Voters demand health reform, not political grandstanding

by Herbert P. Weiss, writer specializing in aging and health care topics, Gaithersburg, MD.

Sen. Harris Wofford's (D-PA) victory over former U.S. Attorney General Dick Thornburgh in the Pennsylvania election sent a chilling message to the Bush administration — turn your attention to solving the nation's domestic ills or face a middle-class voter revolt that could catapult the Democratic party into the White House in 1992.

The special November election was held to fill a U.S. Senate vacancy caused by the unexpected death of Sen. John Heinz (R-PA). Pennsylvania Governor Robert Casey appointed Wofford, a former college president, state party leader, and Peace Corps cofounder, to temporarily fill the seat vacated by Heinz.

With a barrage of television commercials calling for national health care reform aired throughout the election, Wofford slashed Thornburgh's 44-point lead in the polls and won — becoming the state's first elected Democratic Senator in 29 years.

Even as a member of the Senate, Wofford succeeded in painting Thornburgh as "a Washington insider" and captured the anti-Washington vote. His populist message on trade policy, middle-class tax cuts, extended unemployment benefits and national health care reform struck a responsive chord with voters who feared losing their jobs and health insurance coverage.

Most importantly, Wofford continuously hammered in the point that 37 million Americans lack health insurance coverage without ever providing a detailed health care reform or financing plan. His win is considered by political observers as an important referendum of middle-class concern over the health care crisis.

White House shifts its strategy

Before Wofford's win, White House Chief of Staff John Sununu framed the health care reform issue as a "poisoned pill" in a White House meeting, according to a published report.

The Bush administration's strategy has focused on retaining a health care plan until after the 1992 election and allowing the Democrats to pass their own proposal, the report noted. This would enable the Republicans to attack the Democratic plan as "too expensive and intrusive," the report said.

Prediction: Congress will pursue incremental steps to health care reform. — Weiss

Many political observers predicted that Thornburgh's defeat in Pennsylvania now forces the Bush administration to offer a health care reform plan during the upcoming Congressional session rather than waiting until after the 1992 presidential election.

Final report due out

The Advisory Council on Social Security, an internal Health and Human Services task force, was concluding its review of more than 50 health-related proposals and was expected to release its final report at press time. Many of the report's recommendations will most likely be incorporated into the administration's health care reform package.

But don't expect the Bush administration to offer up comprehensive reform. In early September on "Meet the Press," Sununu warned viewers not to expect any "grandiose" plan. He noted, the White House plan will not be one to pour "hundreds and billions of dollars into a system structure that is currently not working well."

Trial balloons over Washington

As the debate on health care reform heats up, more than 30 proposals have been thrown into the legislative hopper.

While most health care reform proposals provide details on reshaping America's crumbling health care delivery system, many don't offer specifics on financing.

But with a growing federal budget deficit and a nation slowly finding its way out of an economic recession, don't expect strong support in 1992 for a reform proposal carrying a big price tag. Small steps may well lead to larger more comprehensive reforms at a later date. □

Outlook '94

Prediction: Credible research outcome studies will lend support to providers pushing for nursing facility reimbursement of unconventional medical therapies.

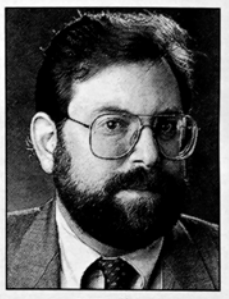
Alternative therapies offer new answers

by Herbert P. Weiss, health care writer

While Congress debates the merits of five major health care reform proposals, a less visible discussion is taking place between the National Institutes of Health and alternative therapy practitioners on the role of unconventional medical therapies in treating patients.

Recently, the institutes' Office of Alternative Medicine awarded $30,000 grants to mainstream research institutions to examine treatment outcomes of a variety of alternative medical practices — including imagery, prayer, Tai Chi, homeopathy, hypnosis, therapeutic touch, massage and macrobiotic diets.

The office's funding of outcomes research on alternative therapies in eight general fields will have a major influence on funding sources that might have once shied away from giving grants to non-traditional researchers, according to Lawrence H. Kushi, an assistant professor in the School of Public Health at the University of Minnesota and a grant recipient who will study the effect of microbiotic diets on cancer patients.



Weiss

"Hopefully, many of the studies will show some promise in providing objective information to support the need for substantial funding of more vigorous studies on alternative therapies," Kushi said.

Scientifically validated alternative medical therapies could have implications on who is considered a "legitimate" health care provider and what is reimbursable, according to Bernie Siegle, M.D., surgeon and acclaimed author of "Love, Medicine and Miracles."

Siegle said, "Massage is not even considered a health care profession in two-thirds of the states. But if studies show results, massage and touch will move into a new area and become a science and a health profession instead of always being associated with massage parlors."

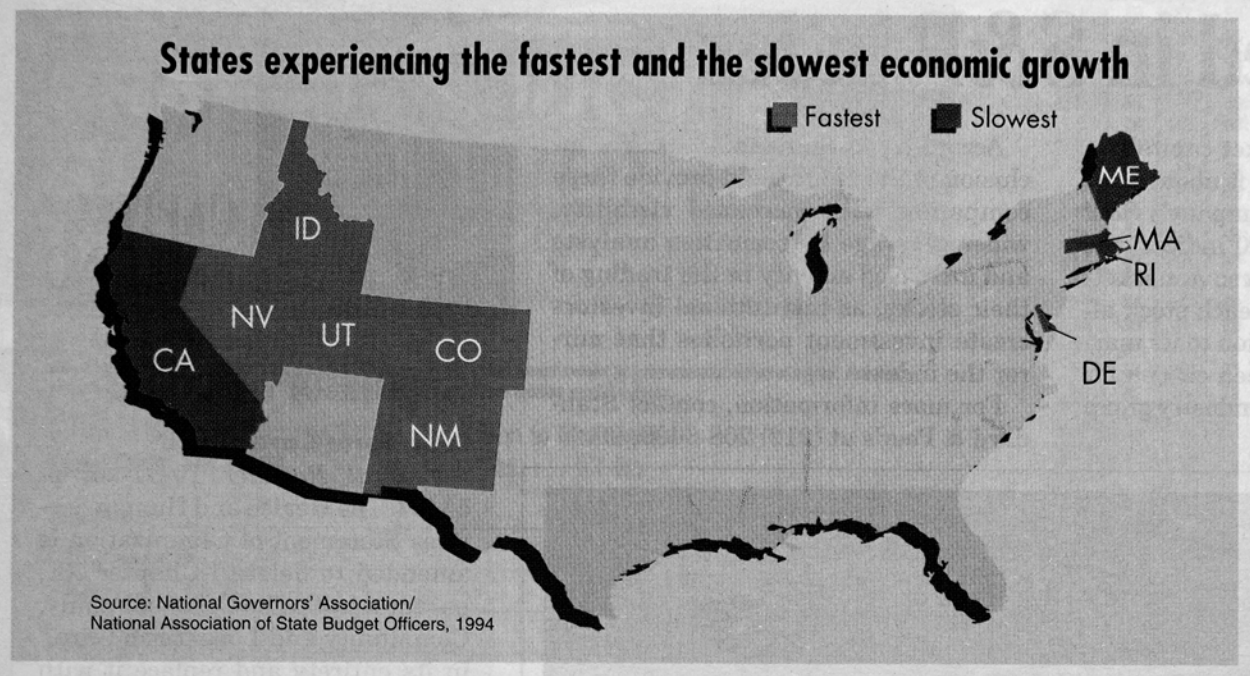
Although the institutes' research results won't be known until 1995, providers are finding alternative medical therapies effective in treating patients. For example, Milwaukee-based Carmel Health and Rehabilitation Center uses biofeedback along with other behavioral techniques for incontinence retaining.

The slow, concentrated movements of Tai Chi — a 250-year-old Chinese martial art — can be used as a range of motion exercise for patients with arthritis whose joints and bones can't take the jarring effects of other more vigorous forms of exercises, according to Sylvia Wilson, chief of physical therapy at St. Joseph Hospital in Providence, RI. Tai Chi reduces stiffness and helps to keep patients' joints flexible, she claimed.

And many providers renovating facilities are choosing interior color schemes with care and the knowledge that colors can be a psychotherapeutic aid to improving residents' emotional attitudes by stimulating and encouraging function.

A program that combines diet, meditation, exercise and support groups to reverse heart disease developed by Dean Ornish, M.D., the University of California at San Francisco, is believed to be the first alternative medical therapy to be covered by an insurance company, with the exception of chiropractic care.

In the coming years, credible research outcome studies will lend support to providers pushing for nursing facility reimbursement of unconventional medical therapies. These low-tech therapies can lower health care costs and improve the quality of care in facilities by allowing staff to treat the total person — the body, mind and spirit. ❍



Federal health bill shifts

Two unrelated reports on health care spending suggest a shift of financial burden from the federal government to the states. And given the new Republican Congress, perhaps this is only the beginning.

At the federal level, medical inflation dropped to its lowest level in seven years. Despite the slowdown, health care spending still rose 2.4 percentage points more than the overall economy, according to HCFA numbers.

Americans spent $884 billion on health care in 1993, a 7.8% increase over the previous year. Long-term care expenditures accounted for about $31 billion of the total.

"Compared to inflation, we're not doing that much better than we have been in the past," said Bruce Vladeck, Ph.D., HCFA administrator.

HCFA's report noted, "It remains unclear whether the moderation in health care spending growth is a temporary lull spurred by the threat of government intervention or the beginning of a long-term restructuring of the private health care system."

Growth tempered

At the state level, robust regional growth during fiscal 1994 helped states stabilize their budgets, according to a report jointly released by the National Governors' Association and the National Association of State Budget Officers.

But despite overall revenue growth, Medicaid continues to absorb an increasing share of state outlays. Medicaid grew from 10% of total state spending in 1987 to 18% by 1993, according to the report.

