards.
- States are required to adjust Medicaid rates to pay for new requirements and must make available to the public what items and services are covered by Medicaid.
- States must supply cost reports to the public which document how a nursing home spends its Medicaid payments.

Source: National Citizens Coalition for Nursing Home Reform

Congress Passes Technical Changes to 1987 OBRA Law

by Herbert P. Weiss, guest columnist

In the final hours of the 101st Congress, lawmakers passed the 1990 Omnibus Budget Reconciliation Act (OBRA). While no major legislative initiatives were included in this Act, it was used as a vehicle for numerous small amendments to Medicare and Medicaid.

Forty technical changes are among these amendments, which modify many of the nursing home reform provisions in the 1987 OBRA.

Strong Lobby From Nursing Home Groups

"These amendments remedy a number of sticking points in the law," says **Sheldon Goldberg**, President of the American Association of Homes for the Aging. "They provide for a more orderly implementation of nursing home reform."

Nursing home groups lobbied successfully against one 1987 OBRA provision that would have prevented facilities with a single, minor infraction of federal rules from training their own nurse aides. As amended, the law now permits most homes to train their nursing aides, unless the home fails certain, more serious regulatory tests.

Congress addressed another complaint that the 1987 OBRA law was too restrictive in denying nursing home admission to individuals with mental disorders. The technical amendments give the Health and Human Services Secretary authority to define "serious mental illness" as it applies to nursing home residents.

Congress adopted another amendment requiring state Medicaid programs to pay for services to maintain nursing home residents' "highest practicable" level of well-being. States are now required to demonstrate in their Medicaid plans how they calculate OBRA cost increases.

In addition, nursing home groups also successfully argued that 14 days, not 4 days, was the preferable amount of time for their staff to assess a newly admitted resident's care needs.

Advocates Fear NHA Licensure Repeal

While the National Citizens Coalition for Nursing Home Reform generally supported most of the technical changes, NCCNHR unsuccessfully opposed an amendment to waive nurse staff requirements in certain circumstances.

The national advocacy group also fought against another amendment passed by Congress which would repeal pre-OBRA requirements for administrator licensing and for state boards after OBRA standards for administrators are in place.

The group fears that states may abolish their licensure boards, especially if no federal law requires it. States will also be free to change the composition of their licensing boards, possibly favoring provider representation, says the group.

A summary of OBRA technical amendments prepared by NCCNHR is available upon request.

*—**Herbert P. Weiss** is a Washington, D.C. based writer, who specializes in health care and aging topics.*

OTHER 1990 OBRA PROVISIONS OF INTEREST

Noteworthy technical changes of interest to ACHCA members include:

➪ **Nurse Aide Training**

Facilities must check out-of-state aide registries if they believe an applicant was employed as an aide in another state.

The state must reimburse aides for their training costs if they enter into an employment agreement with a facility within 12 months after completing a training or competency evaluation program for which they paid. Reimbursement will be on a prorata basis during the period the aide is employed by the facility.

➪ **Preadmission Screening and Annual Resident Review**

Residents who are readmitted to a nursing facility from a hospital are not required to undergo preadmission screening. Preadmission screening also does not apply to acute care hospital patients who are admitted to a nursing facility directly from the hospital, who need care for the condition for which they entered the hospital, and whose physician certifies that they are likely to require less than 30 days of care.

Medicaid cannot pay for residents who do not require the level of services provided by a nursing facility unless they have resided in the facility at least 30 days.

State mental health and mental retardation authorities cannot delegate PASARR screening and review to a nursing facility or to an entity that has a direct or indirect affiliation with a nursing facility.

➪ **Health Care Professionals**

States can permit nursing homes to use nurse practitioners, clinical nurse specialists or physician assistants who are not employees of the facility and who are working with a physician to supervise resident care.

➪ **Intrafacility Transfers**

Residents who become eligible for Medicare coverage can refuse to transfer to a Medicare distinct part without jeopardizing their eligibility in Medicare and Medicaid.

➪ **Pre-OBRA Standards**

Health and Human Service regulations related to nursing facility requirements for social services, dietary services and activities must be at least as strict as requirements in effect prior to OBRA.

Thorpe Talks About Legislative Issues in 102nd Congress

by Herbert P. Weiss, guest columnist

Senior programs took minor hits during the bloody bipartisan battles over the 1990 Omnibus Budget Reconciliation Act. While no sweeping changes were made during last session, Congress did make modifications to Medicare and Medicaid, specifically nursing home reforms.

As the 102nd Congressional session begins, **Richard L. Thorpe**, ACHCA Executive Vice President, talks about the College's legislative agenda.

Where are HCFA's Administrator Standards?

The fiscal 1990 Budget Reconciliation Act repealed federal mandates for state licensure boards and licensing of nursing home administrators once the Health Care Financing Administration releases its new standards under OBRA '87.

"We're waiting for HCFA to release its new requirements on Administrator Standards," says Thorpe, noting that he doesn't expect them to be published until late 1991. Thorpe expects the administrator standards to be similar to ones submitted to HCFA two years ago by a consensus group chaired by ACHCA.

Financing Long-Term Care

"With the economic down turn, state Medicaid programs find it increasingly difficult to adequately reimburse nursing homes," Thorpe says. Many nursing homes receive their Medicaid checks late, forcing them to borrow from banks to make payroll.

"Expect this problem to continue with the implementation of 1990 OBRA technical amendments adding to the operating costs," Thorpe says.

Because adequate financing of long-term care is a critical issue for nursing home administrators, ACHCA's Foundation begins its National Futures Symposium Series of satellite video teleconferences on this issue on January 24, 1991.

"We'll explore various funding approaches Congress will consider in the next session," Thorpe notes, specifically the Pepper Commission recommendations and private financing options.

"Expect this program to be truly unique," Thorpe says. "It's one of the few times CEOs from AAHA, AHCA, and ACHCA appear together on the same panel."

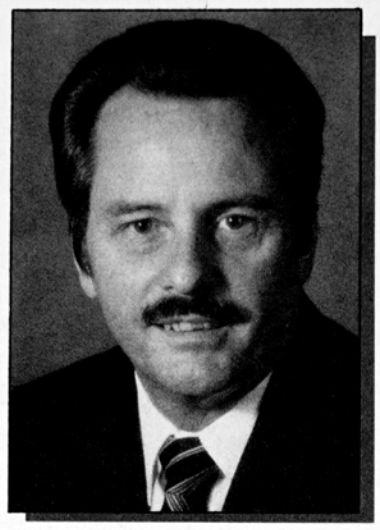
"The long-term care industry can no longer be isolationist. We've learned it's important for us to integrate consumer concerns and regulatory mandates with our concerns."

Funding issues will be examined by **Edward Howard**, Pepper Commission General Counsel; **Richard Clark**, President of the Healthcare Finance Management Association; **Dr. Stanley Wallack**, Director of Brandeis University's Bigel Institute for Health Policy.

Linkages Become Important

"**Dr. Harriet A. Fields**, ACHCA's new Director of Professional Services will track legislative issues of interest to ACHCA," Thorpe says. "Fields plans to zero in on wage parity legislation, implementation of 1990 OBRA technical amendments, advance directive legislation, and access issues to long-term care," he notes.

"She'll meet with provider and consumer groups on quality of care issues," Thorpe says, noting that "Linkages between ACHCA and other groups become more crucial in the 1990s because of limited resources."



Richard L. Thorpe, CFACHCA
Executive Vice President
ACHCA

"While ACHCA doesn't lobby, it's an important activity, especially with the government cutting back programs and services," he says, recommending that members become active in AHCA, AAHA and consumer group lobbying efforts.

"Fields plans to work closely with the American Association of Retired Persons to develop two audio teleconferences in May and June 1991," says Thorpe. The programs will help members establish nursing home ethics committees and help them implement OBRA's advance directives requirements.

"The long-term care industry can no longer be isolationist," Thorpe says, "We've learned that it's important for us to integrate consumer concerns and regulatory mandates with our concerns."

Thorpe concluded, saying, "One thing that's a given is that the legislative agenda for the 102nd Congress will provide us with new challenges as we continue to meld consumer expectations, regulatory demands, and provider needs."

--Herbert P. Weiss is a Washington, D.C. based freelance writer, who specializes in aging and health care topics.

Groups Set Legislative Agendas for 102nd Congress

by Herbert P. Weiss, guest columnist

While Congress turns its attention to a recession and issues of war, provider and aging groups develop their legislative priorities. ACHCA takes a look at the upcoming congressional session.

Alzheimer's Research

Congress increased its ante for Alzheimer's research by giving the National Institute on Aging over $85 million, bringing its budget to $325 million for FY 91. Expect groups, especially the Alzheimer Association and the Alliance for Aging Research to continue the push this year for more research dollars.

Older Americans Act

Look for the National Council on Aging to call for health promotion initiatives to be included in this year's reauthorization. The American Bar Association Commission on Legal Problems of the Elderly plans to push Congress to set a minimum percentage of Title III-B funds to be spent on legal assistance programs. Some states set low percentages which result in limited access to legal services. National Association of Area Agencies on Aging wants the Older Americans Act to emphasize serving rural, frail, and minority, and opposes any congressional attempts to means-test the program. The National Association of State Units on Aging has targeting services and establishing cost-sharing policies on its legislative wish list.

OBRA Reforms

The ACHCA, the National Citizens Coalition for Nursing Home Reform, the American Health Care Association, and the American Association of Homes for the Aging plan to watch the HCFA regulatory pipeline, waiting for the agency to publish final rules to implement the 1990 Omnibus Budget Reconciliation Act's sweeping nursing home reforms. The NCCNHR plans to closely watch PASSAR, OBRA's patient assessment and care plans, to pinpoint costs and results. Any problems, look for this consumer watchdog group to ask Congress to fix it.

Universal Access

With large numbers of Americans lacking access to health care services, look for the American Nurses Association, the American Governors Association, and the National Council of Senior Citizens to release their blueprints for health care reforms in February 1991 and August 1991, respectively.

Don't expect Congress to enact major health and long-term care reforms with big price tags, unless offsetting reductions are found in the budget. President Bush threatens these initiatives with a veto.

The Health Insurance Association of America plans to support tax code revisions to reduce barriers to marketing LTC insurance plans. Expect the group to be vocal about its proposal next year.

Don't expect Congress to enact major health and long-term care reforms with big price tags unless offsetting reductions are found in the budget. **President Bush** threatens these initiatives with a veto.

The administration won't actively push for reforms until the Steelman Commission and the Long-Term Care Technical Group Task Force on the Uninsured release their respective reports to Health and Human Services Secretary **Sullivan**. Until this time, the debate can be described as "the calm before the storm."

Care Givers

Look for the National Council on Aging, the National Committee to Preserve Social Security and Medicare, the National Council of Senior Citizens and other groups to rally behind the re-introduction of the Family and Medical Leave Act. This legislation, vetoed last year by President Bush, would have allowed employees to take leave to care for parents or spouses who need personal care.

Nurse Scholarships

The American Nurses Association, the American Health Care Association, and the American Association of Homes for the Aging are looking for ways to recruit nurses into long-term care.

Look for these associations to push Congress to fund scholarships, loans and fellowships for nursing students when it considers the 1991 Reauthorization of the Nurse Education Act.

***--Herbert P. Weiss** is a Washington, D.C.-based writer, who specializes in aging and health care topics.*

Legislation Favors Pepper Commission Initiatives

Despite the cuts in Medicare of $44.2 billion over the next five years, Congress passed some health care reforms based on the recommendations of the Pepper Commission that set a precedent for our nation's future health care system. One significant initiative, the provision for home care and assisted living services for the elderly, represents the government's increased participation in long-term care.

Another dramatic change requires drug companies to reduce prices on prescription drugs for Medicaid patients. The money saved, around $2 billion, will be used to fund some of the new health programs.

Medicare Takes Direct Hit in Bush FY92 Budget Proposal

by Herbert P. Weiss, guest columnist

Even memories of angry seniors forcing Congress to repeal the Medicare Catastrophic Coverage Act of 1988 didn't keep the Bush administration from putting Medicare on the chopping block.

While the 2,029 page, seven pound budget proposal calls for increases in current spending for 250 federal programs, Medicare gets slashed by $25 billion over the next five years. This is on top of the $43 billion that was trimmed from Medicare during last year's budget agreement.

Wealthy Seniors Pay More

The Bush budget proposal increases the Medicare Part B premium for individuals with incomes $125,000+ and for couples who earn more than $150,000 annually. This move produces a net savings of $41 million in FY 1992 and $1.2 billion over five years, estimates the Office of Management and Budget.

"The proposed changes in Medicare financing take us in a dangerous direction, away from Medicare as an entitlement program and towards means-testing," says Chairman **Roybal** (D-CA) of the House Aging Committee. Expect Congress to oppose the Bush administration's attempt to means test Medicare, Roybal says.

Medicare Laboratory Copayment Hits Limited Budgets of Elderly

Under the Bush budget, beneficiaries would pay more than $4 billion in out-of-pocket costs over a five-year period as a result of a 20 percent coinsurance for clinical laboratory services.

The new Medicare copayment will discourage many sick elderly from getting medical tests, says **Arnold Bennett** of Families USA. Also this proposal would require 211 million lab tests annually to be billed twice, he estimates, saying "It's just more red tape and less health care for our money."

Proposed LTC Tax to Finance Federal Inspection Surveys

The budget proposal calls on nursing facilities to pay for their federal inspection surveys, says **Deborah Cloud** of the American Association of Homes for the Aging. The group opposes the user fee, she says, noting that "the fee boils down to a tax on long-term care providers."

"Pretending that user fees save money is like saying the emperor has new clothes, because user fees merely shift the cost from one budget line item to another."

The American Health Care Association along with the National Citizens Coalition for Nursing Home Reform, a watchdog advocacy group, lineup with AAHA in opposing the user fee concept.

"User fees setup a conflict of interest where surveyors are accountable to the facilities they survey instead of the public," **Barbara Frank**, NCCNHR's Associate Director tells ACHCA, "Pretending that user fees save money is like saying the emperor has new clothes," Frank says, "because user fees merely shift the cost from one budget line item to another."

If the government has no intention of reimbursing survey expenses, facilities may be forced to pay for the surveys at the expense of patient care, Frank tells us.

The budget proposal also eliminates return on equity payments (ROE) to nursing facilities, says **Janet Riley**, American Health Care Association spokesperson. Cutting the payments will reduce the ability of providers to attract investment, Riley says.

"The White House has over estimated how much ROE payments cost," Riley charges, noting the administration puts its cost at $70 million, while the Congressional Budget Office comes in with a lower estimate of $35 million.

Other Federal Agencies Become Losers, Too

The Bush budget hits other federal agencies, too.

- Even with a proposed budget of $4.5 billion, the Social Security Administration will find it difficult to reduce its disability case backlog and lower its 50 percent busy signal rate occurring on peak days.
- The Department of Housing and Urban Development received a major funding cut in its Section 202 grant program. The budget proposal reduces 10,000 elderly housing units in FY 1991 to 1,000 units in FY 1992.
- The Administration on Aging loses funding for its senior employment program. The budget proposal cuts $47.5 million in Older Americans Act, Title III funds. Up to 8,000 jobs will be lost nationwide, says a House Aging Committee staffer.
- Also, the administration proposes freezing all funding for elderly meals and services reimbursed by QAA-Title III.

*--**Herbert P. Weiss** is a Washington, D.C.-based writer, who specializes in aging and health care topics.*

♥

Editor's Note: The ACHCA is extremely grateful to Herbert Weiss for contributing this excellent and informative column over the past year.

Wanted: More "Geriatric-Trained" Allied Health Professionals

by ***Herbert P. Weiss****, guest columnist*

When Congress begins to debate long-term care this year, it's crucial not to overlook manpower requirements necessary to implement new programs and services, said witnesses at the House Select Committee on Aging hearing.

The hearing was held to examine educational and training needs of allied health professionals for an aging society, said Chairman **Edward Roybal** (D-Calif.) of the House Select Committee on Aging. Because the population age 65 and older will grow from 30 million in 1986 to 64 million by 2030, Roybal called for allied health professionals to be trained in "geriatric care."

Major Initiatives Needed

More federal dollars are needed to finance "major initiatives in geriatric training, education and research," says **Dr. Leopold Selker**, associate dean of the College of Associated Health Professions, University of Illinois at Chicago.

Citing an Institute of Medicine report, Selker says current efforts to incorporate gerontology into allied health curriculum are "inadequate," and predicts continued personnel shortages of professionals trained to work with elderly patients if no federal action is taken.

To "ensure access to quality care in light of shortages," Selker recommends:

- Developing curricula for mid-career allied health clinicians who become interested in aging.
- Funding traineeships to bring in new allied health student applicants who want to work with seniors. Financial support could also be given to students who commit to "gerontologic service" for a defined period after graduation.
- Exploring more equitable use and distribution of Medicare funds used for graduate medical education. He urges that greater priority be given to support gerontology and geriatric education.
- Creating national and state level data bases on allied health practice and a system for data analysis.