"States are staring down the barrel of some major spending pressures in the coming years," said Raymond C. Scheppach, executive director for the National Governors' Association.

To limit Medicaid outlays, states are increasingly turning to managed care programs while eliminating optional services.

The study noted that states are also taking advantage of an economic upturn to focus on strategic planning. Emerging statewide reviews, performance-based budgeting initiatives and Medicaid changes "indicate that states are viewing the [current] situation as an opportunity to improve management and restore balance to budgets," the report noted.

States limited their general budget growth to 5% in fiscal 1994 and to 4.9% for fiscal year 1995. The figure was about 8% during most of the '80s. ❍

Managed care puts Boren defense at risk

Providers ask HCFA to ensure protection from pay decreases

WASHINGTON — Long-term care industry representatives are pressing federal officials for assurances that they won't deny Boren Amendment protection to providers participating in Medicaid managed care programs.

Several provider organizations have asked the government to state that the amendment will remain relevant to all Medicaid programs, regardless of whether they are managed care programs.

"We believe the clear meaning of the statutory language is that [the Boren Amendment] applies in a managed care setting," said Dave Kyllo, press secretary for the American Health Care Association.

If payment rates from managed care organizations are too low, many providers that predominantly serve Medicaid and uninsured patients will not survive — and the quality of care will deteriorate, said Kyllo.

In November, HCFA promised to respond in the near future to industry concerns about possible threats to the Boren-Medicaid managed care link. HCFA is currently working on a proposed rule that may also address the issue.

Assurances

In an apparent attempt to appease industry concerns, HCFA Administrator Bruce Vladeck, Ph.D., recently said "the proposed rules will make it easier to administer Boren, not waive it."

However, some HCFA officials previously asserted that because Medicaid managed care relies on private-sector plans, payments are market-driven. In such a scenario, the Boren Amendment would not be necessary because providers could opt out of plans that offered inadequate reimbursement.

In a letter to HCFA, provider groups countered that states cannot legally delegate payment authority to another entity. "Where a state adopts a capitated payment system, the amendment implies that the state must assume some kind of oversight role of managed care organizations' rate setting for payment to hospitals, skilled nursing facilities and intermediate care facilities," stated the letter. ❍

Health care still on the agenda

Republicans gain their chance to run Congress

Outlook '95

Prediction: With the GOP controlling Congress, watch for Washington to place tighter limits on federal outlays.

by Herbert P. Weiss, health care writer, Providence, RI

For many Democrats with plans to find or keep Capitol Hill employment, 1994 became the year of living too dangerously.

When the votes were counted, Republicans had gained eight Senate seats and another 52 seats in the House, giving the GOP control in both chambers for the first time in nearly four decades.

House Speaker Tom Foley (D-WA) joined Ways and Means Chairman Dan Rostenkowski (D-IL) among the most notable Democratic casualties. The two stalwarts had spent a combined 66 years in Congress.

Similarly ignominious for Democrats was the defeat of Sen. Harris Wofford (D-PA). Wofford's previous campaign was generally viewed as a health care plebiscite and helped make reform a legitimate issue during the 103rd Congress.

Rep. Newt Gingrich (R-GA), 51, will become the next speaker of the House. And after an eight-year hiatus, Sen. Bob Dole (R-KS), 71, again becomes the Senate's majority leader.

In the committees with jurisdiction over Medicare and Medicaid, GOP leaders began to emerge at press time. In the Senate, Nancy Kassebaum (R-KS) was in line to replace Sen. Edward Kennedy (D-MA) at Labor and Human Resources. In the House, Bill Archer (R-TX) was in

See ***Congress*** ➢ *p. 11.*

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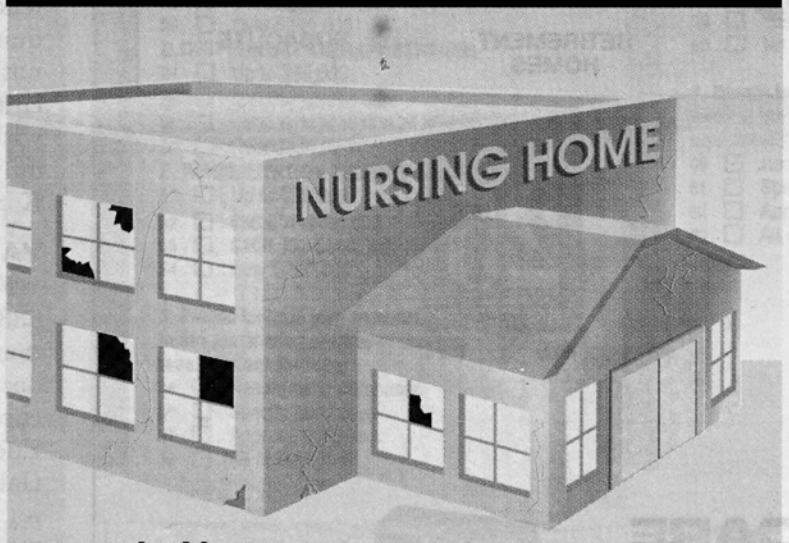


Aging buildings

Average age of plant measures the average accounting age of a nursing home's assets, such as buildings, fixtures and major movable equipment.

1990	6.84 years
1991	8.13 years
1992	8.68 years

Source: "Guide to the Nursing Home Industry," HCIA, 1994

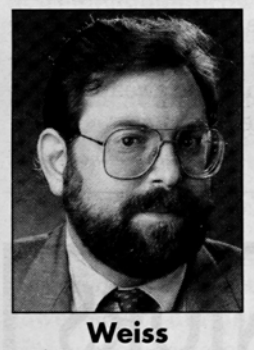
Congress

Continued from p. 3.

position to take control of Ways and Means, while Rep. Thomas Bliley (R-VA) had edged out Rep. Carlos Moorhead (R-CA) for chairmanship at Energy and Commerce.

Balancing act

When the 104th Congress convenes on Jan. 4, Gingrich will put in motion his plans to launch a House makeover that promises to be both aggressive and ambitious. The Georgia Republican said he intends to schedule votes on the "Contract with America" program during the first 100 days of Congress.



Weiss

The contract is a GOP wish list of legislative proposals, including a balanced budget amendment, increased defense spending, an end to unfunded federal mandates, limits on congressional terms and a package of tax breaks such as a reduction in the capital gains tax and the addition of long-term care tax incentives.

Aging advocates warn that the contract also contains hidden dangers.

"If you pass a balanced budget amendment, you can't make the numbers work unless you have either extremely large tax cuts or you slash Social Security, Medicare and Medicaid," said Joshua Wiener, senior fellow for the Brookings Institution, Washington.

Wiener added that Senate Republicans would probably want to use Medicare cuts for deficit reduction, while House Republicans would likely earmark the funds for tax cuts.

"Creating a balanced budget amendment will put enormous pressure on non-defense discretionary spending, like Section 202 Housing programs," said Michael F. Rodgers, senior vice president for the American Association of Homes and Services for the Aging. "We'll have to find new ways to use limited federal funds to enhance the financing of assisted housing for the elderly."

But according to Rodgers, the federal government has never allowed the comingling of Section 202 program funds with other funding sources.

"We're going to need to push [the Department of Housing and Urban Development] to find ways to use existing federal dollars to develop retirement housing communities," said Rodgers. This could be accomplished by combining state housing finance dollars, tax exempt bonds and Section 202 funding for low-income Section 202 housing, he added.

Republicans counter that a balanced budget amendment will not hurt older Americans, but will help the country lower the federal deficit.

"There are no references to Medicare or Medicaid cuts in the contract," said Tony Blankley, press secretary for Gingrich. Blankley told **McKnight's Long-Term Care News** that Democrats' claims about a balanced budget causing Medicare and Social Security cuts were lies. "The most prominent thing that the contract will do is to repeal a Social Security tax that was placed on middle- and upper-income recipients," he said.

States gain power

Congress will not be the only place where Republicans will get to exercise their newly found power. Republicans now claim 30 governors.

During a three-day meeting, congressional Republican leaders told GOP governors and governors-elect that the federal government is too big, too unresponsive and too costly. They called for a smaller federal government where power would move from Capitol Hill to states. Many of the governors seemed willing to trade funding reductions for more autonomy.

As Medicaid budgets grow and states feel pressure to cut outlays, Republican governors will likely follow the lead of previous Democratic governors and look for ways to circumvent or eliminate the Boren Amendment, said David Kyllo, press secretary for the American Health Care Association. "We'll fight hard to keep it from happening because [Boren] is a reasonable public policy," Kyllo said.

Merit Kimball, spokesperson for the Alliance for Health Reform, Washington, said that with most governors being Republican, "there will be even more attention being paid to Medicaid managed care initiatives."

Blankley predicted that Congress will again take up the health care debate early in the year. But scope and breadth of such reform will be reined in. ❍

Subacute care stocks a good buy: Dean Witter

NEW YORK — Well-managed subacute care will remain an attractive investment in 1995, according to several reports from Dean Witter Reynolds.

Favorable demographic trends, better reimbursement, industry consolidation and the expansion of ancillary and subacute care services will aid industry growth in coming years, the investment firm predicted. Within these trends, the developing subacute market will offer the long-term care industry one of its best growth vehicles in recent years, according to Todd Richter, an analyst with the firm.

Subacute care is likely to enhance revenues, expand margins and return on investments, accelerate earnings, expand referral sources and increase managed care firm interest in facilities, Richter said.

Defining subacute

Dean Witter defined subacute services as those that "facilitate the recovery from an injury, illness or disease over and above regular maintenance requirements." The report included such services as infusion therapy, ventilator services, respiratory care, cardiac services, tracheotomy care, dialysis, wound care, specialized rehabilitation therapies, post-operative recovery programs for hip replacement, spinal cord injuries and other potentially rehabilitative injuries or diseases including AIDS.

But Richter warned that subacute will not be a risk-free venture for providers or investors. For example, subacute care carries higher labor costs and greater price competition among multiple competitors.

Richter added that market capitalization remains relatively small and said rising acquisition prices could lead to earnings disappointments. At the same time, greater numbers of payers may create reimbursement risks, and exceptions to routine cost limits could make receivables collection, cash flow and reserve levels less predictable.

▲ Bullish on subacute providers

Company	Advice	Change
The Hillhaven Corp.	Buy	Up
Integrated Health Services	Accumulate	Up
GranCare Inc.	Buy	Same
Health Care & Retirement Corp.	Accumulate	Same
Horizon Healthcare Corp.	Accumulate	Same
Manor Care Inc.	Accumulate	Same
Beverly Enterprises	Neutral	Down

Source: Dean Witter Reynolds, 1994

Rating the players

Dean Witter suggested that investors accumulate or buy stock in all but one of seven long-term care companies delivering subacute care.

However the investment firm downgraded its recommendation for Beverly Enterprises, from "accumulate" to "neutral." Analysts there recommended below-average operating margins at the Fort Smith, AR, company, along with "somewhat lower returns on shareholders' equity and on invested capital relative to our favored names in the group."

Conversely, Dean Witter upgraded its investment opinion of The Hillhaven Corp. stock, from "accumulate" to "buy." The investment firm based its recommendation on strong performances by Hillhaven's subacute, rehabilitation and pharmacy operations.

Dean Witter also increased its rating of Integrated Health Services from "neutral" to "accumulate." Integrated's leadership role in subacute care services, a post-acute spectrum of care and a favorable new HCFA policy on routine cost-limit exceptions should all help the company, analysts found.

Dean Witter also advised investors to buy GranCare Inc. and to accumulate Health Care & Retirement Corp., Horizon Healthcare Corp. and Manor Care. ❍

SEIU targets multifacility operators

For operators trying to limit labor costs, the new year has arrived with mixed news.

Long-term care operators are likely to benefit from a newly elected, pro-business Congress. But at the same time, the nation's fastest-growing union has just launched one of its most ambitious organizing campaigns ever.

Proclaiming 1995 as "the year of the nursing home worker," the Service Employees International Union (SEIU) has already targeted the nation's largest multifacility providers.

The union, which gained 14,000 home care workers in the last four months of 1994, hopes to transfer that success to the nursing home industry. "We haven't named an absolute figure as our goal, but obviously we'd like to see hundreds of thousands of new members," said Ray Abernathy, media representative for the union.

California dreaming?

California appears to be ground zero in the union's latest recruitment drive. In fact, the union is conducting an organizing drive at 15 non-union Hillhaven Corp. facilities, said Michael Perri, the union's California nursing home coordinator.

See ***SEIU*** *➢ p. 15.*

Fate of Section 202 uncertain

HUD survival plan puts LTC programs at risk

by Herbert P. Weiss

In late December, the Department of Housing and Urban Development (HUD) announced plans to pare 60 programs down to three. At press time, the department still had not decided the fate of the Section 202 program.

At issue for HUD officials was whether to keep one of the department's most popular and successful programs independent or to convert it into another block grant program.

The decision could determine long-term prospects for the 202 program for affordable housing for low-income elderly, according to Larry McNickle, director of housing policy for the American Association of Homes and Services for the Aging, Washington. McNickle said that if the 202 program loses its independent status, "funding could end up lost in the shuffle with other competing local priorities."

HUD's master plan would consolidate current department grants for housing production and rehabilitation into a single affordable housing fund that would include housing for the elderly and people with disabilities.

The new Affordable Housing Fund would set up flexible funding so that cities and states could develop, acquire and rehabilitate housing for the needy. Whether the housing would be shared by both groups was still under discussion at press time.

'I think we can do a better job of dealing with the real human needs throughout the country by eliminating the bureaucracy.'

According to HUD, restructure plans will not affect the new Section 232 mortgage insurance program for refinancing or purchasing existing nursing homes, intermediate care or assisted living facilities. The restructure will allow the Federal Housing Authority to operate more like a private corporation.

Major overhaul

HUD secretary Henry Cisneros announced HUD's downsizing in mid-December. The Clinton administration had considered eliminating both HUD and the Department of Energy, but instead settled for dramatic cuts at both departments.

President Clinton announced

See ***Survival plan*** *➢ p. 14.*

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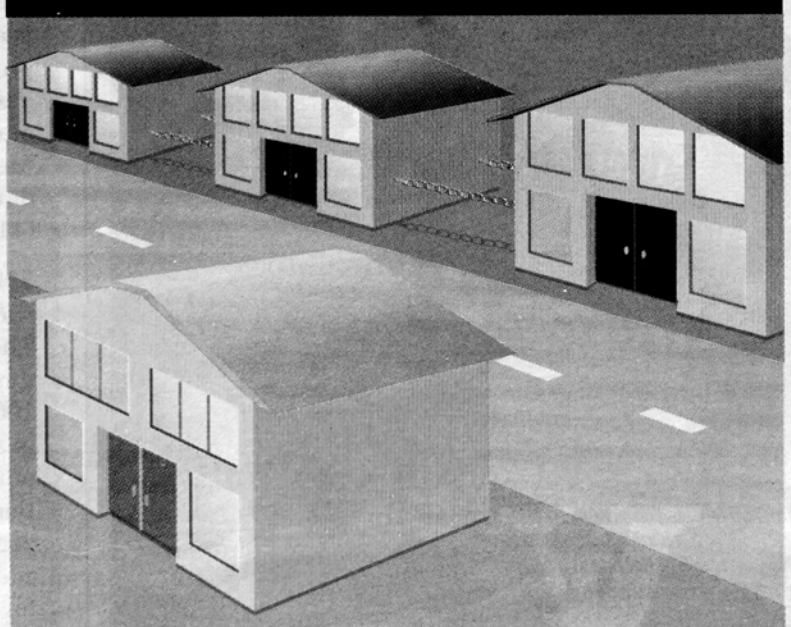


To be owned, or not to be owned

Nursing home ownership	No. of facilities	% of total
Chain-operated	6,163	41%
Independent	8,979	59%
Total	15,142	100%

Source: SMG Marketing Group Inc., 1994

Capital

Continued from p. 1.

looking to secure capital for facility upgrades or additions. At the same time, there appears to be a robust market for capital to refinance existing debt. Funding for new acquisitions ranked a distant third in the fax poll.

According to several industry experts, the findings should not come as a surprise. For more than a year, facility operators have been reading and hearing about how to position themselves for change. Improving operations, adding ancillary services or developing special care units are natural ways to prepare for marketplace changes, said Dave Kyllo, press secretary, American Health Care Association, Washington.

At the same time, facilities are taking advantage of historically low interest rates to reduce debt. For example, The Hillhaven Corp., Tacoma, WA, used such a strategy to refinance about $500 million in debt, according to Scott Mackesy, an analyst with Dean Witter Reynolds, New York.

Despite the widening array of financing options available, banks continue to be the preferred funding vehicle for long-term care providers seeking capital.

"Banks are still where most operators turn to first," said Jeffrey A. Davis, president of Cambridge Realty Capital, Chicago.

Banks accounted for nearly 40% of the loans made to the long-term care industry last year, according to a lender and investment survey conducted by the National Investment Conference (NIC), Annapolis, MD. Mortgage bankers financed nearly 19% of loans, and insurers funded about 13% of long-term care facility loans.

This could be the best year ever for facilities looking to gain capital. The only possible drawback might be increasing interest rates.

— Monroe

"There is considerable lending activity underway, and the trend is increasing," said Anthony J. Mullen, committee chairman for NIC Research Projects, Annapolis, MD. Mullen said he expects lending volume in long-term care and the senior living industry to increase by more than two-thirds between 1994 and 1995.

And he is not alone in his optimism.

"This could be the best year ever for facilities looking to gain capital," said Stephen Monroe, partner, Irving Levin Associates Inc., Stamford, CT. Monroe added that the only possible drawback might be increasing interest rates.

The Federal Reserve Board has raised the prime rate several times throughout 1994 in an attempt to limit inflation. However, the Fed did not raise the rate after meeting in December — a move that industry analysts see as a promising sign.

However, the Labor Department announced in January that its producer price index rose by 1.7% in 1994, the largest advance in four years.

The figure appears to document continuing upward price pressures. The trend led the Federal Reserve Board to raise interest rates six times last year. Many economists believe the board could take similar action again by February.

While a new GOP controlled Congress is expected to promote a more pro-business climate, the news is even better at the state level, where 32 Republican governors now reside. According to several state nursing home association executives, having a Republican governor may fuel industry growth. ❍

Survival plan

Continued from p. 3.

that he would reduce unnecessary federal programs to pay for a promised middle-class tax break. The move was also part of an orchestrated effort to preempt plans by congressional Republicans to downsize the federal government.

To meet the president's mandate, Cisneros announced that HUD would convert scores of programs into "mega-block" grant programs to be managed by local communities. The new scaled-down system would loosen bureaucratic control, according to HUD.

"I think we can do a better job of dealing with the real human needs throughout the country by eliminating the bureaucracy," Cisneros said.

HUD officials said they hope the changes will help convince Clinton and voters that the agency still has a purpose as new Republican leaders consider dismantling the agency to save money.

Cisneros added that HUD intends to give public housing residents the option of moving into affordable private-sector housing by providing vouchers.

According to a HUD official, budget details are being worked out between the agency and the Office of Management and Budget. ❍

Hospice executives earn $45,600 a year

The average executive director of a hospice program earns $45,600 annually, according to the "1994-1995 Hospice Salary and Benefits Report" published by Hospital and Healthcare Compensation Service, Oakland, NJ.