Rural Areas and Inner Cities to be Hit by Personnel Shortages

Allied health personnel shortages will continue "until the early years of the next century," warns **Robert Harmon**, administrator of the Department of Health and Human Services' Health Resources and Services Administration. Harmon states that 28 out of 55 state chief executive officers, responding to a HRSA survey, mentioned that they face serious personnel recruitment problems in the long-term care setting.

The agency's 1990 report notified Congress of this shortage, says Harmon, noting that shortages will occur in clinical laboratory technology, physical therapy, occupational therapy, dietetics, medical records services, and radiologic services.

While the report also predicts a nursing shortage in the future, the problem may be lessening, notes Harmon. A National League for Nursing report shows an upswing in nursing enrollments, an increase of 12-14 percent from 1989, for a total of 220,000 students. Moreover, the number of nursing candidates completing their education rose by 14 percent. Nursing programs are reporting waiting lists and not enough faculty to expand their admissions of qualified candidates.

With more elderly, Harmon told the panel to expect "disproportionately large demand for nurses in nursing homes, the home health area, and other community settings involved with the provision of long-term care."

With more elderly, Harmon told the panel to expect "disproportionately large demand for nurses in nursing homes, the home health area, and other community settings involved with the provision of long-term care."

While "there are no quick fixes nor single policy solutions" to the problem of personnel shortages, according to Chairman Roybal, effective policy responses require the participation of educators and researchers.

--Herbert P. Weiss *is a Washington, DC-based writer who specializes in aging and health care topics.*

HEALTH CARE PERSONNEL SHORTAGES EXPECTED

Allied health professionals make up 60 percent of the entire health care workforce, according to a House Select Committee on Aging study. If no action is taken, look for severe shortages to occur in these occupations.

Allied Health Profession	1986 Jobs	2000 Demand	Increased Demand
Clinical laboratory technologist/technician	239,400	296,300	24%
Dental hygienist	86,700	141,000	62%
Dietitian	40,200	53,800	34%
Emergency medical personnel	65,200	75,000	15%
Medial record administrator/technician	39,900	69,800	75%
Occupational therapist	29,400	44,600	52%
Physical therapist	61,200	114,700	87%
Radiologic technologist/technician	115,400	190,100	65%
Respiratory therapist	56,300	75,600	34%
Speech-language pathologist and audiologist	45,100	60,600	34%

Source: Institute of Medicine Study, 1986

Truce Called in OBRA Dispute

by Herbert P. Weiss

California and the Health Care Financing Administration (HCFA) have hammered out a preliminary agreement to ensure the state's compliance with new federal rules on nursing home surveys that went into effect October 1, 1990.

The agreement postponed a HCFA compliance hearing, which was scheduled for March 12, for one month. During this period, HCFA will work with California to "review and revise" about 200 pages of interpretive guidelines that the state opposes. The compliance hearing will not be held at all if requirements in the agreement are carried out.

During the truce, additional concerns, including the withholding of federal funds, will be addressed. California will also take no action and HCFA will not be required to take any action in the Kizer v. Sullivan lawsuit filed by the state.

Key components of the new agreement include:

- California will begin surveying nursing homes as soon as possible in accordance with federal law, regulations and related guidelines.
- HCFA will make revisions to its interpretive guidelines to clarify that the guidelines per se do not add costs beyond those imposed by the law and its implementing regulations.
- California will also develop an approvable state plan amendment for payments to nursing facilities, as required by Medicaid laws. HCFA will work with the state in developing this plan, as well as expediting its review.

A Win-Win Agreement

"Finally, California's opposition to the illegal 'interpretive guidelines' has been recognized," states Governor **Pete Wilson**, in response to the settlement. The state won't "waste millions of dollars implementing bureaucratically mandated measures that aren't contained in the law, and won't significantly improve nursing home care," Wilson notes. He predicts other states will save hundreds of millions of dollars with the revisions of the interpretive guidelines.

HCFA believes the new agreement will remove California's concerns about added costs and administrative burdens. "It's a win-win situation, at least for now," said HCFA Administrator **Gail Wilensky**. *continued on page 4*

OBRA '87 REGULATORY CALENDAR

Statutory Deadlines and Actual/Estimated Publication Dates

Reg. Number	Subject	Statutory Deadline	Actual/Est.* Publication Date
BPD-662-P	Nurse Aide Training/Competency Evaluation, Nurse Aide Registry	September, 1988	March 23, 1990
BPD-662-F	Final Rule on Nurse Aide Training	September, 1988	April/May, 1991*
BPD-661-P	Preadmission Screening and Annual Resident Review (PASARR)	October, 1988	March 23, 1990
BPD-661-F	Final Rule on PASARR	October, 1988	June, 1991*
BPD-477-P	Costs Charged to Resident Funds	July, 1988	March 20, 1990
BPD-477-F	Costs Charged to Resident Funds	July, 1988	September, 1991*
BPD-488-P	Restraints	No deadline in statute	May, 1991*
	Psychopharmacological Drugs	No deadline in statute	May, 1991*
	Administrator Standards	October, 1988	May, 1991*
	Nurse Staffing Waivers	March, 1988	May, 1991*
	Swing Beds	No deadline in statute	May, 1991*
	Statement of Medicaid Rights	No deadline in statute	May, 1991*
BPD-396-F	Final Final on Requirements	No deadline in statute	April/May, 1991*
HSQ-156-P	Survey and Certification	January, 1990	June, 1991*
	Enforcement	October, 1988	June, 1991*
HSQ-180-P	Specify Minimum Data Set	January, 1989	June/July, 1991*
	Designate Assessment Instrument	April, 1990	June/July, 1991*

The MDS was specified and the assessment instrument designated September 15, 1990.

—States were to decide if they will use the MDS or submit another instrument for approval by October 19, 1990.

—Once approved by HCFA, providers will be notified by the state.

—States must then provide technical support and direction to providers.

Updated: April 15, 1991

Source: American Health Care Association

HCFA Puts Hold on Proposed Changes to OBRA's Interpretive Guidelines

by Herbert P. Weiss, guest columnist

Mounting criticism and unfavorable press derailed the Health Care Financing Administration's (HCFA) attempts to revise OBRA's Interpretive Guidelines before the agency issues its "final final" Requirements of Participation. The Guidelines, included in HCFA's survey protocol, offer a set of instructions which surveyors use to determine how well a facility meets national standards of care.

The agency plans to issue OBRA's "final final" regulations within the next few weeks, a HCFA spokesperson tells ACHCA. Once published, "We'll propose changes to the Interpretive Guidelines and submit them to states and other interested parties for comment," he says.

Until the revisions go into effect, surveyors will continue to use the current Interpretive Guidelines. The Guidelines are "only guidelines," the spokesperson says, stressing that they do not impose requirements on facilities beyond those already set forth in the statute and regulations.

Settlement Creates Opposition

On March 12th, HCFA and California hammered out an agreement to settle their six-month dispute. Before their truce, the state had refused to implement OBRA's sweeping nursing home reforms which became effective October 1, 1990.

The agreement (*LTCA*, May 1991) called on HCFA to "review and revise" about 200 pages of the current Interpretive Guidelines that the state opposed along with creating a new introduction for the document. The settlement also allowed California to suggest changes to the Guidelines and to review and approve HCFA's final draft proposal.

In return, California agreed to begin surveying facilities in accord with federal statute and regulations with surveyors using the revised Interpretive Guidelines.

Growing opposition to HCFA's private pact with California forced the agency to offer each governor's office, and a limited number of national organizations, an opportunity to provide suggestions on the proposed changes.

Growing opposition to HCFA's private pact with California forced the agency to offer each governor's office and a limited number of national organizations an opportunity to provide suggestions on the proposed changes.

While more than 50 groups ultimately provided comments, many groups claimed that HCFA's process to solicit comments was unfair. The 15-day comment period was not long enough to address each of the proposed changes in detail, charges **Toby Edelman** of the National Senior Citizens Law Center.

"The comment period is far too short to review the important issues raised in the Guidelines," Edelman says.

Point Counter Point

Consumer advocacy and provider groups positioned themselves on different sides of the issue in their comments submitted to HCFA. The agency's proposed changes will water down and weaken the current Guidelines, warns **Elma Holder**, Executive Director of the National Citizens Coalition for Nursing Home Reform. The revisions "instruct surveyors to rely on their own judgement, rather than consistent nationwide guidelines, to determine whether a facility is in compliance with OBRA." Holder says.

"As long as you have people entering buildings, reviewing charts, observing patients, you'll have subjective judgements," counters **Richard L. Thorpe**, CFACHCA, ACHCA's Executive Vice-President and a licensed nursing home administrator. "Surveyors will have to rely on their own professional judgement, experience, and sense of propriety in evaluating complaints," Thorpe says.

The Interpretive Guidelines only interpret the law; "they're not law or regulation," adds **Deborah Cloud**, spokesperson for the American Association of Home for the Aging. "They give facilities a little bit of flexibility to operate," Cloud says.

"As long as you have people entering buildings, reviewing charts, and observing patients, you'll have subjective judgements."

Summary

Provider groups were caught by surprise when HCFA decided to shelve its proposed changes until its "final final" rules are released. While it's too early to know its impact, "we're monitoring the situation with a fine tooth comb," says **Lori Costa**, Director of Government Relations for the California Health Facilities Association.

"If surveyors don't follow HCFA's policy that guidelines are ***not*** requirements, we'll take some action," Costa tells us.

*—**Herbert P. Weiss** is a writer who specializes in aging and health care topics.*

Senate Democratic Leadership Makes Health Care Reform a 1992 Election Issue

by Herbert P. Weiss

Senate Democratic leaders are seeking to upstage Republicans on health care reform before the 1992 presidential campaign by unveiling a comprehensive health care proposal emphasizing access to health care and cost-containment. At press time, no Republican bill had been introduced.

Overhauling the nation's health care delivery system is a key election year issue for the 102nd Congress, because of skyrocketing health care costs. Health care spending rose to around $670 billion in 1990, or 12.2% of the gross national product. At the same time, 34 million Americans have no health care coverage, and millions more have inadequate insurance coverage.

It's Play or Pay for Employers

The Democratic package, crafted by Majority Leader **George J. Mitchell** (ME), along with Senators **Edward M. Kennedy** (MA), **Donald W. Riegle, Jr.** (MI), and **John D. Rockefeller** (WVA) assures that the bill will be taken more seriously by Congress than other proposals currently in the legislative hopper.

The plan, phased in over five years, requires all employers to either provide private health insurance to their employees, or contribute to a public program which will provide coverage. Health benefits would cost about $1,680 per employee, with the employer paying for 80 percent of the amount. Use of managed care plans would reduce premiums by about 15 percent.

Employers would pay a tax, set by the secretary of Health and Human Services, if they chose not to offer private health insurance coverage. The employer tax, plus other revenues to be specified later, would be used to create a new program called "AmeriCare." The program's cost is estimated to be $6 billion for the first year, increasing to more than $11 billion in its fifth year.

The federal and state program would replace the existing Medicaid program, except for long-term care. All persons who are not covered by either the employer-provided insurance or Medicare would receive health coverage. Low-income individuals would not pay a premium for enrollment.

The Democratic reform package "picks the pockets of small businesses," charges Senate Republican Leader Bob Dole.

The plan includes a provision to reform the small group insurance market to reduce premium levels, and also provides tax credits to small businesses to help them shoulder the costs of new employee health insurance benefits. Health care cost containment provisions are built into the plan through the establishment of the National Health Care Expenditure Board. This board would set-up a process of rate negotiations between purchasers and providers of health care to set payment levels.

GOP Proposal Being Hammered Out

An internal Health and Human Service task force is working out the Administration's broad health proposal to be released sometime before the 1992 election, says an Administration official. But Senate Republicans are preparing to introduce their own proposal soon.

While acknowledging the Democratic proposal for helping to begin and shape the health care debate, Republicans strongly oppose its cost to employers.

The Democratic reform package "picks the pockets of small businesses," charges Senate Republican Leader **Bob Dole** (KS). "The proposed mandate on employers is, in effect, a heavy tax on jobs," Dole says. "Taxing employment means fewer jobs," he calculates.

continued on page 4

Provider Groups Float Proposals on Health Care Reform

Provider groups are attempting to shape Congressional debate by releasing their prescriptions for health care reform. Here's a sampling:

▲ **American Medical Association**
The May 15th issue of the *The Journal of the American Medical Association* detailed 13 separate reform proposals submitted by lawmakers, economists, university health care policy experts, and business, provider and consumer groups. For info: AMA, (312) 464-5000.

▲ **American Nurses Association**
Endorsed by 29 national nursing organizations, the ANA released its blueprint for creating a new health care system. The report, entitled "Nursing's Agenda for Health Care Reform," calls for universal access to primary health care services. For info: ANA, (202) 766-9094.

▲ **American Hospital Association**
The AHA reform proposal calls for a basic set of health benefits to be made available to all Americans. While employers would be required to offer coverage to workers, a new federal program would protect those not insured at the workplace. The association recommends that a public-private commission be established to address health manpower needs. For info: AHA, (312) 280-6000.

Senate Democratic Leadership Makes Health Care Reform a 1992 Election Issue

by Herbert P. Weiss

Senate Democratic leaders are seeking to upstage Republicans on health care reform before the 1992 presidential campaign by unveiling a comprehensive health care proposal emphasizing access to health care and cost-containment. At press time, no Republican bill had been introduced.

Overhauling the nation's health care delivery system is a key election year issue for the 102nd Congress, because of skyrocketing health care costs. Health care spending rose to around $670 billion in 1990, or 12.2% of the gross national product. At the same time, 34 million Americans have no health care coverage, and millions more have inadequate insurance coverage.

It's Play or Pay for Employers

The Democratic package, crafted by Majority Leader **George J. Mitchell** (ME), along with Senators **Edward M. Kennedy** (MA), **Donald W. Riegle, Jr.** (MI), and **John D. Rockefeller** (WVA) assures that the bill will be taken more seriously by Congress than other proposals currently in the legislative hopper.

The plan, phased in over five years, requires all employers to either provide private health insurance to their employees, or contribute to a public program which will provide coverage. Health benefits would cost about $1,680 per employee, with the employer paying for 80 percent of the amount. Use of managed care plans would reduce premiums by about 15 percent.

Employers would pay a tax, set by the secretary of Health and Human Services, if they chose not to offer private health insurance coverage. The employer tax, plus other revenues to be specified later, would be used to create a new program called "AmeriCare." The program's cost is estimated to be $6 billion for the first year, increasing to more than $11 billion in its fifth year.

The federal and state program would replace the existing Medicaid program, except for long-term care. All persons who are not covered by either the employer-provided insurance or Medicare would receive health coverage. Low-income individuals would not pay a premium for enrollment.

The Democratic reform package "picks the pockets of small businesses," charges Senate Republican Leader Bob Dole.

The plan includes a provision to reform the small group insurance market to reduce premium levels, and also provides tax credits to small businesses to help them shoulder the costs of new employee health insurance benefits. Health care cost containment provisions are built into the plan through the establishment of the National Health Care Expenditure Board. This board would set-up a process of rate negotiations between purchasers and providers of health care to set payment levels.

GOP Proposal Being Hammered Out

An internal Health and Human Service task force is working out the Administration's broad health proposal to be released sometime before the 1992 election, says an Administration official. But Senate Republicans are preparing to introduce their own proposal soon.

While acknowledging the Democratic proposal for helping to begin and shape the health care debate, Republicans strongly oppose its cost to employers.

The Democratic reform package "picks the pockets of small businesses," charges Senate Republican Leader **Bob Dole** (KS). "The proposed mandate on employers is, in effect, a heavy tax on jobs," Dole says. "Taxing employment means fewer jobs," he calculates.

continued on page 4

Provider Groups Float Proposals on Health Care Reform

Provider groups are attempting to shape Congressional debate by releasing their prescriptions for health care reform. Here's a sampling:

▲ **American Medical Association**
The May 15th issue of the *The Journal of the American Medical Association* detailed 13 separate reform proposals submitted by lawmakers, economists, university health care policy experts, and business, provider and consumer groups. For info: AMA, (312) 464-5000.

▲ **American Nurses Association**
Endorsed by 29 national nursing organizations, the ANA released its blueprint for creating a new health care system. The report, entitled "Nursing's Agenda for Health Care Reform," calls for universal access to primary health care services. For info: ANA, (202) 766-9094.

▲ **American Hospital Association**
The AHA reform proposal calls for a basic set of health benefits to be made available to all Americans. While employers would be required to offer coverage to workers, a new federal program would protect those not insured at the workplace. The association recommends that a public-private commission be established to address health manpower needs. For info: AHA, (312) 280-6000.

Proposed Rule Could Make Enforcement System Unworkable

by Herbert P. Weiss

ACHCA moves to derail Office of Management and Budget's (OMB) approval of an unpublished rule that implements survey, certification and enforcement requirements for the nursing facilities mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87).

ACHCA staff have obtained and reviewed a leaked draft of HCFA's enforcement rule. "The agency's proposal will not carry out the statutory intent called for by OBRA '87," says **Richard L. Thorpe**, CFACHCA, Executive Vice-President. "The agency's proposal continues to keep the flawed enforcement system in place."