The national median salary, however, varies by ownership. For example, executives in free-standing hospices earn on average $44,720. Those in hospital-based hospices earn about $51,387. And home health hospice executives earn $45,000 on average.

The 260-page report may be purchased for $195 by contacting Hospital and Healthcare Compensation Service, Box 376, Oakland, NJ 07436, (201) 405-0075. ❍

Consumer attitudes about health studied

The Agency for Health Care Policy and Research awarded a $300,000 contract to the Research Triangle Institute of Research Triangle, NC, to develop a questionnaire and to collect consumer data about attitudes regarding access to health care, use of specific health services, health outcomes, perceived quality of care and satisfaction with care received.

The questionnaire will be developed with substantial input from other public- and private-sector organizations, including the Consumer Satisfaction Consortium organized by the Group Health Association of America. The consortium includes consumer groups, health care practitioners, business, insurance firms, accreditation agencies and government. ❍

'Contract with America'

Long-term care provisions gain congressional support

WASHINGTON — During hearings, the House of Representatives warmly welcomed "Contract with America" provisions to liberalize insurance coverage, to provide caregiver tax breaks and to establish individual retirement accounts for long-term care.

Testifying before the Ways and Means Committee's health subcommittee, Steve Chies, legislative committee chairman for the American Health Care Association, endorsed expanded long-term care insurance coverage as a way to relieve the Medicaid system. "Legislation to clarify the federal tax treatment of long-term care insurance will help establish a significant role for private insurance in financing long-term care," he said.

According to Chies, private insurance pays less than 2% of the nation's long-term care bill. Medicaid and private funds account for most of the funding, he said.

Republican proposals would expand the role of private insurance through several measures, including making private long-term care insurance tax-deductible, declaring employer-paid long-term care coverage as a tax-free benefit, eliminating taxation of pension withdrawals for people 59.5 and older to purchase long-term care insurance and allowing tax-free advance death benefits from life insurance policies to pay for long-term care.

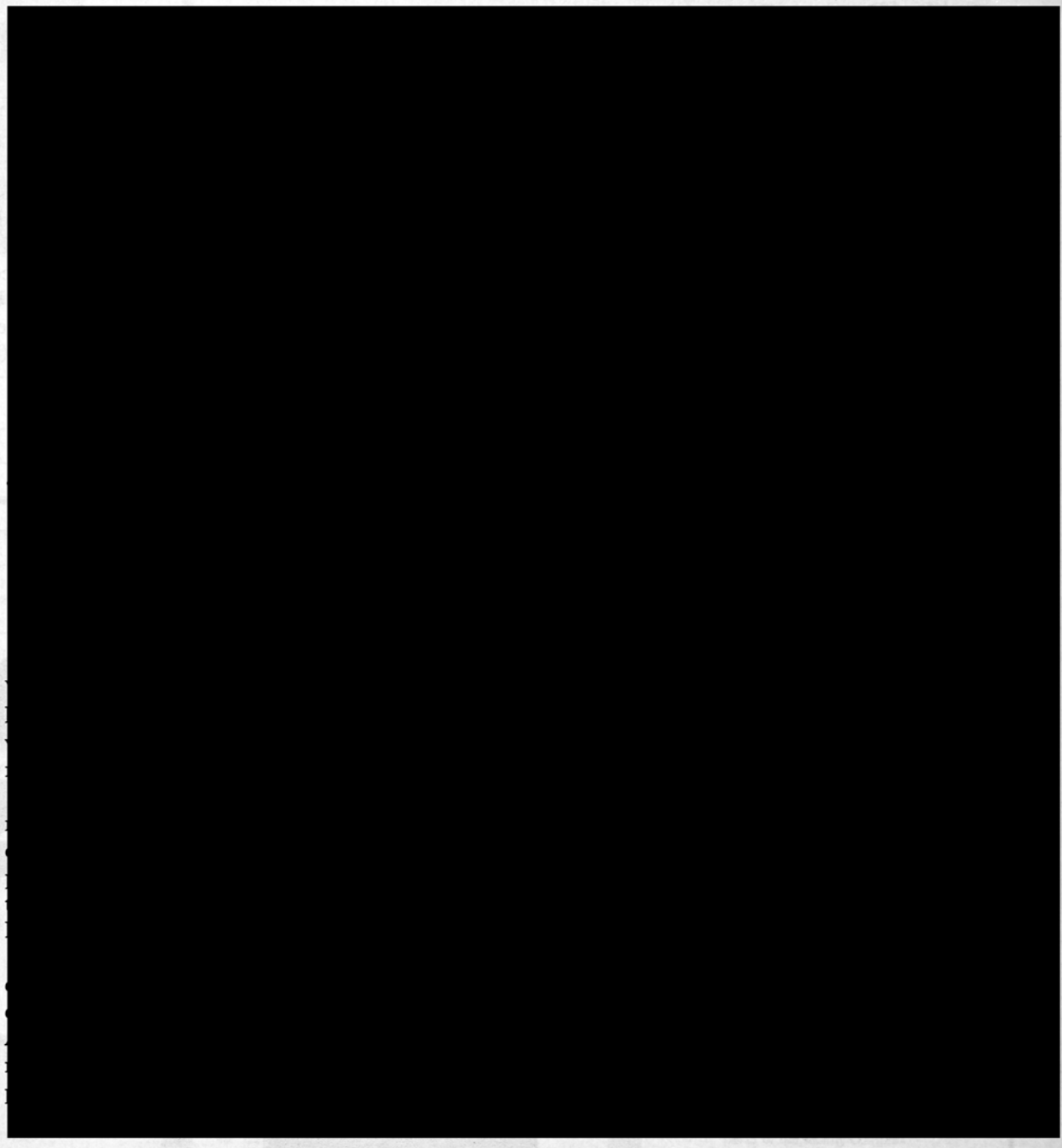
Chies also urged the subcommittee to establish long-term care insurance standards and consumer protections and to remove

*See **LTC provisions** ➤ p. 24.*

▲ AHCA's wish list for LTC provisions

- ➤ Establish federal standards and consumer protections for long-term care insurance that would inspired consumer confidence and foster growth of the market.
- ➤ Create a public awareness program that educates seniors and their families of the likelihood of needing long-term care and the limits of public financing and provide information on choosing long-term care insurance policies.
- ➤ Remove federal barriers to states' ability to create public/private partnerships that allow consumers to protect assets up to the amount of long-term care protections.
- ➤ Add a targeted tax credit for the purchase of long-term care insurance.

Source: American Health Care Association, 1995



Associations seek viability

by Herbert P. Weiss

WASHINGTON — Like the industry they serve, nursing home associations are trying to stay alive.

According to officials from three of the industry's largest associations, providers are grappling with increased competition and possible linkages. And as providers' roles change, so too do their expectations.

In an attempt to meet those expectations, associations are looking to provide new services that will help members thrive in a new health care environment. The result has been change among the associations ranging from the sublime to the revolutionary.

The American Association of Homes and Services for the Aging, for example, added "and Services" to its moniker last year largely to acknowledge expanding activities among its 5,000 members. The expanded name recognizes growing membership involvement in assisted living, subacute care, day care and home health care, according to Sheldon L. Goldberg, president of the association.

Goldberg predicted that nonprofits will need to further develop partnerships and alliances to compete in the changing marketplace. "We will be looking for ways to create networking opportunities for our members with pharmacies and rehabilitation providers," he said.

New construction

The AAHSA's board is also considering other changes that could dramatically change the group's look, as well as the way it operates.

At press time, the board was about to approve a measure that

'We're doing everything we can to educate our members about the industry's diversification.' — Dave Kyllo

will allow the association to develop assisted living facilities.

Under the proposal, the association will assume 80% ownership of the new subsidiary. If approved as expected, the association will hire development staff to work with large for-profit construction companies throughout the nation.

Another proposal the association is considering would allow the association to bring for-profit organizations under its wing. While serious discussion had just begun at deadline on the possible ideological shift, several state affiliates have already taken action. Currently, two state affiliates allow for-profits to attain full membership privileges. An-

*See **Associations** ➤ p. 20.*

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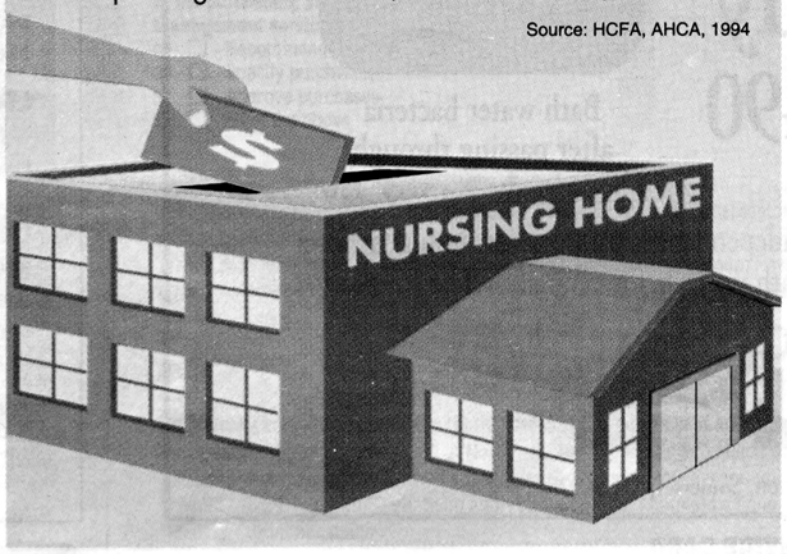
Who's paying for U.S. nursing home care?

	1993	1991
Medicaid	52%	48%
Medicare	9%	4%
Out-of-pocket payment	33%	42%
Private health insurance	2%	1%
Other government programs	4%	4%
Total spending	$69.6 billion	$59.5 billion

Source: HCFA, AHCA, 1994



Associations

Continued from p. 3.

other 13 state affiliates offer for-profit facilities a reduced membership status, according to Goldberg.

Technological fix

The American College of Health Care Administrators has turned to new communications technology in an effort to better serve its members. College leaders see two benefits of offering new technology: enhanced networking among the association's 6,500 members as well as quick distribution of new developments.

For example, more than 300 administrators currently ride the information highway via the association's on-line computer service, said Dick Thorpe, executive vice president of the group. "The on-line forum lets members exchange ideas, retrieve bulletin board information regarding professional issues or receive specific guidance on how to respond to a survey," Thorpe said.

The association has also begun using a broadcast fax service for member alerts. And the association's fax-on-demand capabilities allow administrators to receive issue-specific information.

Quality time

The American Health Care Association recently launched a major initiative aimed at bringing total quality management principles to its 11,000 member nursing homes and assisted living facilities. The association has already hired additional staff to help administrators incorporate total quality management principles into facility operations, said Dave Kyllo, press secretary.

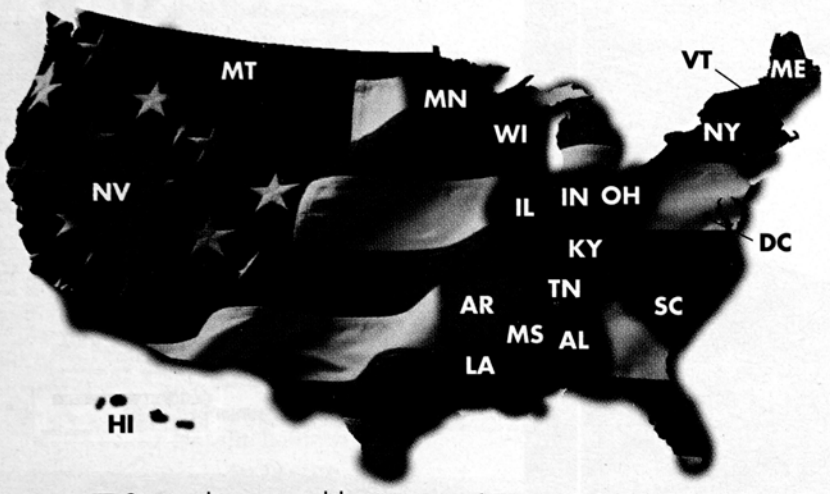
Kyllo said ongoing data feedback based on specific quality indicators will be a powerful tool for administrators. Such information will let providers rank facility performance compared with other facilities locally and nationally.

The association also recently published two manuals to help members enter the managed care environment. At the same time, the group is also helping members deal with more global issues, such as new opportunities, regulatory developments and other emerging trends.

"We are doing everything we can to inform and educate our membership about the industry's diversification," Kyllo said. ❍

▼ Hit List

HCFA is cracking down on states that continue to use provider taxes and dontions to enhance federal Medicaid payments



Source: HCFA, 1995

Medicaid taxes, donations eyed

WASHINGTON — Eighteen states and the District of Columbia may have illegally obtained up to $3 billion in Medicaid matching funds, according to the federal government.

HCFA Administrator Bruce Vladeck, Ph.D., said these states ignored a 1991 law prohibiting future provider tax and donation programs used to enhance federal Medicaid payments.

Vladeck said states levied the taxes on nursing facilities and other providers, only to return the funds in the form of Medicaid payments.

"There is still a lot of fine-tuning going on about what states can and cannot do regarding the provider tax and contribution law," said Diane Fogle, senior research analyst for the American Public Welfare Association, Washington. To address ambiguity, HCFA has stepped up efforts to provide additional information and clarify program requirements in recent months.

A HCFA official said that despite state irregularities, the government is less interested in recouping funds than in eliminating recurring problems.

In fact, about half of the states cited as being in violation of the law may be eligible for a waiver that would exempt them from repaying such funds. These states include Indiana, Kentucky, Minnesota, Mississippi, Montana, Ohio, South Carolina, Vermont and Wisconsin as well

*See **Medicaid** ➢ p. 32.*

Data collection to improve

HCFA releases MDS 2.0

by Herbert P. Weiss

BALTIMORE — Representatives of nursing home and consumer groups gave a four-star rating to HCFA's latest draft version of the minimum data set (MDS).

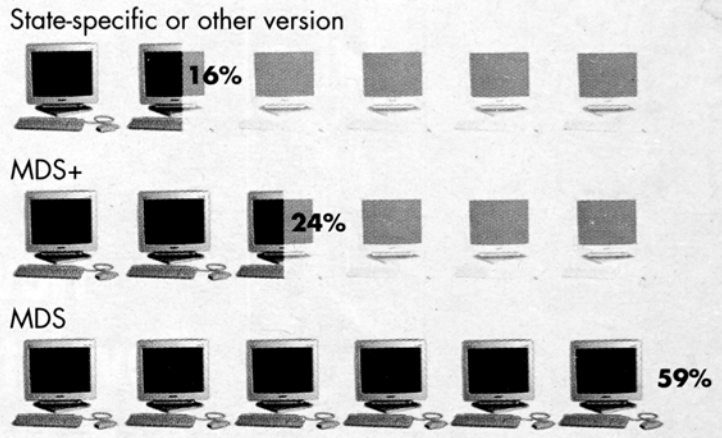
The agency unveiled its final draft of the long-awaited resident assessment tool before more than 150 attendees of a three-day training session held here in February.

HCFA was expected to officially publish the final MDS 2.0 in the state operations manual in late March after incorporating comments gathered at the meeting, according to a HCFA official responsible for MDS implementation. By Jan. 1, 1996, states must use the 2.0 version, unless HCFA grants an extension. Facilities will then be required to use the assessment tool for new admissions, annual assessments, quarterly reviews and documentation of significant changes in resident health status.

The HCFA official told **McKnight's Long-Term Care News** that MDS 2.0 will be the foundation for the agency's plan for a data-driven survey process that targets potential care problems and focuses survey activity.

HCFA said it plans to release a second edition of the resident assessment instrument training manual by August, along with videos and train-the-trainer packages.

▲ Fully 62% of facilities have automated the resident assessment process. What are they using?



Source: American Health Care Association, 1995

A makeover

HCFA developed the revised assessment instrument by taking

*See **MDS 2.0** ➢ p. 23.*

VA launches needs assessment on subacute care for veterans

WASHINGTON — Thousands of veterans could be transferred from hospitals to long-term care facilities that offer subacute care, pending results of a recently launched Department of Veterans Affairs (VA) study.

The investigation could lead to subacute services being contracted to outside skilled nursing facilities or to the VA using its own subacute resources more extensively.

"We are pleased that the VA acted so quickly to conduct this study so that [it] can also take advantage of the cost savings that a subacute program can offer," said Dave Kyllo, press secretary for the American Health Care Association, Washington.

The investigation is aimed at determining the need, availability and cost of subacute services for eligible veterans. Researchers are expected to focus on:

- the amount and cost of subacute care currently provided at VA medical centers;
- the degree to which subacute care could be appropriately provided in community nursing homes and the projected cost;
- the degree to which subacute care could appropriately be provided in other non-acute VA units and the projected cost; and
- potential opportunities or obstacles to providing subacute care in non-hospital settings.

Good timing

"This study is especially important because Congress is looking for ways to cut programs and save money," Kyllo said. He added that subacute care could offer the VA cost reductions without sacrificing service quality.

The VA has recruited 10 subacute care experts as a consensus panel to define subacute care and the associated resources required. The study will also help program managers develop long-term strategies to address future subacute care needs.

'This study is especially important because Congress is looking for ways to cut programs and save money.'

However, veterans, their families and some VA staff could pose a potential obstacle. That's because they may view veterans-sponsored health care in a nearby setting as a right. Such groups could oppose measures requiring patients to move to less expensive settings that are not located on nearby military grounds.

"Although issues such as this will not be quantifiable, they will be discussed as matter for which there is a need for sensitivity," a VA study proposal noted.

The report, which was requested by Congress, is due for release in October. ❍

DEPARTMENT INDEX

LTC NEWS DATABANK

Managing to make a buck

Average CEO total compensation (salary, bonus)

Home health management company	$245,838
Nursing home management company	$288,241
Hospital management company	$375,601

Source: "Management Company Report," Hospital & Healthcare Compensation Service, 1995

MDS 2.0

Continued from p. 3.

into consideration about 150 comments on the proposed MDS rule, information from long-term care industry experts and field testing at 30 nursing homes, the HCFA official noted.

Revisions include an addition to the MDS and almost twice as many quarterly review items. In addition, HCFA rewrote the "mood state" section of MDS 2.0 to ensure usefulness and reliability for clinicians. The revised assessment instrument also requests clinical information on pain, balance, treatments and rehabilitation.

HCFA said it plans to add and revise resident assessment protocols to address the needs of the short-term stay population. The agency also said it expects the first new resident assessment protocol to have a "discharge potential," with additional protocols to include pain management, terminal care and bowel incontinence.

"It is a very well-tested and well-thought-out instrument that provides wonderful information for care planning," said Sarah Burger, policy and program associate for the National Citizens' Coalition for Nursing Home Reform, Washington.

Dave Kyllo, press secretary for the American Health Care Association, Washington, called the latest draft "a great improvement over the first version of MDS."

HCFA said it expects to publish the final rule requiring facilities to encode and transmit the MDS 2.0 to a central repository in late 1995 with implementation in 1996.

Results from a survey conducted by the American Health Care Association have shown that about 62% of the providers have already computerized their resident assessment process. For most providers, that means that the MDS or MDS+ is computerized, with some automating other versions of resident assessment. ❍

Herbert P. Weiss is a Providence, RI-based free-lance writer who covers health care and aging issues.

Continued from previous page.

program's "highly centralized bureaucratic structure offering one menu for everybody in a monopolistic manner is the opposite of how America works."