In a letter to Health and Human Services Secretary **Louis Sullivan**, Thorpe urges the withdrawal of HCFA's proposal (HSQ-156-P) from OMB review because "critical deficiencies must be corrected prior to publication for public comment."

Consensus Document Trashed

The proposed rule would invalidate an agreement reached by a HCFA assembled work group, charges Thorpe. The group met in 1988 to develop the framework for an effective enforcement system. The work group's consensus document was in keeping with the letter and spirit of OBRA '87, he notes. But, "HCFA's recently proposed rule is costly at best and flawed in its approach to improve the survey (inspection) and enforcement process."

"The proposed enforcement system would also waste limited federal and state dollars without providing for additional protection to nursing home residents," Thorpe says, noting that one cost model conservatively estimated that additional costs for implementing the draft regulation could reach more than $325 million.

Thorpe warns that the quality of care in nursing facilities may erode because the proposed rule could negatively impact the recruitment and retention of nurses. Continuity of care may be threatened, he says, if nurses choose to leave long-term care and work in a less hostile health care environment.

"It will be difficult to solve the rule's weaknesses through the public comment process," Thorpe says. "If promulgated as currently drafted, the proposed rule would render the enforcement system unworkable."

***--Herbert P. Weiss** is a writer who specializes in aging and health care topics.*

Negative Impact of HCFA's Proposed Enforcement Rule

- ▲ More inconsistency in survey and enforcement process due to increased reliance on individual surveyor judgment.
- ▲ Greater number of nursing facilities challenging and appealing survey results.
- ▲ Increased surveyor error and inappropriate enforcement actions.
- ▲ Heightened anxiety and unnecessary dislocation of residents and families.
- ▲ Increasing staffing shortages resulting from a hostile working environment.

Congressional Republicans Tackle LTC Financing

by Herbert P. Weiss

While the Democratic party embraces health care reform as a key domestic issue, the White House and congressional Republicans take stock of the political risk involved in taking a position on such a "big ticket" item.

An internal Health and Human Service task force is working out the administration's broad health proposal to be released by mid-December, an HHS staffer says. Before hammering out its final report, the group is looking at more than 50 health-related proposals, she says.

But don't expect the White House to offer its prescription on health care reform soon. One published report said that White House Chief of Staff **John H. Sununu** views health care reform a "poisoned pill." Caution sums up the White House's current strategy on this issue.

While most political pundits don't expect the Bush Administration to offer a serious proposal until after the 1992 presidential election, congressional Republicans take on long-term care financing as their key domestic health issue.

House GOP Task Force Created

In July 1991, House Minority Leader **Robert Michel** (R-IL) created a House Republican health care study group to develop a response to health reform issues currently being debated by Congress. While Michel serves as chairman, **Rep. Newt Gingrich** (R-GA), the Minority Whip, takes the co-chairman slot of the task force, composed of 20 members interested in health care.

By the 1992 presidential election, it is feasible that the task force could hammer out a health care reform package that includes long-term care, a Republican staffer tells *LTCA*.

Senate GOP Leadership Talk LTC

While the White House remains guarded about its position on paying for long-term care services, House and Senate Republicans throw a raft of bills into the legislative hopper to address this issue. And, the Senate Republican leadership puts its stamp on the debate by introducing its LTC package.

Senate Republican Leader **Bob Dole** (KS) and Sen. **Bob Packwood** (R-OR) introduce S 1668, Secure Choice, which provides a three-step approach to addressing the LTC issue.

First, the Dole/Packwood bill would provide for expanded home and community-based care services to certain seniors with incomes up to the federal poverty level ($6,620). States would have the option to extend services to people with incomes up to 240% of the federal poverty level.

Second, the proposal creates a public-private partnership to encourage insurers to increase their options and broaden their market. Under the legislation, the partnership would help seniors with moderate incomes (less than four times the federal poverty level of $26,400) purchase long-term care insurance.

The bill would also require case management services for both public and private programs to promote quality and cost effectiveness.

Third, the tax code would be modified to provide incentives for businesses to offer LTC insurance and encourage individuals to buy it.

While Democrats and Republicans don't agree on how to revamp the nation's health care delivery system and pay for long-term care, both parties understand one point clearly--something must be done.

--Herbert P. Weiss is a writer who specializes in aging and health care topics.

Bills on the Congressional Agenda

Republicans introduced many bills during the 102nd Congress to help seniors finance costly long-term care services. While most Democrats favor an expansion of Medicare and Medicaid to finance LTC services, most of the Republican bills modify the tax code to pay for nursing home care. A few examples of the Republican-sponsored bills are:

HR 702 **Health Care Savings Account Act of 1991**, amends the IRC '86 to allow individuals a credit against income tax for amounts contributed to a health care savings account. The Social Security Act is also amended to provide for a higher deductible and protection against catastrophic medical care expenses for individuals who have established such accounts. Rep. **French Slaughter** (R-VA).

HR 1692 **Comprehensive LTC for the Elderly Act of 1991**, amends the Social Security Act to pay for LTC services under Medicare; amends the tax code to provide a credit for tax payers with certain elderly dependents in their households. Rep. **William Goodling** (R-PA).

HR 1693/S 1021 **Private LTC Insurance and Accelerated Death Benefit Incentive Act of 1991**, amends the tax code with respect to the treatment of LTC insurance and accelerated death benefits. Rep. **Willis Gradison** (R-OH); Sen. **John McCain** (R-AZ).

HR 2446/S 1122 **LTC Incentives Act of 1991**, amends the tax code to provide incentives for the purchase of LTC insurance. Rep. **Don Ritter** (R-PA); Sen. **Arlen Specter** (R-PA).

Wofford Victory in Pennsylvania Puts Health Care Reform on Fast Track

by Herbert P. Weiss

Pennsylvania sends President Bush and the GOP a resounding message at the conclusion of Pennsylvania's special election to replace the late Sen. **John Heinz** (R-Pa.)—ignore the nation's domestic agenda including health care reform and face voter wrath at the election booths during the 1992 Presidential and Congressional elections.

Sen. Wofford (D-Pa.), appointed earlier this year to replace Heinz, chipped away US Attorney General **Dick Thornburg**'s 44-point lead in the polls to become Pennsylvania's first elected Democratic Senator in 29 years. His strategy—to paint the Republican nominee as the "ultimate Washington insider." He also projected himself as a populist candidate to Pennsylvania's frustrated middle class voters when he supported a domestic agenda including middle class tax cuts, extended unemployment benefits, and national health care reform.

Senate GOP Unveils Its Health Care Reform Proposal

In response to Wofford's surprising victory, the Senate GOP Task Force on Health Care in November unveils its health care reform proposal S. 1936, "the Health Equity and Access Improvement Act of 1991." The Senate Democratic Leadership released their proposal (S. 1227) for revamping the nation's health care delivery system last June (*LTCA*, July 1991).

Minority Leader **Robert J. Dole** (Kan.) and Whip **Alan K. Simpson** (R-Wyo.) along with 19 Republicans are co-sponsors of the plan.

"The proposal builds on the good in our system, reforms the bad, and encourages innovation in both the private and public sectors," says Sen. **John H. Chafee** (R-RI), chairman of the health care task force. Chafee says that the proposal is "not set in stone," and he expects to refine and improve it.

The cost of the proposal is not addressed yet, Chafee says, noting that "when a majority of the Senate is prepared to move forward on reform, we will reach an agreement with the Democrats and the Administration on how to pay for it."

Key features of S. 1936 include:

▲ **Tax credits for individuals.**
Federal income tax credits would be available for individuals without health insurance coverage to offset out-of-pocket expenses for premiums and services. The tax credit would be refundable and would equal 100 percent of out-of-pocket costs, up to $600 for individuals and $1,200 for a family. The credit would be phased out fully at $16,000 annual income for individuals and $32,000 for couples. Self-employed individuals would be able to deduct the cost of premiums.

Health care reform may well be the issue that can deliver the White House to the Democrats and a bigger majority in Congress.

▲ **Tax credits for small businesses.**
A tax credit would be provided against costs beginning at 25 percent in the first year—declining to five percent in the fifth year. A similar tax credit would help businesses expand coverage to dependents or to establish managed care plans such as health maintenance organizations. In addition, businesses that form combined purchase plans for insurance would receive a tax credit equal to 20 percent of expenses.

▲ **Medical liability.**
Reforms would include actions to encourage non-litigated settlements of claims and early settlement. Also, punitive damage awards would go to state consumer agencies and professional disciplinary boards.

▲ **Prevention.**
Expands existing programs which have a focus on primary and preventive care such as community health centers and the Childhood Immunization Program. The bill also creates a new tax credit for individuals who receive preventive services including cancer screening, immunizations, and well child care.

▲ **Rural health.**
The proposal would increase authorization for area health education centers and the Rural Outreach Grant Program, reallocate funding under the Health Professions Training Act and Nurse Education Act, and increase funding for the Medicare Rural Health Care Transition Grant Program to promote access to health care in rural areas.

▲ **Public program.**
The proposal would allow states to establish a new program to provide basic health coverage for low-income uninsured individuals not eligible for Medicaid.

More than two dozen health care reform proposals, calling for incremental changes to major overhaul of the health care delivery system, are currently being considered by Congress. Many political pundits predict that Thornburgh's defeat in Pennsylvania will force the Bush Administration to release its health care reform proposal during the 1992 Congressional session.

Health care reform may well be the issue that can deliver the White House to the Democrats and a bigger majority in Congress. The middle class has spoken in Pennsylvania and the Republicans are listening.

—Herbert P. Weiss is a writer who specializes in aging and health care topics.

OSHA Releases Final Rule on Exposure to Bloodborne Pathogens

by Herbert P. Weiss

The Occupational Safety and Health Administration (OSHA) issues its final rule, effective March 6, 1992 (see box), on bloodborne pathogens in the December 6 issue of the *Federal Register*. Until this final rule, LTC facilities were mandated to comply with the "essence" of the agency's proposed bloodborne pathogens rule issued by OSHA in May 1989.

As a result of the agency's final standard, states with OSHA-approved plans will now be required to adopt a comparable standard.

OSHA's final standard is expected to protect more than 4.9 million workers in health care facilities. More than 480,000 workers are employed by nursing facilities, an OSHA official tells *LTCA*. He estimates that the standard will prevent more than 9,200 Hepatitis B virus (HBV) infections and 200 deaths each year.

More Than 3,000 Comments Reviewed

In developing its final rule, OSHA reviewed more than 3,000 comments and testimony gathered from more than 400 participants in public hearings.

The requirement provides greater guidance to employees on prevention of bloodborne diseases, including HBV infections and human immunodeficiency virus (HIV), which causes AIDS.

The agency's final regulation requires nursing facilities to establish a written exposure control plan that specifies how workers exposed to blood and other potentially infectious material will be protected and trained about bloodborne infectious diseases.

The standard also calls for engineering controls such as puncture resistant containers for used needles; work practices such as handwashing to reduce contamination; and providing personal protective equipment such as gowns and gloves.

The final rule also requires the nursing facility to offer, at its own expense, voluntary HBV vaccinations to all employees potentially exposed to body fluids or contaminated waste. Appropriate medical follow-up and counseling must be given to workers after an exposure incident.

Dates to Remember

While the rule becomes effective March 6, individual standards have their own effective dates:

- Exposure control plans: May 5
- Recordkeeping, information, training provisions: June 4
- Engineering, housekeeping, work practice controls, personal protective equipment, and HBV vaccinations, postexposure follow-up and labels/signs: July 6

While the clinical standards make sense to provider groups, they oppose its price tag and regulatory duplication.

"Nursing facilities must pay as much as $160 per employee at risk of exposure to a bloodborne pathogen and that's not including training costs," notes **Dina Elani**, health payment specialist for the American Association of Homes for the Aging.

"The vaccine is expensive," **Elani** tells us. "If you think about the high turnover of nurses aides, it could become a considerable cost factor."

Elani also identifies a new "Catch-22" nursing homes will find themselves in.

"In a time where you are trying to cut costs, facilities will now be surveyed by HCFA and OSHA on infection control matters," **Elani** says. "This puts the facility in an unfair position," she notes, "You can get penalized by two separate agencies for the same violation."

"Fines could be hefty," says **Elani**, "ranging from $10,000 to $60,000."

For further information, contact your OSHA regional office.

--Herbert P. Weiss is a writer who specializes in aging and health care topics.

ACHCA's 800# Off to a Ringing Start

On January 6, ACHCA began the New Year by instituting its own voice information service designed to provide members with the most current information on products and services. Members can catch late-breaking news about College activities, education programs, Convocation, the Foundation, and legislative developments.

ACHCA vendors may sponsor 800# extensions by advertising products and services. Another feature of the 800#: members can participate in surveys on current issues. If you would like to learn more about the 800# service, contact **Michael W. Hodge**, Director of Member Services, (703) 549-5822, at the National Office. Clip and save this menu for reference!

ACHCA Info Line

☎

ACHCA Member-Sponsored Voice Information Service

Call ACHCA and enter the code for up-to-the-minute information on the topic(s) of your choice.

1000 INSTRUCTIONS
2000 BENEFITS UPDATE
2001 SURVEY
3000 CONVOCATION
6000 LEGISLATIVE UPDATE
7000 FOUNDATION NEWS
9001 EDUCATION
9002 CERTIFICATION

800-765-LTCA

(800-765-5822)
Call between
8 am - 8 pm EST

Proposed Administrator Standards Vague in Key Areas

by Herbert P. Weiss

After more than three years in development, the Health Care Financing Administration (HCFA) finally releases the long awaited proposed Administrator Standards (see box). The proposed rules appeared in the February 5 *Federal Register*.

"A Focus Group on Administrator Standards, chaired by ACHCA in 1988, gave HCFA comments to be incorporated into the proposed rule," says **Richard L. Thorpe**, CFACHCA, executive vice president of ACHCA. "HCFA passed over many of the Focus Group's concerns, but did accept some of our major recommendations." These recommendations included:

▲ All nursing home administrators must have a college degree;
▲ 20 CE hours per calendar year;
▲ AIT requirement;
▲ Passage of a national exam;
▲ Grandfathering provisions for those in the profession now.

"With the complexity of the administrator's job in today's regulatory environment, these requirements are an absolute necessity," he says.

ACHCA Gives HCFA Failing Grade

"While ACHCA staff, Advocacy Advisory Committee members and selected leaders are currently analyzing the proposed standards' impact—at a cursory look—the requirements leave us with too many unanswered questions," **Thorpe** says.

First, "While the 1990 technical amendments of OBRA '87 eliminate the federal mandate for nursing home licensure in favor of federal administrator standards, HCFA's proposed rule seems to negate this," **Thorpe** notes.

"ACHCA has always opposed fragmented state licensure requirements, but favors uniform state-to-state licensing requirements that adhere to a national standard," he adds, "Only national standards that ensure uniform licensure requirements nationwide will ensure uniform competence among administrators."

Second, "HCFA's proposed AIT internship requirements are too vague," **Thorpe** points out. "They should spell out a specific number of hours to be served as an AIT, not simply a 12-week time period."

ACHCA supports the waiver of the AIT program if an individual has at least one year of management experience in a facility. "But before we give our blessings to this waiver, HCFA must hammer out its definition of management," **Thorpe** says.

He notes that ACHCA also supports the proposed standards' flexibility to allow an individual to complete the internship requirement while working towards his or her college degree.

Third, about HCFA's testing requirement: "We support the agency's call for an individual to pass a national examination with a score of at least 75 percent," **Thorpe** says. However, "it is unclear to us what the agency means by a state-selected standardized examination or state-developed examination as alternatives."

Fourth, individuals are deemed to meet the requirements of the standard if they are continuously employed as a nursing home administrator by the same facility for at least one year from the date of publication of the final rule.

"Forcing people to meet this strict requirement will keep the unemployed, those with inactive licenses and individuals who enhance their careers by changing facilities from being grandfathered in," **Thorpe** charges.

Fifth, ACHCA disagrees with HCFA's opposition to administrator licensure of hospital administrators who run swing bed units in hospitals if state law doesn't require licensure.

"Doesn't a patient deserve the same level of competence and quality of care in an acute hospital as they do in a skilled nursing facility? The needs of the patients are very different," he notes.

Finally, "ACHCA is very concerned that the proposed administrator standards are silent about implementation and enforcement," **Thorpe** says.

"This may be the most difficult component of the proposed rule that HCFA will have to address before issuing its final rule," he adds.

ACHCA wants to hear from leaders and members on this issue. Your input will be used to develop ACHCA's formal response to HCFA.

Contact ACHCA for highlights of the proposed administrator standards.