Other GOP lawmakers appear ready to promote managed care as a way to cut Medicare outlays. Currently, 90% of all Medicare recipients currently use fee-for-service health plans.

At a mid-February House Ways and Means health subcommittee hearing, Chairman Bill Thomas (R-CA) said he plans to introduce a "medi-check" proposal that would give Medicare beneficiaries vouchers they could use to enroll in private plans, possibly to include social health maintenance organizations that deliver long-term care services.

"A prospective payment system could be used as one component in a larger congressional attempt to change Medicare," noted Dave Kyllo, press secretary for the American Health Care Association.

And at the same time that Medicare may enlist managed care's services, managed care is increasingly expanding into long-term care. For example, in mid-February, the Robert Wood Johnson Foundation, Princeton, NJ, awarded $2.5 million to nine providers to enhance health services for chronically ill patients cared for in health maintenance organizations.

"[These groups] will have the opportunity to develop innovative programs to care for the elderly and those with chronic diseases," said Lewis Sandy, M.D., foundation vice president.

All for the better?

As Medicare, managed care and prospective payment take preliminary steps into new directions, some experts are wondering whether these evolving changes will actually benefit the nation's health care system.

For example, when prospective payment was introduced into acute care, many hospitals responded to quality regulations by creating parallel utilization review staffs. As money previously spent on patient care was shifted to administration, the net result was a reduction in health care rather than a reduction in care costs, said Elizabeth Olmsted Teisberg, Ph.D., associate professor for the Harvard Business School, Boston.

Moreover, the emerging trend to pool customers and providers could create bilateral monopolies with little incentive for innovation, Teisberg warned. "Rather than managed competition, reform must foster rigorous competition among providers and among payers to deliver value to customers," Teisberg said. ❍

Conference delegates warn against entitlement cuts

by Herbert P. Weiss

WASHINGTON — The 2,200 delegates attending the 1995 White House Conference on Aging sent a clear message to the administration and Congress: don't gut entitlement programs that serve the elderly.

Delegates overwhelmingly supported resolutions aimed at enhancing or protecting programs such as Social Security, the Older Americans Act, Medicaid and Medicare. Delegates also called for universal health care coverage and expanded home and community-based services.

Although delegates overall called for expansions, the issue of cost didn't go unnoticed. Republicans and conservative seniors groups charged that the final resolutions would be too costly to implement — especially at a time when federal spending is under unprecedented scrutiny. But Sen. David Pryor (D-AR), conference policy committee chairman, disagreed, noting that approved resolutions would not add new programs or create any new bureaucracies.

While the 50 resolutions formally approved by the conclusion of the conference are not legally binding, they represent priorities among older Americans, said Robert B. Blancato, executive director of the conference. Blancato predicted that the final conference report will be forwarded to President Clinton and Congress early next year.

Block and blue

Consumer and industry groups generally praised the conference.

Despite the unexpected defeat of a resolution calling for full OBRA '87 enforcement, the National Citizens Coalition for Nursing Home Reform called the event extremely successful.

"The conference came out with some very progressive resolutions that will have an impact on care provided to people in nursing homes," said Elma Holder, executive director of the coalition. Holder noted that several resolutions strongly support advocacy functions in the Older Americans Act, specifically the importance and need for the nation's ombudsman program.

Holder added that endorsed resolutions opposing Medicaid block grants were important to consumer advocates. "If the Medicaid program is weakened through block granting, it would be a threat to the implementation of the nursing home reform law," Holder said.

Provider groups joined the coalition in endorsing conference recommendations, particularly those that opposed Medicaid block grants.

Michael F. Rodgers, senior vice president for the American Association of Homes and Services for the Aging, said his organization is concerned that the elderly might be shortchanged under a block grant system. "We're fearful that the elderly may lose out significantly as program dollars are reallocated to other categories," Rodgers said.

"From our point of view, we accomplished our goals," said Dave Kyllo, press secretary for the American Health Care Association. He noted that the association had strongly supported resolutions opposing block grants and the financing of long-term care, as well as a resolution that called for long-term care to be recognized as a health care program rather than welfare program. ❍

Herbert P. Weiss is a Providence, RI-based writer who covers health care aging issues.

A sampling of White House Conference on Aging resolutions

- Keep Social Security sound
- Preserve the Older Americans Act
- Preserve the nature of Medicaid
- Increase funding for Alzheimer's disease research
- Ensure the availability of a broad spectrum of services
- Finance and provide long-term care and services
- Acknowledge the contribution of older volunteers

Source: White House Conference on Aging, 1995

Breakdown ahead for mental health coverage?

'96 OUTLOOK

Prediction: Public funding for mental health programs will likely decline in 1996.

by Herbert P. Weiss, health care writer, Providence, RI

Weiss

Congressional plans to cut Medicare and Medicaid outlays will unfairly target mental health funding for nursing home residents, according to mental health advocates. Ironically, the proposed reductions come at a time when we are learning more about how to make mental health funding more effective.

A report titled "Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care for Nursing Home Residents" will be released later this month. The study calls for federal policy changes in areas such as financing, reimbursement, treatment and practice, service delivery and quality management.

Specifically, the report calls for additional funding for research and staff training, as well as consumer education initiatives that would reduce barriers to providing mental health care to nursing home residents. It will also recommend:

- Improving Medicare and Medicaid reimbursement for mental health liaison services.
- Unbundling mental health services from nursing home per diem rates.
- Implementing all OBRA '87 and OBRA '89 mandates.
- Increasing the percentage of mental health services paid for by Medicare and other federal and private insurance to match that paid for by other medical services.

The report further recommends that reimbursement incentives be redirected to recognize behavioral methods and to de-emphasize medication-only treatments.

Bucks stop here

Given the current climate in Washington, additional funds are unlikely to be seen any time soon, said Nancy Emerson Lombardo, Ph.D., principle organizer of a conference upon which the report is based. The two-day conference brought together more than 130 mental health and aging experts.

But according to Lombardo, facilities can take steps to improve mental health services for their residents. "Facility in-service training budgets could easily be used to bring in experts to teach staff how to care for residents with mental illness or behavioral problems," she said.

In addition, nursing home administrators should encourage staff to learn more about meeting residents' mental health needs, according to Lombardo. "Every person should attend training on mental and behavioral issues," she said.

Continuing problem

That nursing home residents need adequate mental health services is a well-documented issue.

A 1982 Government Accounting Office report concluded that mentally ill residents who are left undiagnosed and untreated face "limited prospects for improvement."

As a result, their conditions "may decline more rapidly and ultimately place greater demands on the health care system."

According to many mental health experts, funding cuts approved by the current Congress would lead to similar consequences. ❍

Anti-fraud pilot project rakes in millions

Where has the government's anti-fraud pilot program been established?

- California
- Florida
- Illinois
- New York
- Texas

Source: Department of Health and Human Services, 1996

by Herbert P. Weiss

A five-state Medicaid and Medicare fraud pilot program recovered $42.3 million during its first year, according to Department of Health and Human Services figures.

"This constitutes a $10 return for every $1 spent on the project," said Donna Shalala, Ph.D., the department's secretary.

The anti-fraud initiative targets home health agencies, nursing homes and durable medical equipment supply companies that receive Medicaid and Medicare reimbursement.

Besides monetary recoveries, Operation Restore Trust has also yielded 35 criminal convictions and 18 civil convictions, according to Judy Holtz, an investigator for the Department of Health and Human Services' Office of Inspector General.

Holtz said that nursing homes were connected to 11 of the 35 criminal convictions. In addition, nearly half of the people and corporations barred from the Medicare or Medicaid programs were connected to nursing homes, Holtz said.

In one case, a Sacramento, CA-based geriatric specialist pled guilty to all charges in a 38-count

See ***Anti-fraud*** ➢ *p. 17.*

Research fellow

Q&A: Clifton R. Gaus

Name: Clifton R. Gaus, Sc.D.

Job: Gaus is administrator for the Agency for Health Care Policy and Research, Rockville, MD.

Gaus is directing the agency's shift away from developing clinical practice guidelines. In its new role, the agency will act as a partner with long-term care providers and other health professionals. Gaus has a diverse health care policy and research background. He has previously served in senior health positions under Presidents Nixon, Ford and Carter.

During the past six years, the government's Agency for Health Care Policy and Research has investigated new ways to improve medical care quality, reduce care costs and broaden access to health services.

The agency recently announced that it would curtail one of its hallmark activities: developing clinical practice guidelines.

Administrator Clifton R. Gaus, Sc.D., recently spoke with ***McKnight's Long-Term Care NEWS*** *about the agency's evolving role as a research partner.*

McKnight's LTC NEWS: Why will the agency no longer develop clinical practice guidelines?

Gaus: We're restructuring the program to meet our customers' stated needs.

We have done extensive consultation with guideline users, including states, managed care organizations and clinical societies. They have told us they would prefer to formulate clinical policy recommendations, based on the scientific findings that we uncover.

We feel this approach will increase how well clinical practice guidelines are adopted and allow us to use our limited resources to develop a broader science base.

McKnight's LTC NEWS: What are some of the leading nursing home quality issues your agency will focus its research efforts on?

Gaus: We have several initiatives underway that touch upon long-term care and the nursing home industry.

For example, one project we recently funded will evaluate how well our urinary incontinence update is being implemented.

We also just finished a study that developed a quality assurance methodology for patient outcomes in Massachusetts nursing homes. This also adjusted the measures to reflect differing patient characteristics.

McKnight's LTC NEWS: Do you anticipate that the American Medical Directors Association will take the lead role in developing clinical practice guidelines in the long-term care setting?

Gaus: I think the American Medical Directors Association will play a major leadership role. They are already working with us on several initiatives.

We've also entered into a dissemination partnership with the American Medical Directors Association and the American Health Care Association. Both associations will distribute our urinary incontinence guideline update.

McKnight's LTC NEWS: Is it reasonable to assume that the agency will direct some of its research capital into finding lower-cost alternatives to nursing home care?