*--**Herbert P. Weiss** is a writer who specializes in aging and health care topics.*

HCFA's Proposed Qualifications for Administrators

A facility may not employ an individual as an administrator unless that individual and facility meet the following requirements:

▼ The individual must be licensed to serve in a nursing home as an administrator in accordance with state law.
▼ The individual must possess at least a baccalaureate degree.
▼ The individual must complete an internship of at least 12 weeks.
▼ The internship requirement is waived if the individual has at least one year of management experience in a nursing facility.
▼ The internship may be completed while the individual is working towards his or her degree.
▼ The internship will consist of practical training in daily facility operation and instruction in areas including: environmental health and safety; administration; applicable federal, state and local health and safety laws and regulations; state personnel licensing and/or regulation requirements; psychology of patient care; personal care and social services; therapeutic and supportive long-term care services; community resources and interrelationships; and other areas determined by the state.
▼ The individual must pass with a score of at least 75 percent one of the following: a state-selected standardized examination; a state-developed examination; or a national standardized examination.
▼ The individual must complete at least 20 clock hours of continuing education for any calendar year.
▼ An individual continuously employed as a nursing home administrator by the same facility for at least one year—on date of publication of the final rule—is deemed to meet the administrator standards.
▼ By the extent of state law, a licensed hospital administrator may serve as administrator of a hospital-based nursing facility without meeting the administrator standards.

Source: February 5 Federal Register

Top Democrats Support Comprehensive Long-Term Care Financing Proposal

by Herbert P. Weiss

Comprehensive long-term care reform is back on the front burner as Senate and House Democratic leaders introduce a proposal to reestablish the issue's legitimacy in the debate over comprehensive health care reform.

Senate Majority Leader **George J. Mitchell** (D-ME) and House Majority Leader **Richard A. Gephardt** (D-MO) along with Senator **John D. Rockefeller** (D-WV) and Representative **Henry Waxman** (D-CA) introduced S 2571/HR 4848, "The Long Term Care Family Security Act of 1992," to provide universal coverage long-term care services for disabled persons of all ages.

A number of long-term care reform bills have already been thrown into the legislative hopper, notes Executive Vice President **Edward Howard** of the Washington, D.C.-based Alliance for Health Care Reform.

The new proposal (S 2571/HR 4848) has the support of the key Democratic players in the long-term care debate, **Howard** tells *LTCA*. "With the support of the Majority Leaders of the House and Senate, it is just the beginning to getting a consensus on the issue."

Protection From the Devastating Expense of Long-Term Care

"The long-term care package would be based in large part on several recommendations of the Pepper Commission," says **Sen. Rockefeller**. He notes that it would extend benefits to four million severely disabled Americans, including 800,000 under age 65.

The proposal would pay for up to 88 hours a week of home services and two six-month episodes of facility care in a lifetime, regardless of an individual's income or age.

In addition, a spend-down provision allows those who need to remain in nursing homes for more than six months to protect assets ($30,000 per person; $60,000 per couple) as well as their home and income of their spouse.

The bill also encourages the development of the private long-term care insurance market and establishes mandatory National Association of Insurance Commissioner standards for private long-term care insurance policies.

American Public Supports Paying For Long-Term Care Services

☞ In a RL Associates poll, 68% of registered voters said they were willing to pay specific amounts in additional taxes (corresponding to their income) to fund a federal long-term care program.

☞ In a Peter Hart poll, 65% said that a long-term care program was an important investment and were willing to see taxes raised to pay for it. Only 14% said the program should wait until the deficit is reduced.

☞ In a Hamilton, Frederick and Schneiders poll, 65% of persons with incomes below $20,000 were willing to pay $20 per month for a federal long-term care program; 53% of persons with incomes between $20,000 and $30,000 were willing to pay $42 per month; and 59% of persons earning over $30,000 were willing to pay $58 per month.

☞ In a Louis Harris poll, 71% favored lifting their $48,000 Medicare payroll tax cap to pay for a federal long-term care home care program; 73% of those earning over $50,000 favored this form of financing. *Source: The Long-Term Care Campaign*

While the Senate bill includes no specific financing mechanism to pay for the cost of the $45 billion a year proposal, the House companion bill calls for a new payroll tax, a new tax on unearned income and a reduction of the amount of an inheritance that is free from taxes from $600,000 to $200,000. The bill would be phased in over a five-year period because of its costs.

A Starting Point

While nursing home and consumer groups applaud the unveiling of the Democrats' comprehensive long-term care package, they point out that it is only a starting point in the long-term care debate.

The American Association of Retired Person (AARP) notes that one of the Senate proposal's weaknesses is its lack of a specific financing mechanism. "Until revenues are specified (in the bill), it is not possible to make a definite judgment on a total proposal," says **Horace B. Deets**, AARP Executive Director.

"While it is encouraging that Congress is focusing on long-term care alternatives, it is disturbing that few bills address the catastrophic financial implications of needing true long-term care," says ACHCA Executive Vice President **Richard L. Thorpe, CFACHCA**.

Thorpe states that, "A congruent long-term care bill must not only address the care needed in the first six months of medical and social intervention, but the catastrophic financial burden resulting from the continuation of these services."

"Congress must resolve the long-term care puzzle as a continuum of care and then develop a financing mechanism to underwrite it," he continues, "This mechanism will need to include long-term care insurance. To fail will result in another band aid approach to a much more complex problem."

While Republicans favor insurance market and tax code reforms to finance long-term care, Democrats push for more comprehensive solutions.

With an anti-incumbent mood sweeping the nation, lawmakers can no longer consider this issue politically unsolvable. Americans demand a bipartisan solution now, not a political stalemate.

*—**Herbert P. Weiss** is a writer who specializes in aging and health care topics.*

AHCA Denies Consumer Group Charge That It Stalled OBRA '87 Enforcement Rule

by Herbert P. Weiss

A coalition of consumer and union groups, led by the National Citizens Coalition for Nursing Home Reform (NCCNHR), calls on 10 members of Congress to intervene and direct federal officials to implement OBRA '87 nursing home reforms "fully and swiftly."

But the American Health Care Association (AHCA) charges NCCNHR misrepresented its position to congressional leaders on the Health Care Financing Administration's (HCFA) proposed enforcement rule.

Coalition Alleges AHCA Put Brakes to OBRA '87 Nursing Home Reforms

Despite a congressional mandate to enforce OBRA '87, HCFA "has told states that they don't have to follow the law until federal regulations are final," complains NCCNHR in a April 8 letter to Congressional leaders. "The law calls for swift enforcement," the group notes. Now the agency's proposed enforcement rule remains bottled up in the Office of Management and Budget (OMB).

The enforcement system will become essentially "non-functional," NCCNHR claims, if AHCA's comments to OMB are incorporated into the proposed rule.

NCCNHR charges that AHCA has lobbied OMB to change the proposed enforcement rule to allow facilities to "appeal" any deficiency through "conflict resolution." AHCA wants to subject survey findings to a complex, technical scale before they can result in a deficiency, the group says.

"It's untimely to judge the survey system at this early period in implementation of the law," NCCNHR says. The group called on OMB to release the enforcement rules "free of the appeals and limitations proposed by the nursing home industry."

AHCA Sets the Record Straight

After NCCNHR's coalition sent its letter to congressional leaders, **Paul R. Willging**, Ph.D, AHCA's Executive Vice-President, wrote a letter to HCFA's Acting Administrator **William Toby**, to "set the record straight."

While NCCNHR implies that AHCA seeks to weaken OBRA '87 survey and enforcement provisions and delay the rules publication, "quite the opposite is true," **Willging** says. "The publication of the regulation was delayed by OMB's own requests for further clarification on several issues." AHCA has worked informally and through a HCFA-sponsored work group to hammer out workable enforcement rules, **Willging** says.

Willging charges that NCCNHR misunderstands the purpose of an informal dispute resolution mechanism in the final rule. "Providers and surveyors must have an informal means for resolving disagreements that arise during the survey process," he notes.

An informal dispute resolution mechanism will protect nursing facilities from "unnecessary and undeserved penalties along with reducing the need for costly litigation," **Willging** predicts, "without delaying enforcement actions needed to protect the quality of resident care."

Other Issues Highlighted By NCCNHR to Congress

Along with NCCNHR's concern over HCFA's failure to implement enforcement standards, its letter to Congressional leaders addressed:

★ **Administrator Standards.** The Feb. 5 proposed administrator standards (*LTCA*, March 1992) published by HCFA are weaker than those in at least 25 states, NCCNHR claims, noting that they don't even require administrators to meet standards of professional competence.

"ACHCA is very concerned that HCFA has left too many holes in the administrator standards to ensure uniform competence among entry level administrators," says **Richard L. Thorpe**, CFACHCA, Executive Vice-President. "We have developed a formal response to HCFA that received unanimous approval at our recent Convocation," **Thorpe** notes.

★ **Nursing Waivers.** Under HCFA's Feb. 5 proposed rule permitting nurse waivers, "facilities would be able to operate without the direction and clinical skills of registered nurses and could have shifts in which there are no licensed nurses on duty if the health and safety of residents are not endangered," NCCNHR notes.

★ **Nurse Aide Training.** Because nurse aide training will not be reviewed in regular HCFA surveys, "things have to go wrong before the agency wants a surveyor to determine whether aides have the training they need to do their job," NCCNHR claims.

Because HCFA permits nurse aides to "test out" of training requirements, "the statutory requirement for competency is undermined," NCCNHR charges, noting "that one of those aides who tests out and is not trained may well be the person in charge of a nursing staff during a shift when a facility operates with a waiver."

★ **Inappropriate discharge.** NCCNHR charges that HCFA's final Sept. 26, 1991 rule waters down the OBRA '87 provision that enables residents to return to the next available bed if they are temporarily or improperly discharged. The final rule does not prevent residents from being transferred within the facility for financial reasons, NCCNHR says.

★ **Contact ACHCA for its response to HCFA on proposed administrator standards.**

—Herbert P. Weiss is a writer specializing in aging and health care issues.

Exclusive interview with Sen. Brock Adams (D-WA)

Strengthened Ombudsman Program in Older Americans Act Will Protect Vulnerable Seniors

by Herbert P. Weiss

While the House and Senate passed their versions of the Older Americans Act (HR 2967/S 243) in Fall 1991, the reauthorization bill remains bottled up in the Senate over a disagreement on a controversial Social Security earnings limit amendment. At press time, the OAA reauthorization bill had not been enacted. However, once the Social Security earnings limit issue is settled, it is expected to be signed into law without major changes.

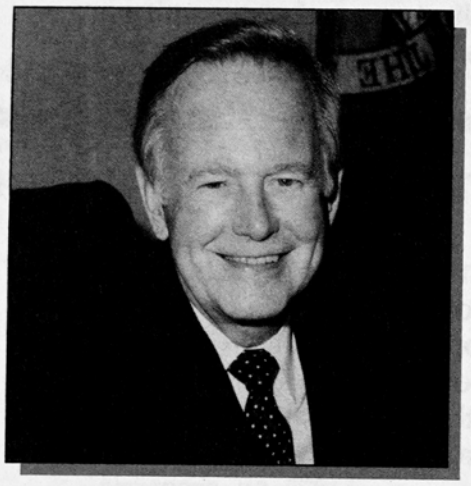
In a July interview, **Chairman Brock Adams** of the Senate Subcommittee on Aging, a subcommittee with jurisdiction over the Older Americans Act (OAA), discussed highlights of the legislation of interest to ACHCA members.

LTCA: The OAA reauthorization bill would create a new Elder Rights Title (Title VII). How does this new title change the ombudsman program? Various consumer groups call on the federal government to strengthen the ombudsman program. How will Title VII accomplish this?

Sen. Adams: As we moved to reauthorize the OAA, there were few areas of consensus–one was to strengthen the ombudsman program. In fact, most major aging organizations called for a new ombudsman Title in the Act. The Elder Rights Title evolved from this. I am delighted with the support for the Title VII, and it may turn out to be the centerpiece of the 1992 OAA Reauthorization bill.

The New Elder Rights Title would strengthen the ombudsman program in two ways: first, this new Title would place the ombudsman program in context with other client advocacy and service programs, such as legal assistance and elder abuse, in the OAA. It also sends a very clear message that elder advocacy services must protect vulnerable elders in their homes and in group and institutional settings. Under Title VII, states would be given marching orders and the tools to take a leadership role in protecting the rights and well-being of older Americans.

Second, Title VII redefines the provisions that govern the roles and responsibilities of ombudsmen. The current set of amendments build upon the substantive changes made in the 1987 OAA Amendments. It addresses potential conflicts of interest of those appointing ombudsmen and by ombudsmen themselves, access to records, advocacy on behalf of facility residents, ombudsman training, data collection on ombudsman activities and federal support to state ombudsman programs through the Administration on Aging at the Department of Health and Human Services.



"I am confident that when the OAA is enacted and the data collection implemented, the information will be of great value to long-term care providers."
—Sen. Brock Adams

LTCA: Currently, ombudsmen can examine medical and social records of nursing home residents. The OAA reauthorization bill expands access to administrative records. Is this not duplicative of OBRA survey and certification procedures and practices?

Sen. Adams: No, I don't see it that way at all. State ombudsmen have a broad federal mandate to investigate complaints of facility residents. Many of the complaints that they look into are cases that State Licensing and Certification infrequently, if ever, address. For instance, an ombudsman can follow-up a complaint that a guardian is not performing appropriately in his or her duties on behalf of a nursing home resident. Or the issue may concern a payment or contractual dispute between resident and facility—a conflict that may be handled by an ombudsman. These are situations in which administrative records may be crucial to understanding and successfully resolving the particular problem.

Congress created and empowered the ombudsman program to investigate complaints. Their ability to carry out this mandate may be severely hampered by a lack of access to key administrative records and other pertinent documents.

In June 1991, the General Accounting Office (GAO), in testimony before my Subcommittee on Aging, recommended that ombudsmen be given access to a facility's administrative records. To me, that was sound advice and my colleagues have followed it. The final language on public access to administrative records was not created in a vacuum. We sought input from the nursing home industry and the final language is the product of a compromise.

LTCA: In light of current fiscal constraints regarding appropriations for OAA Title III services, how can you justify the creation of an Associate Commissioner, a federal ombudsman position, within the Administration on Aging (AOA)? Why add a whole new layer of bureaucracy in the AOA when scarce fiscal resources could be used to fund new services?

Sen. Adams: One of the major criticisms to emerge during the 1992 OAA reauthorization debate

continued on page 13

Nursing Home Enforcement Rule Finally Comes Out of HCFA's Regulatory Pipeline

by Herbert P. Weiss

Federal government finally released the long-awaited and controversial proposed rule August 28 on survey, certification and enforcement for nursing facilities. Draft propósed regulations were stalled in the Office of Management and Budget and many believed OMB would delay publication in the *Federal Register* until after the November presidential election.

Rules Shook From HCFA's Regulatory Pipeline

The rules came out of the Health Care Financing Administration's (HCFA) regulatory pipeline after intense lobbying efforts of consumer advocate groups, led by the National Citizens' Coalition for Nursing Home Reform (NCCNHR), and through pressure from six Democratic congressional leaders.

While welcoming the release of the nursing home enforcement rules, nursing home groups expressed concern over different provisions.

"We support the swift application of remedies outlined in the proposed rule to ensure that poor performing providers are isolated and that serious flaws in care giving and other facility practices are corrected," said American Health Care Association's Executive Vice-President **Paul Willging**. He noted that a consistently applied survey process is essential if the enforcement system is to work.

"A strong enforcement system must be built on a consistent survey process, one that distinguishes poor providers from good ones," **Willging** said. "As proposed, the survey and enforcement rule would not accomplish this," he charged.

"To distinguish between serious problems and minor observations, surveyors need to work within an established decision-making framework in exercising professional judgment," **Willging** said. AHCA calls for changes, specifically one that requires the survey team to evaluate the scope and severity of a problem before surveyors label a problem a deficiency.

Rule Lacks Formal Appeals Process

HCFA has also failed to add simple and informal means of resolving disputes, short of a formal appeals process in the proposed rule, said **Richard L. Thorpe**, ACHCA's Executive Vice-President. "This process could settle many conflicts without costly litigation," he noted.

"A dispute appeals process becomes even more critical now with HCFA's intent to limit the rights of the nursing home to appeal surveyor decisions," **Thorpe** said.

Consumer advocates have mixed reviews from their preliminary review of the rule.

"It seems we were successful in keeping the regs from being watered down but HCFA is seeking public comment on several controversial issues," said NCCNHR Executive Director **Elma Holder**, noting that the issues include scope and severity scales in the survey process, conflict resolution, programs to maintain consistency, and its description and use of the scope and severity scale in determining which enforcement remedy to use.

But she noted, "The regulations offer strong support for swift enforcement, requiring that enforcement proceed during the pendency of a hearing, except in cases of civil fines, but allows states to give discounts on fines if facilities pay without challenging." Comments are due on October 27.

ACHCA is developing comments to submit to the Health Care Financing Administration. Contact **Juanita Smith**, ACHCA Librarian, (703) 549-5822, to obtain a copy of HCFA's proposed enforcement rule.

ACHCA Testifies at Congressional Panel on Nutritional Needs of Elderly

Older American's nutritional needs are not being met because of lack of nutritional guidelines, charged witnesses at a hearing before the House Aging Committee.

The July 30th hearing followed-up a General Accounting Office (GAO) report released in June that found data was limited on nutritional intake of the elderly and little was known about nutritional needs.

"Two national surveys on the nutritional intake of Americans don't even look at the intake of the elderly," said Chair **Edward Roybal** of the House Aging Committee.

"As a result, the elderly's actual nutritional needs have yet to be translated into specific and standard guidelines," **Roybal** said.

During his testimony, **Richard L. Thorpe**, Executive Vice-President, told the panel about ACHCA's involvement on the Blue Ribbon Advisory Committee of the Nutritional Screening Initiative.

"The Advisory Committee's efforts have been very successful," **Thorpe** said. "Their efforts have elevated public awareness of proper nutrition and hydration for the elderly."

Recognizing the interplay between good nutrition and quality of life of the elderly, **Thorpe** called on Congress to support H.R. 5179, the Nutrition Screening Act, introduced by Reps. **Marilyn Lloyd** (D-TN) and **Ron Wyden**, (D-OR).

Democratic Caucus Reforms Would Weaken House Aging Panel

By Herbert P. Weiss

Responding to calls to increase the efficiency of the House of Representatives and the way it operates before the beginning of the 103rd Congress, the Democratic Caucus' Committee on Organization, Study and Review (OSR) considers reform proposals which could weaken the House Select Committee on Aging.

This is not the first challenge to the Aging panel's existence. Even when legislative maneuvering took place in 1974 to collect votes to establish the select committee, there were congressmen like **John Brademas** (D-IN) and others who asserted that the proposed responsibilities of the new select committee were already being fulfilled by existing House subcommittees. Again in 1986, the fiscal impact of Gramm-Rudman brought the jurisdictional turf battle back to the surface.

For almost 20 years, the House Select Committee on Aging has been the advocate of America's elderly. It has principle oversight and investigative responsibility for issues pertaining to the elderly and plays an important role in creating and moving the aging agenda at the federal level.

The panel was created by a floor amendment offered by **C.W. Bill Young** (R-FL) to H.R. 988, the Committee Reform Amendments of 1974. Approved by a vote of 323 to 84, the amendment established the select committee as a permanent body.

Not Just a Rumor, But a Real Threat

For years, the Republican leadership has called for the elimination of select committees, says a House staffer. "But the threat has become more real especially when it comes from the Democratic side of the aisle," he notes.

While the OSR, chaired by Rep. **Louise M. Slaughter** (D-NY), backed down from its initial draft proposal to disband the four House select committees—on children, hunger, narcotics and aging—their existence are still in jeopardy, the staffer tells *LTCA*.

The leadership of the House Aging panel lobbied to derail the draft proposal to eliminate select committees. In a "Dear Colleague Letter" circulated to 435 members of Congress, Chairman **Edward R. Roybal** of the Aging panel and three of his subcommittee chairs—Reps. **Marilyn Lloyd** (D-TN), **William J. Hughes** (D-NJ) and **Thomas J. Downey** (D-NY)—charged that OSR's proposal to eliminate the Select House Committee on Aging "would have a devastating impact on the Congressional review and development of solutions to problems involving our nation's elderly Americans."

Eliminating the committee would send the wrong signal to the elderly about how Congress views the important issues confronting this population, the letter noted.

New Math for Counting House Memberships

Instead of directly eliminating the select committees, **Slaughter** and the Democratic leadership now call for a change of House rules—membership on select committees would be counted the same as membership on subcommittees. All members would be allowed to sit on only five subcommittees—select committees included.

Many consider **Slaughter**'s proposal to be a "back door attempt" to pit the select committees against subcommittees, the staffer charges. "If somebody wants to serve on a select committee, a majority of House members would have to give up a subcommittee," he says.

While the select committees don't have legislative jurisdiction like subcommittees, they do give members high visibility to publicize issues of importance to their constituents. But directly influencing legislation on standing committees may cause House members to think twice about serving on select committees, the staffer notes.

Slaughter even agreed with this scenario. In the October 8 issue of *Roll Call*, a newspaper covering Congress, when referring to the proposal, she stated that "many select committees may dissolve on their own as a result of members leaving the panels in favor of subcommittees."

While the full House Select Committee on Aging will likely survive the latest OSR proposal, "it could have a disastrous effect on House Aging subcommittee's ability to retain membership and ultimately its political clout," the House staffer claims.

Aging groups are closely following OSR's reform package, too, but keep a watch-and-see attitude.

"It is not clear what the impact would be since the proposal would also eliminate many standing committees," says **John Rother**'s AARP's Legislative Director. "As a result, it still might be attractive for members to join select committees."

"We have been talking with the Democratic House leadership and they are fully aware of our concern," **Rother** tells us. "So far they are assuring us that this proposal would not weaken the House Select Committee on Aging."

The full Democratic Caucus committee is expected to vote on OSR's reform package on December 8, 1992.

—Herbert P. Weiss is a writer who specializes in aging and health care topics.

HCFA Issues PASARR Rule

By Herbert P. Weiss

Thirty-two months following the publication of its March 23, 1990 proposed rule, the Health Care Financing Administration (HCFA) issues its long-awaited final rule outlining the Pre-admission Screening and Annual Resident Review (PASARR) program in the Nov. 30 *Federal Register*. The rule took effect January 29, 1993 even though nursing facilities and states have had to comply with the requirement since 1989, without federal guidance.

HCFA sifted through 736 comments from states, nursing facilities, hospitals, consumer advocates, provider groups and members of Congress before hammering out its 64-page final rule to implement PASARR for mentally ill individuals that was mandated in OBRA '87 nursing home reforms.

Under the law, states are required to deny nursing home admission to mentally ill or mentally retarded (MI/MR) individuals identified, through a pre-admission screen, not to need that level of care. States must also decide if current MI/MR residents require facility care and if they need other specialized services or placement in an alternative setting to treat their condition. All residents must be rescreened annually.

Residents that do not need facility care or specialized services must be discharged from the facility. Those needing both can remain. Individuals requiring special services but not facility care must be transferred unless they have lived in the facility for more than 30 months and choose to stay. The state must ensure that MI/MR individuals receive the specialized services they need.

The Nuts and Bolts

Under the new rule, PASARR applies to anyone seeking admission to or continued stay in a Medicaid-certified facility, including private-pay individuals and veterans. More than 50% of the comments HCFA received regarding the proposed rule objected to the application of PASARR requirements to non-Medicaid eligible applicants and LTC residents.

As to payment, PASARR screens are also reimbursable under the Medicaid program—regardless of payer source—because it is a requirement of the program.

The final rule also defines "serious mental illness" so narrowly that it will reduce the number of individuals who will require a PASARR screen. Residents diagnosed with Alzheimer's disease and organic dementia disorders are excluded from the definition of mental illness and PASARR screens.

Included in the rule is a provision that limits duplicative screening by facilities. Individuals new to the PASARR program, who are not readmissions or transfers from another facility, are exempt unless a significant change in their condition occurs. For more information about PASARR, contact: **Julie Walton**, HCFA, (202) 890-7890.

—Herbert P. Weiss a writer who specializes in aging and health care issues.

A Quick Glance at Other Changes in the PASARR Rule

◆ Changes the period of time in which the pre-admission screen must be conducted. It requires that the average time for the screen is seven to nine working days from the time of referral to the completion of the decision, and permits the HHS Secretary to approve a long time-frame when justified.

◆ Prohibits nursing facilities from conducting PASARR evaluations.

◆ Requires the "home" state to pay for and do the evaluation. The home state is defined as the state the resident lives in or will be living in when he or she becomes eligible for Medicaid.

◆ Permits such determinations for provisional admissions for respite care, emergency placements of up to seven days, or pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears. In these cases, the state must still determine whether an individual needs specialized services.

◆ Revises personnel requirements to permit qualified mental health professionals to conduct evaluations for mental illness, as long as a physician conducts or reviews the "comprehensive history and physical examination." Permits the state to determine who can conduct the mental retardation evaluation, as long as a psychologist identifies the "intellectual functioning measurement."

◆ Promotes use of community services over nursing home care.

◆ Strengthens the role of the individual and his or her family and legal representatives, requiring that they participate in the evaluation and receive the results and notice of their options.

◆ Affirms use of Medicaid Fair Hearing Process for appeals. Limits use of appeals to Level II PASARR determinations, transfers or discharges. Explicitly prohibits use of appeal rights for intra-facility "relocations" that do not involve a change in "certified entity."

◆ Promotes coordination between resident assessment and Annual Resident Review (ARR) by permitting the ARR to coincide with the care planning meeting.

Source: National Citizens Coalition for Nursing Home Reform, Preliminary Overview, December 21, 1992.

Chafee's Mainstream Health Care Proposal is a Mixed Bag

By Herbert P. Weiss, NHA

Lawmakers hurriedly left Capitol Hill to campaign or vacation during Labor Day recess without passing a comprehensive health reform package. Having failed to overhaul the health care system, White House officials and the House and Senate Democratic leadership now concede that only small fixes can be made before the congressional elections in November in 1994.

With so little time left on the legislative calendar this year, it is not politically feasible to pass sweeping changes called for in the House and Senate Democratic reform packages. Some say that the best chance for compromise lies with a "mainstream" proposal hammered out by 20 moderate Democrats and Republicans led by Senator John Chafee (R-RI). But advocacy groups (see box) strongly oppose the minimalist approach.

Compromise Plan Offered

Two weeks of negotiations in Senator Chafee's hide-away office in the Capitol produced a bipartisan proposal that gives priority to slashing the federal budget deficit by reducing national health care costs. It also provides subsidies to help low-income families with incomes of up to 200% of the federal poverty level pay for premiums. Those between 100 and 200% of poverty would get a partial subsidy, with the benefit being phased in between 1997 and 2004.

The bipartisan plan does not call for universal coverage, but would raise coverage from 85% to 95% by 2002. If this goal is not reached, a commission would recommend to Congress ways to increase coverage. Then lawmakers would be required to vote on the recommendations, or propose alternatives, via an expedited process.

To expand access, the mainstream proposal calls for health insurance reforms that most Democrats and Republicans generally agree must be undertaken. Specifically, the reforms would require health plans not to deny or limit coverage based on an applicant's health status. Coverage would also not be denied if a person has an already existing chronic illness. In addition, health care coverage is increased through voluntary cooperatives for small businesses and individuals, adjusted community rating and low-income subsidies.

The politically unpopular employer mandate to pay for worker health care plans is dropped by the mainstream coalition of Senators in favor of helping the self-employed and people who must buy their own insurance by phasing in a 100 percent tax deduction for the cost of their health insurance premiums.

Minimalist Approach Taken

Critics of the mainstream proposal charge that its benefits for the elderly are less than those offered in other Senate or House proposals.

The plan creates a new capped federal program for home- and community-based services, limited to those with incomes below 150% of the poverty level. Tax deductions would be available to deduct expenses for long-term care and premiums for long-term care policies.

Medicaid costs would be controlled by allowing states to enroll in managed-care style plans without obtaining a waiver. While the plan does not include a subsidy for prescription drug coverage to Medicare recipients, it makes it easier for these individuals to join managed care programs, which often include a prescription benefit.

To pay for the benefits, the proposal calls for a 45-cent-per-pack increase in cigarettes, extends the Medicare Hospital Insurance tax to all state and local employees, increases Medicare Part B premiums for individuals who make over $75,000, and couples who earn more than $100,000, and imposes

continued on page 12

Mainstream Proposal Falls Short in Protecting Elderly

The Long-Term Care Campaign, an advocacy group that calls for comprehensive long-term care benefits to be included in any final reform package, identifies how the mainstream proposal falls short. The proposal:

- Cuts Medicare by $302 billion over 10 years while raising premium payments.
- Offers a minimal, underfunded long-term care program that services only a fraction of those with severe disabilities and leaves out all but the very poorest elderly Americans (covers only those with incomes below 150% of poverty).
- Provides no tax credit for the personal assistance services for persons with disabilities who are employed.
- Gives new tax breaks for the sale of private long-term care insurance and requires only minimal consumer protection standards for the sale of private long-term care policies. But private insurance, however, is usually unavailable to those who already have symptoms or need nursing home care. Maybe less than 10% of those over age 65 can afford to purchase a decent policy.
- The standards for private insurance required by the proposal are approved by the insurance industry and are substantially weaker than other key reform proposals.

Source: August 24 Issue Brief prepared by Stephen McConnell, Senior Vice-President of the Alzheimer's Association and Chair of the Long-Term Care Campaign. For a copy of the Brief, call the Alzheimer's Association at (202) 393-7737.

National Conference Explores Ways to Improve Mental Health of Nursing Home Residents

By Herbert P. Weiss, NHA

Up to 88% of all nursing home residents exhibit mental health problems: these include dementia, depression, emotional reactions to illness or bereavement, and problems with self-control. These residents usually do not receive treatment from mental health specialists, and most facility staff are not adequately trained to identify and address even the most common mental health problems, according to a draft proceedings report from an invitational conference of 130 mental health and aging experts from all over the country.

Last December's two-day conference, "Overcoming Barriers to Mental Health Care for Nursing Home Residents," was organized by the Hebrew Rehabilitation Center for Aged's Research and Training Institute, Boston, and the Mental Health Policy Resource Center, in Washington, DC. The research findings and policy recommendations will be detailed in an issue brief and book which will be published in the near future.

"It has been about 10 years since the last national conference was held to examine the issue of mental health care for nursing home residents," says Nancy Emerson Lombardo, Ph.D., a principal organizer of the conference. She believes that the relative neglect of this problem is the result of no one group in the federal government or in national associations taking ownership of this particular issue.

Although nursing home organizations and resident advocacy groups have expressed concern about the issue they have never assigned even one full-time staff person to give the issue their full attention, notes Emerson Lombardo. On the other hand, mental health consumer groups attend primarily to the concerns of younger adults and children and assign little staff time to the elderly and virtually none to nursing home patients, she says.

Mental Disorders Are Common in Facilities

Regardless of the physical illness cited in the resident's medical chart, a contributing factor in most admissions is a problem of mood, behavior or cognition that limits self-care or makes home care virtually impossible, the draft report says. Once admitted to a facility, almost half of all residents, including those without dementia, exhibit problem behavior at some time.

The draft report cited a variety of obstacles that keep the mentally ill nursing home residents from receiving appropriate mental health services. These include: a shortage of mental health professionals trained in geriatrics; lack of in-service training in nursing homes to teach facility staff to manage

continued on page 12

Conferees Reach Consensus on Six Broad Principles

The 130 conferees perceived that the needs for improved mental health for residents were so great and the issues so complex. There was mutual recognition of the legitimacy of and urgent need to address the issue—with a variety of different approaches and in a comprehensive manner. The conferees reached an unprecedented consensus on six broad principles that serve as a basis of the draft report's recommendations.

1. Mental health services are an essential component of nursing homes residents' primary care.

2. Mental and physical health are integrally related, particularly for frail elders. Care for physical disorders and disabilities must be integrated with care for mental and behavioral problems.

3. Nursing homes must attend to the mental health needs of special populations, such as those with diagnosed acute depression, those without diagnosis but evidencing symptoms of mood problems, those whose mental problems are caused by physical illness and medications, and Alzheimer's disease or a history of chronic mental illness.

4. Each facility staff member must be trained, as appropriate, to either participate in providing mental health care or to help create an environment conducive to mental health.

5. Families play an important role in treating residents' mental and behavioral problems, and should be invited to participate in care planning.

6. The active involvement of mental health specialists in care planning as well as in direct treatment should be facilitated and encouraged.

Source: Emerson Lombardo, N., Barry S. Fogel, G. Robinson and H.P. Weiss (eds). Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care, draft policy brief, HRCA Research and Training Institute, Boston, July 29, 1994.

Provider Groups Give Thumbs Up to Final Enforcement Rule

By Herbert P. Weiss, NHA

When nursing facility provider groups studied the August 28, 1992 *Federal Register*, they were disturbed by the Health Care Financing Administration's (HCFA) proposed enforcement rule calling for perfect compliance to federal nursing home regulations. Many facilities could have been closed down or sanctioned by the unrealistic regulations, they charged.

Provider and consumer concerns over the proposed enforcement rule generated over 28,000 comments that the agency reviewed before issuing the final rule.

Last month, after more than two years in preparation, HCFA released the long-awaited 136 page final rule that provided regulators with a wider range of available penalties to enforce quality standards in the nation's 16,700 nursing facilities. HCFA guidelines to states will be published in the Spring of 1995.

Recent press releases issued by the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA) did not call the regulation "unrealistic," rather they applauded its release.

New Rule Calls for Daily Fines

Under the new regulation, announced in the November 10 *Federal Register*, state regulatory agencies will have the option of levying fines to prod nursing homes into regulatory compliance. It provided for daily civil money penalties ranging from $50 to $3,000 for serious or persistent problems, and as high as $10,000 for facilities where conditions pose an immediate jeopardy to resident health and safety. HCFA also defines requirements for unannounced surveys of nursing facilities, authorizing a fine of up to $2,000 for anyone who alerts a facility to the date and time of a scheduled inspection.

Previous enforcement tools were limited to terminating nursing facilities from the Medicaid and Medicare programs or denying payments for new admissions until deficiencies were correct.

Directed plan of corrections and directed inservice have also been added to the list of sanctions in the final rule. When conditions in a nursing facility threaten the health and safety of residents, state or federal officials will now have the authority to install temporary management or terminate the facility from the Medicare and Medicaid programs.