Gaus: I think there probably will be some research that focuses on most appropriate care sites. But I don't think the nursing home industry ought to worry about what our research will do to their occupancy levels.

Our efforts will likely have much less of an effect on future nursing home populations than the aging of America.

McKnight's LTC NEWS: Could you address the current status of the National Medical Expenditures Survey?

Gaus: The survey has been redesigned, and we are now calling it the National Medical Expenditure Panel Survey.

The survey's new design is going to dramatically improve the efficiency of our data collection and the timeliness of the results.

In addition, the National Nursing Home Survey will be integrated with the National Center for Health Statistics and HCFA surveys. Merging these studies will provide a better database of nursing home residents and nursing home characteristics.

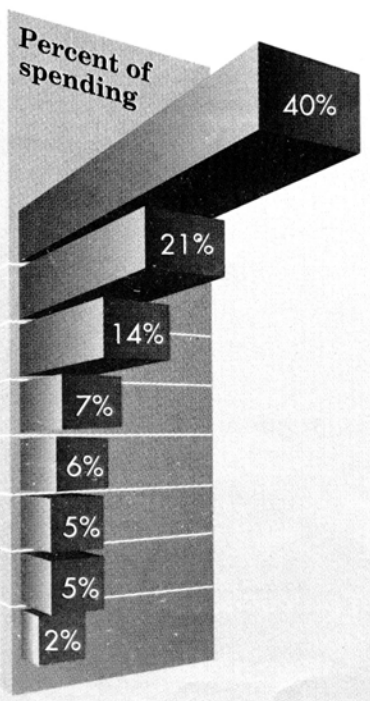
Our goal is to make the survey data available more quickly. We'll make announcements this summer that will make the data accessible to providers and others on a more timely basis. We're going to develop research centers that will have access to the unedited data and have rights to publish preliminary findings.

See ***Gaus*** ➢ *p. 12.*

DEPARTMENT INDEX

LTC NEWS DATABANK

How does Medicaid spending break down?



Source: Urban Institute, 1996

Survey system

Continued from p. 1.

of community relations for the American Health Care Association, also in Washington, agrees.

"[The new system] shifts the focus away from patient care concerns," he said.

But HCFA maintains that while the new survey system is not perfect, the enforcement system does address legitimate problems.

"By and large, there are not a lot of inappropriate citations or deficiencies cited," said a HCFA official. "And when anything is identified as a problem, providers are expected to correct it. Most facilities do [develop] some sort of remedy," the official said.

But not everyone agrees that providers are imposing remedies. "Enforcement is not happening," said Lori Owen, law and policy specialist for the National Citizens' Coalition for Nursing Home Reform, Washington. "Surveyors are doing a good job of citing deficiencies, but they don't follow up," she said.

Both providers and consumer advocates said that recent changes in HCFA's enforcement terminology and policies are disconcerting.

"We are very concerned about delays in implementation and the changes that have occurred regarding revisit policies and the definitions of 'deficiency' and 'out of compliance,'" Owen said.

Owen said nursing home industry pressure has caused HCFA to revisit its policies. "HCFA should not change the system in response to industry concerns before it knows if the system it designed even works," she said.

The beginning of year two finds administrators still adjusting to the system.

"It's difficult if you don't practice what [HCFA] wants you to do," said Johnny Sicat, administrator of Alden Terrace Convalescent Hospital, Los Angeles.

"[HCFA] is going back to the same old patient care issues. They want facilities to be more involved. But overall, the experience [with the system] has been positive. It's better for the resident," he said.

Sue Morse, administrator of Grundy County Home in Morris, IL, said that she has been pleased with surveyors' work.

"They have been professional, responsible, well-trained and not as confrontational," she said.

"But I would like to see [surveyors focus more on] resident-oriented outcomes," she said.

Uneasy listening?

In the months ahead, HCFA plans to be more receptive to providers' suggestions. Beginning in August, HCFA will hold the first of three to four "listening sessions." These programs will enable providers to voice their opinions regarding the system. ❍

What have surveyors found?

	Standard	Complaint surveys
Surveys completed	13,308	18,428
Facilities substantially complying with new law	29%	80%
Facilities with Level D or higher deficiencies	71%	20%
Facilities found to be in substantial compliance during a revisit	5,443	1,329
Facilities found not to be in substantial compliance during a revisit	1,097	309

How is HCFA handling facilities determined to require remedies?

Remedies	Proposed standard surveys	Complaint surveys	Imposed
State monitoring	1,110	423	146
Directed plan of correction	2,063	467	198
Temporary management	17	15	4
Payment denials for new admissions	3,222	878	395
Payment denials for all residents	84	23	0
Directed inservice training	2,274	815	208
Monetary fines	2,929	995	158
HCFA-approved alternative state remedy	52	6	2
Residents transferred	75	7	0
Facilities terminated	4,211	1,541	36

Source: HCFA, 1996

Anti-fraud

Continued from p. 3.

indictment. Charges included mail fraud, as well as falsifying Medicare claims by more than $300,000 over two years. The defendant admitted that he routinely billed Medicare for comprehensive examinations without seeing the patients. He also admitted to billing Medicare for follow-up examinations that were never performed.

In another instance, a 240-bed nursing home in New York agreed to pay a $24,000 civil monetary penalty after filing inaccurate Medicare cost reports. In a third case, a Miami nursing home paid $245,488 to settle its civil liability in a billing scheme.

The ongoing federal investigation has primarily focused on several key fraudulent activities. These include practices such as unbundling services, double billing, using excessive vendor numbers, delivering services to ineligible beneficiaries and falsely claiming procedures or supplies.

Holtz said the program has also initiated several strategies to nab skilled nursing facilities suspected of fraud. These include additional facility inspections, implementing a voluntary disclosure program and prosecuting providers under anti-laundering, mail fraud and racketeering statutes.

At press time, Holtz's office was about to release a fraud and abuse alert for nursing homes.

The alert will define and give examples of what constitutes false or fraudulent claims. It will also define what constitutes claims for services not rendered or provided as claimed.

Currently, the entire anti-fraud program is jointly run by HCFA, the Office of the Inspector General and the Administration on Aging. ❍

Herbert P. Weiss is a Providence, RI-based writer.

Funds

Continued from p. 1.

members have developed a strong grassroots program and a good working relationship with state legislators, independent of any political action committee contributions.

"We are not trying to buy our way into talking with lawmakers," Cochran asserted. He stated that relationships develop as administrators and staff volunteer to work on political campaigns and participate in voter registration drives. "Locality" is what gives members access, he emphasized.

Being one of the largest employers in many Texas communities is what helps nursing facilities look attractive to lawmakers, stated Tom Suehs, executive director of the Texas Health Care Association.

According to Suehs, elected officials know that they can find a large number of potential voters in nursing facilities — including residents, staff and family members. Events hosted by facilities, such as open houses, town hall meetings and civic functions also offer opportunities for lawmakers to meet voters, he added.

But Jennifer Hendrick, director of legislation for the California Association of Health Facilities, acknowledged that political action committee funds help providers gain access to lawmakers.

Hendrick said that contributions are useful in establishing relationships or to support legislators who favorably view industry positions.

Does money equal influence?

But while nursing home groups generally deny a link between contributions and political favors, their view is not universal.

"Clearly, the playing field is tilted in favor of interest groups that give lots of money to political candidates," said Eric Lorenzini, state issues coordinator of Common Cause, Washington.

Lorenzini said that it is hard for an elected official to be impartial after receiving contributions from a lobbying group.

"It is human nature for you to remember those who made large contributions to your campaign and to factor that into your decision-making process," he said.

In California, "the nursing home lobby is very democratic in giving out political contributions to Republican and Democratic lawmakers alike," quipped Pat McGinnis, executive director of California Advocates for Nursing Home Reform, an organization that represents 10,000 consumer advocates.

She alleged that industry lobbyists had better access to state lawmakers, and have sometimes instructed lawmakers how to vote.

"Consumer groups only have the power of their voices and not the power of the purse string," added Sarah Burger, associate director for policy of the National Citizens' Coalition for Nursing Home Reform, Washington.

But consumer-supported bills and initiatives are not always undermined by political action committee contributions, according to Beth Farris, president of the Texas Advocates for Nursing Home Residents. In Texas, for example, public outcry against substandard nursing home services helped bring about recent nursing home reforms, she said.

Moreover, using political contributions can backfire, according to Burger. She said that efforts by nursing home groups to block state-level enforcement of quality standards helped bring about a federal nursing home law in 1987.

Reforms coming

According to Common Cause's Lorenzini, state-level campaign reform is slowly taking place. In Massachusetts, a reform coalition is putting together a comprehensive campaign-finance reform initiative for the 1998 ballot. Reform coalitions in Arizona, Idaho, Michigan, Missouri, Oregon, Washington state and New York also are drafting campaign finance-reform initiatives.

In June, Vermont Gov. Howard B. Dean signed a sweeping campaign-finance reform bill into law. The measure eliminates unlimited "soft money" contributions, sets mandatory spending limits for legislative candidates and reduces contribution limits.

In 1997, Connecticut, Kansas, Maine, Maryland, North Carolina and Virginia passed new restrictions on fund raising during state legislative sessions.

Combined, these state-level changes could dramatically change how providers, lawmakers and consumer groups interact. ❍

Herbert P. Weiss is a health care writer based in Rhode Island.