Consumer Watchdog Group Has Concerns About Implementation of Rule

"The new rule now offers a whole range of remedies that survey agencies can use to help providers come back into compliance with the Nursing Home Reform Law," says Lori Owen, Law and Policy Specialist at the National Citizens Coalition for the Nursing Home Reform (NCCNHR).

NCCNHR applauds many aspects of the final regulations, including: the requirement that civil monetary penalties be imposed quickly; the prohibition of facilities from challenging the regulatory agency's selection of a remedy; and the application of "scope and severity" ranges to the determination of the remedy but not to the determination of the deficiency.

"However, despite the strong enforcement tone that exists through the regulations, we have real concerns about provisions in the final rules and how they will be applied, such as 'substantial compliance' and informal dispute resolution," Owen says.

According to Owen, residents' input is crucial in determining the substantial compliance of a facility with the Nursing Home Reform Law. But these individuals might not feel comfortable expressing their concerns or whether or not they have been harmed for fear of retaliation, she says.

HCFA's defining of the term "harm" and "minor deficiency" is key to determining if a facility is judged in substantial compliance, she tells the *LTCA*. Minimal deficiencies will not delay a facility's certification or result in the state imposing sanctions to force compliance, she says.

"We're hoping that we can work with HCFA and provide them input in defining these terms and how the regulations will be implemented," Owen adds.

Finally, Owen also expressed concern that the final rule makes no provision for residents and their families to play a role in the formalized dispute resolution process.

Provider Groups Support New Approaches to Enforcement

The final enforcement rule, taking effect July 1, more accurately reflects the operating conditions in the real world, says Susan Pettey, Director of Health Policy at AAHSA.

"HCFA came up with a regulation that is pretty reasonable and equitable while it still does the job of protecting the well-being of very frail residents," notes Pettey.

"HCFA's efforts to recognize good faith attempts to obtain and sustain compliance is very important because it follows the spirit of the law that promotes compliance rather than simply punishing facilities," Pettey says.

continued on page 13

Regional WHCoA Participants Call for Changes in the LTC Delivery System

By Herbert P. Weiss, NHA

Today's long-term care delivery system, driven by reimbursement and budget considerations, must give way to a more "person centered" and "user friendly" system. One that allows individuals to live independently at home as long as possible, if that is their choice.

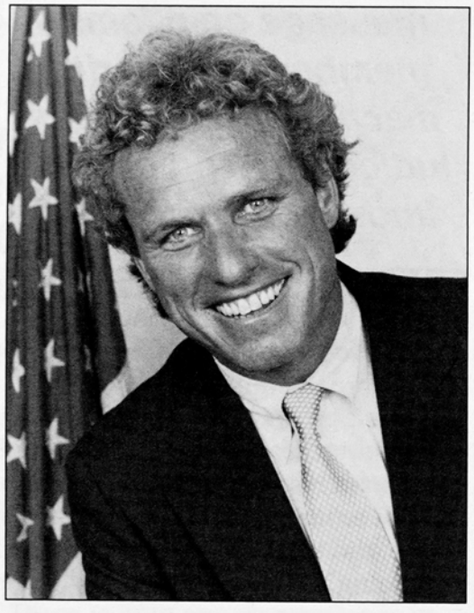
This major policy recommendation was among scores of others put on a policy wish list by more than 400 seniors and aging advocates from six New England states who attended a regional mini-White House Conference on Aging (WHCoA) held on December 6-7. Over 85% of these individuals were age 60 and older, the remainder representing human service and health care agencies.

During the two-day regional conference, concurrent workshops were held to address the policy issues of economic security, long-term care and elder abuse. The New England region's WHCoA report containing a summary of these issues and proposed policy recommendations will be placed before the WHCoA delegates in Washington, D.C. next May 2-5, who will consider them for inclusion into the final conference report.

At press time, more than 150 reports have been received by the 1995 WHCoA staff. More than 20,000 participants attended more than 250 pre-WHCoA events, 26 state and 18 regional conferences. More than 12,000 of these individuals are age 55 and older.

"The 1995 WHCoA will be the single most important forum to discuss issues affecting seniors in our country," said Phil Johnston, New England Health and Human Services Regional Director, one of the many federal officials to attend the event. Its report will influence the aging policy debate over the next 10 years, he noted.

"We're pleased with the sound recommendations and strong support for community-based long-term care services emerging from our Regional Conference," said Thomas L. Hooker, regional administrator of the U.S. Administration on Aging (AoA). "Supporting programs and services to keep older people independent and at home is one of AoA's major initiatives," Hooker added.



Rep. Joseph P. Kennedy II (D-MA) was the keynote speaker at the New England mini-WHCoA last month.

Growing Need for LTC Services

In a ballroom filled near to capacity, Rep. Joseph P. Kennedy, II (D-MA), urged federal policy makers to prepare for the soaring demands and rising costs of long-term care services in his keynote address.

According to Kennedy, the number of people needing mostly nursing home care will jump from 7 million today to about 14 million by 2010. Today, many seniors are forced to pay over $35,000 per year for costly nursing home care.

Kennedy predicted that the nation's health care crisis won't be solved until Congress seriously addresses the need for long-term care and prescription drug coverage.

But with a Republican majority in Congress, Kennedy conceded that passage of legislation creating a new community and home-care benefit and prescription drug coverage will be unlikely next year—but he pledged to continue to push for enactment of such initiatives.

"The bottom line is that without long-term care coverage, no family has security against devastating costs of serious illness or disability," Kennedy told the audience. He pointed out that long-term care is an intergenerational issue and should not be considered just an elderly issue.

Long-Term Care Issues Addressed

According to Anne Harrington, Ph.D., an Arlington, MA-based consultant in aging issues and long-term care workshop facilitator, many workshop participants called for "individual choice and preference, autonomy, dignity, independence and personal rights" to be reflected in any newly developed long-term care delivery system. In addition, they wanted any long-term care setting to promote the individual's highest level of functioning, she added.

Many persons in the workshop said that long-term care has to encompass more than nursing home care. They suggested that the term be expanded to include medical, nursing, rehabilitative, preventive, social, mental health, and supportive services provided

continued on page 12

ACHCA Member Services Help Administrators Adapt to Changing Times

By Herbert P. Weiss, NHA

Now representing 6,200 administrators, ACHCA is adapting its services to the regulatory environment that long-term care facilities must operate in—one of increased competition and economic pressures that force facilities to integrate services, build networks and form alliances with managed care organizations.

Republicans Take Charge

With the GOP taking the reins of Congress, ACHCA is closely monitoring the efforts of House and Senate Republicans to cut red tape and down sizing of the federal bureaucracy, said Richard L. Thorpe, Executive Vice-President.

Thorpe said that the new GOP agenda calls for a smaller federal government with power moving from Capitol Hill to the states. "ACHCA chapters must actively work with for-profit and nonprofit trade groups to become a driving force at the state level to shape regulation and allocation policies for block grants," he said.

Republican cost cutting efforts could end the long-standing tradition of Congress passing proclamations to give visibility to worthy causes, such as National Long-Term Care Administrators Week (March 20-26, 1995).

"This won't stall our efforts of getting administrators recognized for their efforts to deliver good resident care," Thorpe said. ACHCA chapters have been successful in getting states to issue proclamations recognizing the week-long event.

Disparity of Survey Interpretation

"Over the years we have supported calls for less regulation," Thorpe said. "While administrators don't oppose well-written rules, they will go ballistic at the wide disparity of interpretation of regulation by federal and state surveyors," he noted.

According to Thorpe, problems with the survey and certification process have been documented in the Foundation's recent *Level A Compliance Decision Making Report.* The study found that 33 percent of the citations for noncompliance to survey requirements were not justified, and 13 percent of the Level A citations were written with the wrong tag number.

"ACHCA is working with the Health Care Financing Administration to overcome the disparity of interpretations of regulations," Thorpe told *LTCA*. He added that the Illinois and Virginia Chapters are working with state regulatory agencies to bring consistency to the way regulations are interpreted.

New Resources Give Compliance Tips

ACHCA is developing ways to help members cope with a changing regulatory climate. The association has recently formed a new alliance with Albertville, Alabama-based Heaton Publications to provide members with manuals, policies and regulatory information.

For example, administrators will now find it easier to dispute surveyors' findings by using a quick index that references current OBRA regulations by F-tag number, alphabet, interpretive guidelines and by surveyor procedures.

Under HCFA's new enforcement rule, patterns of noncompliance can lead to stiff fines and penalties—it could even lead to losing a professional license.

"We've provided ACHCA active members with a four-page self-analysis checklist to identify deficiencies for the past five years," Thorpe noted. By analyzing this historical data, administrators can better prepare themselves for surveys and comply with the enforcement rule that takes effect July 1, 1995.

Also included as part of the checklist is a guide in determining what sanctions will be imposed for repeat or substandard quality of care deficiencies.

Riding the "I-Way"

ACHCA is taking advantage of new communication technologies to enhance services to promote membership networking as well as provide administrators with access to information on regulatory issues and new management trends.

More than 300 administrators are on their way to riding the information highway through ACHCA's *LTC On-Line* computer forum, Thorpe said. "It's the first and only service dedicated exclusively to long-term care administration," he pointed out.

The "members only" on-line forum allows administrators to talk, exchange ideas and network.

In addition, broadcast fax technology allowed ACHCA to warn members about ABC's *20/20* segment on nursing home abuse and to alert them to potential press calls, Thorpe said.

Road Map to Future Changes

ACHCA's Foundation is also developing a workbook to help members prepare for future trends that will overtake the long-term care industry, Thorpe said.

"The workbook will walk members through a step-by-step process to help them develop strategies to better position themselves in emerging markets," he added.

—Herbert P. Weiss, NHA, is a Providence, Rhode Island-based freelance writer on health care and aging issues. He is a member of and newsletter editor for the RI Chapter.

ACHCA Members Bring Expertise to WHCoA Event

By Herbert P. Weiss, NHA

More than 30 ACHCA members were among the 2,227 delegates chosen to participate in the fourth and final White House conference on Aging (WHCoA) event of this century. ACHCA members and other delegates came to Washington D.C. on May 5 to begin a serious discussion of the problems faced by 33 million older Americans. And, they came prepared to hammer out consensus resolutions that would influence policy debates for the next ten years.

Delegates sent a loud message to the Clinton administration and Republican-controlled Congress: preserve and maintain Social Security and the Older Americans Act; prevent arbitrary cuts in the Medicare program; and oppose the block granting of the Medicaid programs. The delegates also called for universal health care coverage, development of home and community-based services, and increased funding for medical research.

Throughout the conference, Republicans and conservative senior groups charged that the "wish list" of final resolutions would be too costly to implement especially with Congress looking for ways to trim the huge federal budget deficit.

But WHCoA Policy Committee Chair Senator David Pryor (D-AR) disagreed with critics calling the delegates "pragmatic," stating that their final recommendations did not support any new programs or create any new bureaucracies. Pryor said that they only called for the existing federal programs to "work and work better."

Workshops Refine WHCoA Resolutions

Sixty draft Issue Resolution Development Session resolutions (IRDS) were developed by WHCoA staff after a review of thousands of recommendations in more than 800 pre-conference reports. The delegates amended these resolutions in workshops held throughout the three-day event.

Changes made during workshops were incorporated into the 60 IRDS resolutions. A full conference vote reduced the number of IRDS resolutions to 40. Ten resolutions initiated and approved by conference delegates were selected out of a total of 39 considered.

While not legally binding, the resolutions will provide older Americans with a forum to identify their priorities, said Brian Preston, WHCoA press secretary.

According to Preston, before the final report is released in early 1996, state governors will receive an executive summary by Aug. 3, and have 90 days to review and submit their findings back to WHCoA staff. At press time, 35 post-conference events are scheduled to allow organizers to discuss particular resolutions and how to implement them.

Provider Groups Map Out Strategies

WHCoA delegates with ties to long-term care associations met numerous times—beginning at a May 1 caucus meeting and ending at a May 4 reception—to develop strategies to gain support for their issue resolutions. (The groups included ACHCA, AHCA, AMDA AAHSA, NADONA and ASCP).

"We considered the initial caucus meeting a success because it helped us to identify issues that were important to each group," said Richard L. Thorpe, CFACHCA. The groups all opposed the block granting of Medicaid, supported the preservation of Medicare, and called for the WHCoA's final report to identify nursing homes as an appropriate service in the long-term care continuum, Thorpe said.

According to Thorpe, the delegates at the reception found that their collective efforts were successful in modifying many of the IRDS resolutions.

WHCoA Impact

This year's WHCoA emphasized the importance of health and productive aging and recognized the positive contributions made by elders to their communities, observed Margaret M. Hastings, Ph.D., delegate and education chair of ACHCA's IL Chapter.

According to Dr. Mark A. Jerstad, president and CEO of the Evangelical Lutheran Good Samaritan Society, the beating of the drums for tax outs and federal budget balancing might keep Congress from supporting WHCoA resolutions that call for preserving Social Security and the Older Americans Act, preventing Medicare cuts and opposing the block granting of the Medicaid programs.

"With the presidential campaign heating up in 1996, senior concerns will be heard," Jerstad predicted. He warned that it is in each presidential candidate's best interest to listen to what seniors consider important.

—Herbert P Weiss, NHA, is a Providence, Rhode Island-based writer.

Top 10 Resolutions Adopted by WHCoA Delegates

Here are the top ten resolutions receiving the most delegate votes:

1. Keep Social Security Sound for now and for future generations; 1595 votes.
2. Preserve the Integrity of the Older Americans Act; 1576 votes.
3. Preserve the Nature of Medicaid; 1438 votes.
4. Reauthorize the Older Americans Act; 1414 votes.
5. Ensuring the future of the Medicare program; 1413 votes.
6. Increase funding for Alzheimer Research; 1217 votes.
7. Preserve advocacy functions under the Older Americans Act; 1388 votes.
8. Ensure the Availability of a Broad Spectrum of Services; 1385 votes.
9. Finance and provide long-term care and services; 1360 votes.
10. Acknowledge the contribution of older volunteers; 1360 votes.

—Source: Adopted Resolution, Official 1995 WHCoA Conference Report.

Capitol *Report*

By Herbert P. Weiss, NHA

Senate Puts Nursing Home Reform Act at Risk

Shortly before the stroke of midnight on October 27, consumer advocates received a setback in their lobby efforts to retain federal nursing home standards in the Senate reconciliation bill. Senate action put the Nursing Home Reform Act at risk.

Early that day, moderate Republicans, including Sens. Olympia Snowe of Maine, James Jeffords of Vermont and William Cohen of Maine, sided with Senate Democrats to narrowly pass an amendment (S. 1357) to the budget bill during a floor debate by a vote of 51-48 to keep the Nursing Home Reform Act intact. But prior to passing the budget bill that evening, the Senate approved a compromise introduced by Sen. William V. Roth of Delaware, allowing states to receive a waiver exempting them from federal nursing home standards if their rules are at least as strict as the federal rules.

Before the Senate vote, consumer groups had watched the House Republican majority scrap the Nursing Home Reform Act on October 18. The chamber passed its reconciliation bill by a razor thin vote of 227-203 that included a provision that wiped out the Act. The House budget bill would transfer oversight of nursing home quality to the states.

As the dust settles, House and Senate negotiators are sitting in conference committee to reconcile the Senate bill with its companion House measure. This process is likely to last until late December.

Roth Amendment Vague

While the Roth Amendment grants waivers to states which meet or surpass the provisions of the Nursing Home Reform Law, the National Citizens Coalition for Nursing Home Reform (NCCNHR) charges that the compromise amendment is vague and unworkable.

"We don't think that a waiver is really necessary because if a state has stronger standards than federal requirements they don't currently need a waiver to defer to their standards," Lori Owen, NCCNHR's law and policy specialist told the *LTCA*.

Before the Senate vote, consumer groups had watched the House Republican majority scrap the Nursing Home Reform Act on October 18.

According to Owen, the lack of standards by which to grant waivers leaves open the opportunity for states to obtain waivers using general categories rather than meeting the substance of the Nursing Home Reform Law. Therefore, it is important that the waiver require all nursing home standards to be stronger than federal requirements, Owen said.

Another problem NCCNHR has with Roth's amendment deals with the 120-day waiver approval period. Owen noted that the time frame, which includes a public comment period, is unrealistic unless the language is changed so that any waiver not approved in writing within the specified time period is deemed denied. "Past experience requires pinning down those details to avoid misinterpretation," Owen said.

Presently, the federal government can levy a fine of up to 100 percent of Medicaid nursing home program dollars against any state out of compliance with federal standards, noted Owen. "The penalty for noncompliance against the state is only up to two percent loss of state MediGrant dollars in the Roth Amendment," she said. "This amount is just too low to have an impact on a state compliance," she predicted.

Owen said that Roth's amendment could also be interpreted to mean that federal authority applies only to action against the state and not to facilities for failing to comply with the Medicaid law, or with the state law granted under the waiver. "If a facility is really providing egregious care but the state is not doing anything about the problem, the amendment allows no action to be taken against the facility by the federal government," she warned. NCCNHR calls for a change in language that clearly declares that a federal authority exists over the facility as well as the state for noncompliance, Owen said.

Reimbursement Must Cover Compliance Costs

As the debate over the need for federal nursing home standards continues, provider groups urge Congress to adequately fund Medicaid and tie reimbursement rates to cover compliance costs.

"Lawmakers currently are arguing that the proposed repeal of federal standards will turn back the clock, while ignoring other Medicaid proposals that might just stop the

Continued on page 8

By Herbert P. Weiss, NHA

Republican OAA Reauthorization Bill Jeopardizes Ombudsman Program

With the federal budget battle taking center stage on Capitol Hill, the Older Americans Act (OAA) FY 1995 reauthorization bill process takes a lower legislative priority. At press time, aging groups charge that the reauthorization bill (H.R. 2570) passed on Nov. 16 by the Subcommittee on Early Childhood, Youth and Family will put the long-term care ombudsman program in jeopardy if Congress passes the legislation. The bill will now go to the full Economic and Educational Opportunities Committee for discussion and markup. The Senate plans to markup its version of OAA in January.

In an exclusive December interview with the *Long-Term Care Administrator*, Bill Benson, the U.S. Administration on Aging's deputy assistant secretary for aging says that he is concerned the GOP efforts to streamline the five-year reauthorization bill will take a bite out of the ombudsman program.

According to Benson, H.R. 2570 eliminates Title VII, Elder Rights, created during the last reauthorization of the Act. Title VII places the ombudsman program in context with other client advocacy and service programs (such as insurance and benefits counseling and elder abuse prevention) in the OAA, Benson said. Title VII also defines the provisions that govern the roles and responsibilities of ombudsmen. Finally, Title VII also addresses potential conflicts of interest of those appointing ombudsmen and by ombudsmen themselves; access to records; advocacy on behalf of facility residents; ombudsman training; data collection on ombudsman activities and federal support to state ombudsman programs through the Administration on Aging at the Department of Health and Human Services.

"Title VII was one of the more creative things done in the Act in a number of years and it really protects the most vulnerable," Benson said, noting that it was initially enacted with bipartisan support in 1992. There was virtually no criticism of it during Congressional hearings on the reauthorization.

H.R. 2570 requires states to have an ombudsman program but in a substantially weakened form.

"One GOP argument for eliminating Title VII is that they are looking for ways to streamline the law," Benson said. But Republicans say they are protecting the program by moving it into Title III of the House bill and Title II of the Senate bill.

Benson said that H.R. 2570 requires states to have an ombudsman program but in a substantially weakened form. While the GOP proposal requires an ombudsman program, it eliminates the actual mandate that states have an ombudsman, Benson said.

"This would be a major step backwards," Benson said, noting that "the philosophy of the ombudsman program is based on the concept of an individual who serves as the ombudsman. The buck must stop with this person."

In addition, the Republicans' dramatic overhaul of the OAA reauthorization bill takes out specific provisions that ensure that the ombudsman remains free from conflicts of interest, Benson said. "Under H.R. 2570, ombudsmen could be owners, investors in nursing homes or long-term care service providers," he said. This would prevent the ombudsman from truly representing the interests of nursing home residents with an independent voice.

The House reauthorization bill also deletes the uniform ombudsman reporting system to Congress, threatening the accountability and credibility of the program, Benson noted. "Information gleaned from these reports could actually help support administrator arguments that they can't provide certain things because adequate funding is not provided or bureaucratic barriers exist," he said.

In an unusual move, H.R. 2570 creates a ceiling for funding but establishes no minimum funding level, Benson noted. "The ceiling could prevent a state from adequately funding its statewide ombudsman program and could possibly keep a state from expanding into other areas like home and community-based services and assisted living," Benson said.

While H.R. 2570 makes substantial changes to the OAA, including the ombudsman program, only one hearing has been held to gather public comment, Benson said, adding that he fears there will be virtually no opportunities for hearings when the Senate subcommittee begins its markup.

This is a rather dramatic contrast

Continued on page 12

Capitol *Report*

By Herbert P. Weiss, NHA

Consumer Report Calls on Congress to Save Nursing Home Quality Standards

After 50 hours of face-to-face talks between President Clinton and GOP leaders, budget negotiations stalled in mid-January, giving consumer watchdog groups needed time to generate public support to force Congress to keep nursing home protections in the 1995 budget reconciliation bill.

The Medicaid Transformation Act, part of the Congressional budget bill vetoed by President Clinton, but still under consideration at press time, would block grant the Medicaid program, giving lump sums of money to each state with few federal restrictions on the use of the funds. The budget proposal also scraps the 1987 Nursing Home Reform Law, consumer groups charge. More than $133 billion over seven years in projected federal spending would be cut from the grant package to states under the plan still being debated by Congress, they say.

Loss of federal standards and oversight will likely bring a return to unchecked abuse and neglect of nursing home residents, warns the National Citizens' Coalition for Nursing Home Reform, a consumer watchdog group representing nursing home residents and Consumers Union, the nonprofit publisher of *Consumer Reports,* in a newly-released report, "Congress Brings Back the Horrors: Budget Bill Rolls Back Nursing Home Standards."

According to the 38-page report released in December 1995, the budget bill still being negotiated in high-level talks between the Clinton Administration and GOP leadership strips so many critical consumer protections that it compromises the essence of the Nursing Home Reform Law and puts the 1.5 million Americans currently living in nursing homes at risk of abuse and neglect. The report highlights consumer group concerns about major limitations of the Medicaid Transformation act of 1995. These include:

Loss of federal standards and oversight will likely bring a return to unchecked abuse and neglect of nursing home residents.

- No standard for providing residents with quality care. The bill repeals the current law that requires facilities to provide care and services that afford residents the "highest practical and emotional well-being."
- No required training for nurse aides, who provide 80 percent of the care to nursing home residents. Current law requires 75 hours of training and gives states the option to allow untrained staff to care for residents.
- Weakened protection against eviction. While current law ensures residents notice and preparation before transfer and discharge from a facility, the budget bill allows the 30-day eviction notice to be eliminated when "impractical."
- No protection against discrimination or financial exploitation. Current law prohibits facilities from forcing residents to waive their rights to Medicaid or from charging separately for basic items and services that would be included in the basic Medicaid daily rate. The budget bill repeals these protections.
- No guarantee of receiving appropriate services. Current law affords "each" resident rights to quality of life and care. The budget bill deletes the word "each," eliminating a guarantee of individual rights to necessary treatment and services.
- Federal oversight is weakened. The Secretary of the Department of Health and Human Services currently sets and enforces compliance with federal nursing home standards. The budget bill requires states to be consulted first about problems with nursing homes, even in a life-threatening situation. While facilities are paid by federal tax dollars, the budget bill allows the federal government to give up control over how these dollars are spent.
- No uniform system for assessing individual needs. Current law directs facilities to assess carefully residents' individual needs using a national uniform resident assessment system. Under the budget bill, states are allowed to set their own criteria.

Point/Counterpoint

Consumer groups call on the GOP Congressional leadership to

Continued on page 14

By Herbert P. Weiss, NHA

Despite Provider Groups' Opposition, Governors Hope Medicaid Proposal Will Break Budget Logjam

After two months of negotiations, the nation's governors hammered out a bipartisan proposal on Medicaid to jump start the federal budget negotiations between the Clinton administration and the Republican majority in Congress. Philosophical differences over how to fix the hemorrhaging Medicaid, Medicare and welfare programs have been major obstacles in the fiercely partisan budget debates.

Using its 1996 Winter Meeting as a backdrop, the National Governors Association (NGA) unanimously endorsed a policy statement which outlines a hybrid Medicaid program—one that would keep Medicaid as an entitlement program as Democrats want, while also satisfying Republican demands for block grants.

According to the NGA, annual Medicaid growth over the last decade has been well in excess of 10 percent. In half of those years annual growth approached 20 percent. While the recently unveiled proposal has yet to be evaluated by the Congressional Budget Office, the nation's governors expect the cost savings to fall between the Clinton administration's recommendation of $59 billion over seven years and the Congressional Republicans' call for $85 billion in cuts.

"It (the Medicaid policy) is very well structured and allows both sides to claim victory," said NGA Chairman Tommy G. Thompson, Republican governor of Wisconsin. Thompson was one of a group of six Republican and Democratic governors who negotiated the complex bipartisan agreement. The policy is "replete with all of the provisions that as a governor I have only dreamed of having," Thompson said.

Despite his optimism, however, Thompson warned that the agreement is "very fragile" and predicted that "if changes are made to the major features of it, it will fall apart."

Key Provisions of the Medicaid Bipartisan Agreement

The bipartisan governors' proposal calls for guaranteed coverage of certain eligible populations and optional coverage for others. Certain benefits would remain guaranteed only for guaranteed populations, such as those receiving inpatient and outpatient hospital services, prenatal care, nursing facility services, home health care, laboratory and x-ray services and Early and Periodic Screening, Diagnosis and Treatment services. The "T" in EPSDT would be redefined so that a state need not cover all Medicaid optional services for children. All other benefits defined as optional under the current Medicaid program would remain optional and long-term care options would be significantly broadened.

Under the NGA proposal, states would also have complete flexibility in the amount, duration and scope of services. The proposal also defines the rights for individuals and the classes of Medicaid eligibility in order to prevent states from having to defend against suits on benefits in federal court.

The governors also recommended that states should no longer have to appeal to the federal government for waivers to use all available health care delivery systems and should not be subject to federally imposed limits on the number of beneficiaries who may be enrolled in any network. One controversial provision opposed by nursing home groups allows states to have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action from the provider or plan. The proposal also strongly urges repeal of the Boren amendment and other similar measures.

The proposed restructuring for the Medicaid program also recommended reforms to nursing home standards. Although states will be required to abide by the OBRA '87 standards, they will have the flexibility to determine enforcement strategies for nursing home standards and will be required to include them in their state plan. In addition, current provider tax and donation restrictions in federal statute would be repealed with the Department of Health and Human Services (HHS) dismissing current and pending state disputes over provider taxes.

Additionally, the NGA proposal would allow each state to have a maximum federal allocation that would provide them with the financial capacity to cover Medicaid enrollees. The allocation would be available only if the state puts up a matching percentage and would be based on the sum of four factors: base allocation, growth, special grants (with no state matching required) and an insurance umbrella that would help states pay for unanticipated changes in the number of beneficiaries if certain conditions are met.

Finally, states would be unbur-

Continued on page 13

By Herbert P. Weiss, NHA

Despite Provider Groups' Opposition, Governors Hope Medicaid Proposal Will Break Budget Logjam

After two months of negotiations, the nation's governors hammered out a bipartisan proposal on Medicaid to jump start the federal budget negotiations between the Clinton administration and the Republican majority in Congress. Philosophical differences over how to fix the hemorrhaging Medicaid, Medicare and welfare programs have been major obstacles in the fiercely partisan budget debates.

Using its 1996 Winter Meeting as a backdrop, the National Governors Association (NGA) unanimously endorsed a policy statement which outlines a hybrid Medicaid program—one that would keep Medicaid as an entitlement program as Democrats want, while also satisfying Republican demands for block grants.

According to the NGA, annual Medicaid growth over the last decade has been well in excess of 10 percent. In half of those years annual growth approached 20 percent. While the recently unveiled proposal has yet to be evaluated by the Congressional Budget Office, the nation's governors expect the cost savings to fall between the Clinton administration's recommendation of $59 billion over seven years and the Congressional Republicans' call for $85 billion in cuts.

"It (the Medicaid policy) is very well structured and allows both sides to claim victory," said NGA Chairman Tommy G. Thompson, Republican governor of Wisconsin. Thompson was one of a group of six Republican and Democratic governors who negotiated the complex bipartisan agreement. The policy is "replete with all of the provisions that as a governor I have only dreamed of having," Thompson said.

Despite his optimism, however, Thompson warned that the agreement is "very fragile" and predicted that "if changes are made to the major features of it, it will fall apart."

Key Provisions of the Medicaid Bipartisan Agreement

The bipartisan governors' proposal calls for guaranteed coverage of certain eligible populations and optional coverage for others. Certain benefits would remain guaranteed only for guaranteed populations, such as those receiving inpatient and outpatient hospital services, prenatal care, nursing facility services, home health care, laboratory and x-ray services and Early and Periodic Screening, Diagnosis and Treatment services. The "T" in EPSDT would be redefined so that a state need not cover all Medicaid optional services for children. All other benefits defined as optional under the current Medicaid program would remain optional and long-term care options would be significantly broadened.

Under the NGA proposal, states would also have complete flexibility in the amount, duration and scope of services. The proposal also defines the rights for individuals and the classes of Medicaid eligibility in order to prevent states from having to defend against suits on benefits in federal court.

The governors also recommended that states should no longer have to appeal to the federal government for waivers to use all available health care delivery systems and should not be subject to federally imposed limits on the number of beneficiaries who may be enrolled in any network. One controversial provision opposed by nursing home groups allows states to have complete authority to set all health plan and provider reimbursement rates without interference from the federal government or threat of legal action from the provider or plan. The proposal also strongly urges repeal of the Boren amendment and other similar measures.

The proposed restructuring for the Medicaid program also recommended reforms to nursing home standards. Although states will be required to abide by the OBRA '87 standards, they will have the flexibility to determine enforcement strategies for nursing home standards and will be required to include them in their state plan. In addition, current provider tax and donation restrictions in federal statute would be repealed with the Department of Health and Human Services (HHS) dismissing current and pending state disputes over provider taxes.

Additionally, the NGA proposal would allow each state to have a maximum federal allocation that would provide them with the financial capacity to cover Medicaid enrollees. The allocation would be available only if the state puts up a matching percentage and would be based on the sum of four factors: base allocation, growth, special grants (with no state matching required) and an insurance umbrella that would help states pay for unanticipated changes in the number of beneficiaries if certain conditions are met.

Finally, states would be unbur-

Continued on page 13

By Herbert P. Weiss, NHA

HCFA, NCCNHR at Odds Over First Year — Implementation of the Enforcement Rule

As July 1996 approaches, marking the first year anniversary implementation of the enforcement provisions of the Nursing Home Reform Law, the National Citizens Coalition for Nursing Home Reform (NCCNHR) called for changes in the way the system has been implemented to make it more resident-directed and consistent with the federal law and regulations.

In an April 16 letter to the Health Care Financing Administration (HCFA), NCCNHR, a Washington, DC-based consumer advocacy group representing nursing home and other long-term care residents, charged that continuous delays in fully implementing HCFA's enforcement system, the continuous fine-tuning of the systems, and numerous proposals to change regulatory terminology do nothing to improve the conditions of residents in facilities.

"There appears to be overriding concern for the interests of providers with serious incidents of neglect and harm going unnoticed and/or unremedied," NCCNHR told HCFA. Changes in regulatory terminology to appease the nursing home groups, specifically terms like "out of compliance" to "correction required" or "significant corrections required," only make consumers more skeptical of the enforcement system, NCCNHR said.

Remedies Not Likely Imposed

HCFA's policy of requiring onsite revisits only if deficiencies fall into boxes D, E, or F (denoting no substandard quality of care) will derail the final rule's enforcement provisions, NCCNHR pointed out, noting that 80 percent of all deficiencies are placed in lower level boxes. By requiring revisits prior to imposing remedies, the agency's current policy almost assures that actual enforcement will become a rare event, NCCNHR warned.

According to NCCNHR, even with a majority number of facilities being cited for deficiencies under the new enforcement system, the percentage of cases where remedies are actually imposed on facilities is extremely small.

In addition, the agency's continued moratorium on civil money penalties (CMPs) and waiving fines is another area of major concern for NCCNHR. "Waiving these fines serves only to make a mockery of the enforcement system and to perpetuate poor care and noncompliance," NCCNHR said.

HCFA Counters Charges

While the regulatory requirements for nursing homes to meet have remained the same, the method to ensure compliance has significantly changed with last year's implementation of the enforcement rule, said Anthony Tirone, HCFA's Deputy Director of Health Standards Quality Bureau. "It has involved a considerable effort from the state and federal government to put [the system] in place but while not perfect we believe implementation has gone remarkably well," Tirone said.

"If the process is being misapplied give us specifics. Give us the facility name and we will look at the 2567, the statement of deficiency," Tirone said, then the agency can "go behind the survey" to respond to the complaint.

Tirone said NCCNHR has been somewhat consistent in their views that the enforcement process should automatically punish people who are out of compliance. "We quite frankly do not agree with that [position]," he noted. "If you identify problems and a facility does not have a bad history then the facility should get an opportunity to fix them before it faces remedies," he added.

"While NCCNHR complains that the number of facilities receiving remedies is not high enough you have to remember that prior to July 1, 1995 the number receiving remedies was virtually nonexistent. About 72 percent of the nation's nursing homes now are found out of compliance and are subject to remedies," he said. Of these facilities a small percentage are considered "poor performers" and face immediate remedies, he noted. Of the rest, over 400 have been subject to various remedies because they failed to come into compliance within a reasonable time.

"Where you have circumstances of either immediate jeopardy or have a poor performing facility, that is where a facility should be subject to an immediate CMP," Tirone told the *LTCA*. "Prompt corrective action can limit the impact of CMP but you won't be able to avoid it," he said.

Intuitively we thought that CMPs would have been imposed more than the remedy had been during the first year of implementation, Tirone said. He noted that the agency's assessment of this year's survey activity will determine if it has occurred appropriately and where it should have occurred.

Continued on page 10

By Herbert P. Weiss, NHA

Federal Policy Changes are Necessary to Improve Mental Health Care in Nursing Homes

The principle authors of a new report predict that planned cutbacks in Medicare and the block granting of Medicaid will have a disproportionately large impact on funding of mental health treatments—mentally ill residents once again will become a forgotten constituency, they charge.

Ironically, cutbacks in mental health funding come at a time when we are learning more and more about how effective mental health treatments are and when we know physical illnesses of the frail elderly cannot be treated separately from mental illnesses, the authors say.

Budget Battle Looms

According to Nancy Emerson Lombardo, one of the report's authors, mental health experts worry that the situation for hundreds of thousands of mentally impaired nursing home residents may worsen if budget proposals are passed by the 104th Congress to drastically cut Medicare, dismantle the Medicaid program and repeal essential features of the Nursing Home Reform Act.

Given the Republication majority in Congress, "it will take a big battle to restore mental health funding even to the inadequate levels of a few years ago, let alone bring it up to par with payments for treating other medical problems," Lombardo writes. She notes that evidence has mounted in recent years, some from federal investigators, that physical illnesses of frail elders cannot be treated separately from mental illness.

As the Clinton administration and Congress continue to fine tune the Medicare and Medicaid programs in 1996, it becomes more timely for them to reassess and pull down the continuing barriers to optimal mental health for nursing home residents. This report provides them with a blue print to rethink federal policy for mental health services.

Pulling Down Barriers

Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care for Nursing Home Residents was published in June by the nonprofit Hebrew Rehabilitation Center for the Aged's (HRCA) Research and Training Institute in Boston, in conjunction with the Mental Health Policy Center (MHPRC) in Washington, D.C. It is based on a two-day 1993 invitational conference that brought together more than 130 experts in mental health and aging.

The report enumerates a variety of obstacles to the provision of appropriate mental health services. These include a shortage of mental health professionals trained in geriatrics; lack of in-service training in nursing homes to teach facility staff to treat behavior and functional consequences of mental illness or dementia; and inadequate Medicaid and Medicare payments and reimbursement rules that do not reflect the relative costs of preferred treatments.

Even with these obstacles, the report notes that model mental health programs do exist in some nursing homes that are funded by an array of federal and state agencies, by nonprofit foundations and even by some of the facilities themselves, drawing upon nonfederal funds. The report recommends that these programs be identified, cost benefits calculated, and the results widely disseminated to nursing homes for replication.

But whatever progress has been made, many mental health experts agree that progress is slow and that good mental health care in nursing homes is still the exception rather than the rule.

Fixing the Problem

According to the report, improving mental health of nursing home residents calls for an array of federal policy changes in financing, reimbursement, treatment and practice, service delivery and quality management. Key recommendations include:

- Additional funding for research, staff training and consumer education initiatives.
- Improved Medicare and Medicaid reimbursement to pay for psychiatrists to train nursing home staff members in mental health services.
- The "unbundling," or separating, of mental health services from nursing home per diem rates, so that funding intended for such assistance cannot be buried in lump-sum reimbursement for care and forgotten.
- Full implementation of all federal nursing home reform mandates passed in 1987 and 1989, such as those which require training for nursing home staff and which strictly limit the use of psychotropic drugs and physical restraints with residents.
- Increasing the percentage of mental health services paid for

Continued on page 14

Capitol *Report*

By Herbert P. Weiss, NHA

LTC Costs Are Deductible Under Health Insurance Reform Act

After his failed efforts to enact comprehensive health care reform legislation two years ago, a jubilant President Clinton, in a ceremony held on the White House lawn last month, signed a bipartisan health care insurance reform bill into law.

Primary sponsors of the bill (HR 3103) were Nancy Kassebaum (R-KS), chair of the Senate Labor and Human Resources Committee, and Edward Kennedy (D-MA), the committee's ranking Minority Member.

Although the Health Insurance Portability and Accountability Act of 1996 does little for people without health insurance coverage, the landmark legislation could help up to 25 million Americans who fear losing their insurance if they get sick or change jobs. Clinton told a large crowd who gathered to watch the historic signing ceremony. In his address, the president stated that the new law would allow workers to take their insurance from job to job and strictly limit the ability of insurance companies to deny coverage to persons with preexisting medical conditions.

Kennedy-Kassebaum Bill Almost Derailed

The House and Senate had passed health insurance reform bills back in April. But last minute negotiations between Senator Kennedy and Rep. Bill Archer (R-TX), chair of the House Ways and Means Committee, cleared a major political hurtle between the two chambers that had threatened to keep House and Senate bills from reaching the Conference committee.

A compromise was reached in late July between Kennedy and Archer in a dispute over Medical Savings Accounts (MSAs). Initially objections had been raised by Congressional Democrats and the Clinton Administration over Republican efforts to push for a large pilot test, open to 40 million people nationwide, of MSAs. The Democratic Senators supported a test limited to less than a million people.

Proponents argued that MSA would allow many Americans not now insured to cover their health care costs. Money deposited in tax-exempt MSAs could be withdrawn to pay for routine medical care, while the insurance company would only cover catastrophic health care needs. Critics of

Tax code clarifications allow Americans for the first time to write off long-term care expenses.

MSA feared that the payment mechanism would draw away healthier and wealthier people away from traditional insurance plans, leaving those with less money and more health problems behind in an increasingly costly insurance pool.

In the Kennedy/Archer compromise, the MSA pilot test, beginning in 1997, would only involve up to 750,000 policies for people in firms with 50 or fewer employees and the self-employed. The pilot test would last four years. The availability of MSAs would terminate at the end of the pilot program, unless Congress acted to extend the program. People who establish MSAs during the test period would be allowed to keep them.

With the MSA issue settled the health insurance reform legislation reached the conference committee, whose report was ultimately passed by Congress.

Impact on LTC Financing

Nursing home groups hailed the passage of the health insurance reform law. Tax code clarifications allow Americans for the first time to write off long-term care expenses. Employers and individuals can treat long-term care insurance premiums as deductibles as they can for other forms of medical insurance. In addition, the law allows persons with terminal illness to use the cash value of whole life insurance policies to pay for long-term care expenses.

"The new law fundamentally reshapes how Uncle Sam will view LTC insurance premiums and long-term care expenses when tax time rolls around," said Paul Willging, American Health Care Association (ACHA) Executive Vice-President. Long-term care costs as other medical expenses will be deductible, provided that they exceed the federal government's 7.5% threshold of adjusted gross income.

Starting January 1, 1997, individuals will be able to include out-of-pocket expenses for long-term care services and long-term care premiums with their other itemized medical expenses on their annual tax returns. Consumer protections for the purchase of long-term care insurance policies are also included in the law.

Currently, two out of three nursing home residents—more than one million people—rely on the Medicaid welfare program to pay for their care. Long-term care insurance now pays for a mere 2% of the nation's total nursing home bill. Nursing facility care costs an average of about $105 per day, or $38,000 per year.

Continued on page 10

By Herbert P. Weiss, NHA

Not Complying with Medical Device Reporting Rule Can Be Costly

Even with widespread publicity from nursing home trade groups and industry trade publications about Food and Drug Administration's (FDA) Medical Device Reporting Rule, some nursing facility providers may be still unaware of the new rule's requirements and regulatory impact on them.

FDA's New Reporting Requirements

For the first time nursing homes—along with hospitals, hospices, home health agencies and other health facilities—are required by federal law to report to FDA deaths and serious injuries or illnesses connected with the use of medical devices.

The agency's rule, clarifying the agency's proposed 1991 regulation to implement provisions mandated by the Safe Medical Devices Act of 1990, took effect July 31. Initially the rule was scheduled for implementation in April but the agency gave providers extra time to prepare for the rule's implementation.

According to FDA, all medical devices used by nursing facilities are covered by this rule, specifically wheelchairs, hoyer lifts, intravenous pumps, mechanical restraints, apnea monitors, foley catheters—even glucometers, thermometers and bandages.

Under FDA's rule, medical facilities must report all serious device-related incidents within ten days. Deaths must be communicated directly to the agency as well as to the manufacturer, or to FDA if the firm's identity is not known. The facilities must send every six months a summary of these reports to FDA.

Informal Poll Shows Some Facilities Still Unaware of FDA Rule

While not a random survey, recent phone calls to 30 nursing facilities in two New England states (representing 4.5% of all licensed facilities in those states) revealed that only 6.6% of the providers polled were aware of FDA's Medical Device Report Rule but none was aware of how to comply nor what impact it would have on him or her.

"Calling these facilities made us aware that there were many administrators who were totally unaware of the FDA's Medical Device Reporting Rule," said John Grieco, President of Quality Assurance Consultants, Inc., a Woburn, MA-based firm that provides operational consulting for regulatory and reimbursement issues to nursing facilities throughout southern New England. "Many of the individuals who knew of the rule thought that nursing facilities were considered voluntary report-

Continued on page 13

Resources on How to Comply with the Safe Medical Devices Act

Nursing home trade groups have published comprehensive compliance kits to help nursing home providers comply with the medical device reporting regulation of the Safe Medical Device Act, which took effect on July 31.

Medical Device Reporting: Provider Compliance Kit, published by the American Health Care Association, provides practical compliance tools, including sample policies and procedures, sample forms, an implementation checklist and a decision-making flow chart. The kit explains user facility reporting requirements, recordkeeping, written procedures and how to complete FDA Forms 3500A and 3419. Reference information and a copy of the final regulation also are included in the manual. A 71-minute video features excerpts from the Food and Drug Administration's teleconference on medical device reporting.

The cost is $49.95 for AHCA members, $74.95 for nonmembers. To order, call (800) 321-0343.

FDA Guidelines: Complying with the User Facility Medical Device Reporting Requirements of the Safe Medical Device Act, available from the American Association of Homes and Services for the Aging. This package, developed by the FDA, includes an overview of the Medical Device Reporting Rule regulation, a copy of the Medwatch form 3500A (the mandatory reporting form), instructions for completing form 3500A and a copy of the Rule's Semi-Annual User Facility Report. You'll also receive a copy of the regulation.

The cost is $35 for AAHSA members, $50.00 for nonmembers. To order, call (800) 508-9442.

Capitol *Report*

By Herbert P. Weiss, NHA

Top LTC Journalists Give Views on 105th Congress

While Washington survived the Republican revolution led by House Speaker Newt Gingrich (R-GA) in the 104th Congress, the intense partisan battles over passage of a federal budget and federal agency shut downs created legislative logjams.

On November 5, voters sent Democratic President Bill Clinton back for a second term and gave the GOP narrow majorities in the House and Senate. As the dust settled, the message was clear to politicians—voters called for checks and balances through a Democratic White House and a Republican-led Congress.

Although the 104th Congress is barely over, nursing home providers are already looking ahead to next year's battles. The *LTCA* gets the scoop from two prominent journalists on which legislative initiatives will be on the 105th congressional agenda.

Many Issues to Affect Nursing Facilities

To be brought to the table for Congress to consider will be many issues that have a big impact on the nursing home provider community, said Elise Nakhnikian, Editor-in-Chief of *Contemporary Long-Term Care.*

Nakhnikian sees a continuation of debates over how to balance the budget by cutting Medicare and Medicaid and reallocating Medicaid moneys from costly nursing home care to community-based services. "There is no way of balancing the budget without going after these entitlement programs," she predicted.

According to Nakhnikian, the growth rate of Medicaid is flattening. With the Clinton administration supporting Medicaid waivers to control costs, there likely will be a lot more waivers approved to fund home and community-based initiatives.

Look for Congress to revisit the question of whether to keep or eliminate the Boren amendment, Nakhnikian told *LTCA.* During the

> "A Democratic White House and a Republican-controlled Congress is probably the best result that the nursing home industry could have hoped for."

104th Congress, Republican governors called for the repeal of the Boren amendment and for depriving providers with the right to challenge state-set Medicaid reimbursement levels in federal courts. The amendment requires states to pay "efficiently and economically" operated nursing facilities the cost of providing care in accordance with federal law.

"Bipartisanship may result from President Clinton wanting to leave his stamp on history and from a more pragmatic GOP," Nakhnikian said. She noted, "Everybody is talking much more positively than they did two years ago when the Republican freshmen took over the House." She noted that Senate Majority Leader Trent Lott (R-MS) is a compromiser known for making things work in Washington.

Finally, the 105th Congress will continue federal efforts to save Medicare dollars by rooting out fraud and abuse in the health care system, said Nakhnikian.

Congress to Tackle an Array of Issues

"A Democratic White House and a Republican-controlled Congress is probably the best result that the nursing home industry could have hoped for," observed John O'Connor, editor of *McKnight's Long-Term Care News.* "This industry has somewhat of a successful track record of dealing with the status quo. They already know how to lobby the President and Congress so we don't have to reinvent the wheel."

In regard to Medicare, there is talk on Capitol Hill of putting in place a Medicare Commission, much like the one that addressed Social Security issues in 1983, O'Connor said. Look for this commission to consider a number of recommendations for a long-term fix of Medicare. Congress might include making dramatic reductions in Medicare reimbursement to providers, with subacute care reimbursement being targeted along with the traditional Medicare coverage for skilled nursing home services.

"You will see both sides holding their cards close to the vest until the President releases his next budget in February 1997," O'Connor noted. The real spin control with take effect as the President defends his budget deadlock stalled this proposal.

According to O'Connor, there is less of a chance of Congress block granting Medicaid today. "You will see the White House and Congress take a hard look at how welfare reform works at the state level. That will be the litmus test for the block granting of Medicaid to be a viable alternative to the current financing and reimbursement

Continued on page 9

By Herbert P. Weiss, NHA

Proposed Changes to Survey Become Political Hot Potato

The White House moved quickly to quell political damage resulting from a front page article in the December 17 *New York Times* that charged the Health Care Financing Administration (HCFA) with planning to limit the scope of long-term care survey procedures at 17,000 federally certified nursing facilities.

Even *USA Today* got into the brief fray. On December 19, the daily paper covered the controversial issue on its editorial page calling for HCFA to keep "the teeth" in the survey enforcement process. Paul Willging, Executive Vice-President of the American Health Care Association, countered the paper's position by calling for fine tune monitoring of the nation's inspection system.

The short-lived controversy erupted over an October 31 HCFA memorandum sent to Federal and state health officials and long-term care organizations. The federal agency had requested comments on proposed changes to the State Operations Manual (SOM) No. 274, Appendix P, the long-term care survey procedures.

Provider and Consumer Views

Consumer advocates loudly complained that the focus of the survey process continues to narrow, and there is a strong push, reflected in the proposed changes, to save time and resources by getting surveyors in and out of the facility as quickly as possible. Two proposed changes were the elimination of the Phase 2 sample for facilities with no problems and a revision to the Residents Review that would begin with the Resident Assessment Protocol summary and emphasize use of staff as an information source. Other changes included an optional closed record review, elimination of medication pass observations in Phase 1 surveys, and moving Part 1 of the Quality Assessment and Assurance Review to Phase 2 of the survey.

"We think that the changes made a lot of sense and were logical given the limited resources that states have to work with," stated Michael Rodgers, Senior Vice President of the American Association of Homes and Services for the Aging. "While consumers saw HCFA's plan as an attempt to water down the enforcement survey process we saw it as an effort to effectively target resources."

> "Hopefully we can get more agreement on the appropriate allocation of resources to ensure quality and to not excessively micro-manage."
> —*Chris Jennings, White House aide*

Zeroing in on the *New York Times* article that brought to public attention HCFA's plan, Rodgers stated: "It would have been interesting if the headline of [Robert] Pear's article had been 'HCFA Gets Smart and Targets Resources on Bad Performing Facilities'."

"The overall goals of the changes to the SOM would allow surveyors to spend more time in facilities with problems," Rodgers said. "Surveyors would not spend one less hour in facilities they surveyed," he added, noting that the agency's proposed plan for surveying facilities reflects a turning away from a "one size fits all" survey philosophy.

"HCFA's proposed changes put blinders on surveyors, reducing their ability to detect problems during the survey process," counters Toby Edelman, lawyer at the National Senior Citizens Law Center and board member of the National Citizens Coalition for Nursing Home Reform. With less comprehensive reviews, surveyors would only be looking at just what they knew was a problem when they walked in, not what might actually be occurring, she said.

Eliminating the requirement that facilities provide surveyors copies of the written information provided to residents regarding their rights, the activity calendar, menus, the admission contract and accident reports, will further hinder surveyors from identifying residents' rights and quality of life issues, Edelman charged. Even without changes to the survey process surveyors do a poor job in identifying quality of life and resident rights problems in facilities, as a HCFA-sponsored study by Apt Associates found several years ago, she noted.

HCFA and White House Caught by Surprise

The intense backlash of releasing the proposed SOM changes caught HCFA by surprise. "We thought we were strengthening the enforcement process, not walking away from it," stated a HCFA official, noting that the memorandum only solicited information. The official quipped: "It was old news by the time it hit the *New York Times*."

HCFA's memorandum was never seen at senior levels of the Department of Health and Human

Continued on page 9