McKnight's
Long-Term Care NEWS
Business News for Long-Term Care Management
$5.00
NOVEMBER 1997 • VOL. 18, NO. 11

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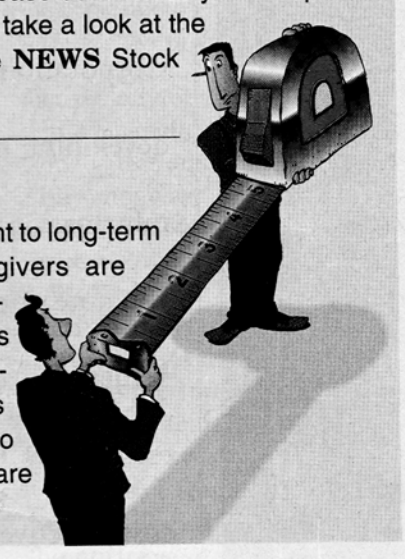


LATE BREAKING NEWS

➢ **The Labor Department has proposed regulations designed to reduce tuberculosis cases among nursing home employees.** The Occupational Safety and Health Administration is recommending that facilities require routine medical testing for residents who have highly contagious or fatal diseases. The regulations would also require high-risk workplaces to provide exposure-control plans for all employees and respirators for those most at risk of contracting the disease.

➢ **New York Mayor Rudolph Giuliani has filed a lawsuit challenging the constitutionality of the presidential line-item veto.** The suit came after President Clinton used a line-item veto to nullify provider tax provisions in New York. State officials fear New York may lose $2.6 billion if the provision is not restored. The case could also affect nursing home operators in other states where provider taxes are in place.

➢ **The U.S Supreme Court refused to hear a challenge to Oregon's physician-assisted suicide law**. As a result, the ruling by the U.S. 9th Circuit Court of Appeals has been upheld. In November, Oregon voters will decide whether to repeal the highly controversial three-year-old law through a mail ballot referendum.

What does $842,000 buy?

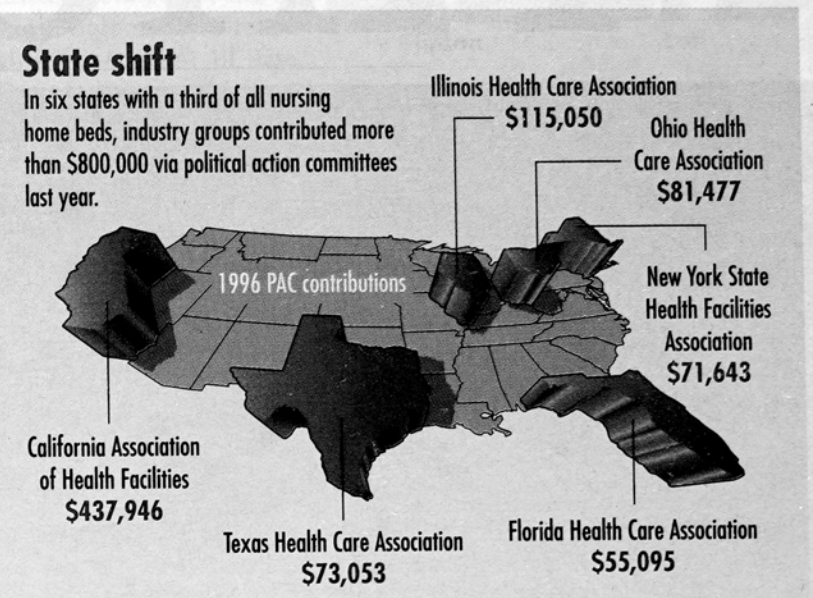
by Herbert P. Weiss

As the Medicaid program becomes less centralized, state lawmakers are playing a larger role in shaping laws and policies affecting long-term care.

At the same time, long-term care associations are actively financing state-level campaigns, an investigation by **McKnight's Long-Term Care NEWS** has found.

The investigation focused on six key states that account for more than a third of the nation's nursing home facilities and beds. Nursing home groups in these states — California, Florida, Illinois, New York, Ohio and Texas — contributed more than $842,000 last year through political action committees, according to state records and the associations' own figures.

The totals ranged from a low of $55,095 in Florida to $437,946 in California. But these amounts may not account for all the funds that state associations actually contributed in 1996, because they do not include individual donations.



Sources: Associations and state oversight organizations, 1997

Keys to access?

Critics have accused the industry of using these funds to gain political access and affect legislation at the state level. But industry officials generally deny the charge. Constituency efforts at the grass-roots level are the real keys to gaining access, they countered.

Stephen Cochran, executive vice president of the Ohio Health Care Association, said that his

*See **Funds** ➢ p. 13.*

States may limit payments

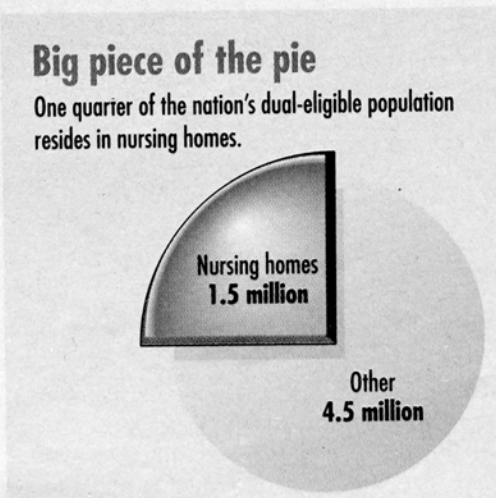
Dual-eligible provision could hurt providers

WASHINGTON — Long-term care providers could see significantly lower reimbursement rates for the care they provide to dual-eligible residents, under a provision in the latest federal budget agreement.

According to the new law, states can decide that their Medicaid reimbursement rates are an all-inclusive rate for services delivered to residents eligible for Medicare and Medicaid coverage. For many providers, the net effect of this shift would be a dramatic reduction in reimbursement for dual-eligible services.

"In a worst-case scenario, it could mean that reimbursement rates for low-income beneficiaries in skilled nursing faculties get cut by two-thirds," said Robert Hartwell, a legislative analyst of the American Health Care Association, Washington.

*See **Reimbursement** ➢ p. 14.*



Source: HCFA, 1997

'Nursing homes' assume new names, new roles

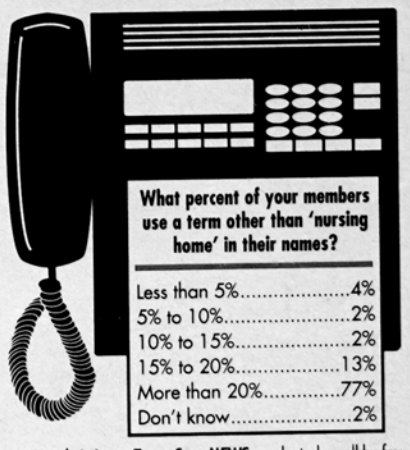
by Jennifer A. Gilbert

If you work in a nursing home these days, there's a good chance it's not called a nursing home.

In an effort to emphasize new services and to avoid the stig-

*See **Name change** ➢ p. 15.*

FAX POLL



McKnight's Long-Term Care NEWS conducted a poll by fax machine of all state affiliates of AAHSA and AHCA. The poll had a 60% response rate.

Source: **McKnight's Long-Term Care NEWS**, 1997

HAVING MY SAY

Good media relations important to your facility's future success

by Herbert P. Weiss

The long-term care business keeps getting more difficult. As never before, operators must deal with changing regulations, reimbursement shifts and new competitors.

One way to help future success is to improve your facility's media relations. While such an effort may seem like yet another task, it can pay off handsomely.

First, it may help minimize negative press about your facility's operations and caregiving practices. And perhaps just as important, it may lead to favorable, even glowing coverage.

But keep in mind that media relations really are just that: the relationship that you or your firm has with media outlets.

So how do you go about building the relationships and expertise needed to become media savvy? Like any skill, it will take practice and concentrated effort. But a few suggestions may help ease the transition.

Be media friendly

Make yourself available to reporters. If they are calling, chances are pretty good that they need a quick answer. Try to take the call immediately or call back as soon as possible – particularly if they are calling for background information or are trying to find a "sound bite" that will spice up an article.

While covering the White House Conference on Aging in 1995, I was amazed to see a senior staffer from the Washington-based American Association of Retired Persons enter the press room throughout the day. Besides distributing press releases, this person was right there to provide statements. Reporters were able to get quotes with very little effort. As you can imagine, this person was widely quoted in articles about the event.

> *The poise and professionalism that you show during times of duress may actually lead to better press coverage later on.*

When you attend health care conferences, visit the press room to talk with reporters about innovative and interesting programs at your facility. Ask for a list of reporters attending the conference. Make it a point to introduce yourself to reporters – and give them your business card. After the conference, send them a copy of your facility newsletter or press releases. By developing a working relationship, you may soon find yourself being called to comment as an authority. You may even be asked to author an article.

Stay connected

Call the city desk editor or health care writer regularly to keep them updated about your facility's activities. I know an administrator who raises Yorkshire terriers. At dog shows, she met and slowly developed a relationship with a reporter who has a similar interest in dogs. Guess who ended up in a feature story about pets in nursing homes?

It's also worth noting that many media outlets pay more attention to press releases that are faxed.

Talking points

Unfortunately, it's unlikely that all your conversations with reporters will be about the good things that your facility is doing. Sometimes, reporters may call to discuss negative survey findings, resident complaints or another sore subject that you'd prefer to avoid.

When this happens, keep in mind that the reporter's job is to cover news. Moreover, the poise and professionalism that you show during times of duress may actually lead to better press coverage later on.

While it's not always easy being questioned "for the record," there's no need to make things worse. Don't begin an interview without a purpose. Before the interview, carefully determine the main point you want to get across, particularly if the interviewer is likely to address a sensitive

Continued on next page

◀ Circle 94 on reader service card

Continued from previous page

or potentially damaging issue. Try to visualize this main point as a headline that you would like to see in the next edition of the newspaper.

During the interview:

- Listen carefully to a question before responding.
- When answering a question, use simple, standard English.
- Always tell the truth.
- Avoid saying "no comment," as the phrase is most likely to arouse suspicion.
- If you don't know the answer, say so.
- If you can't answer a question, explain why.
- Don't get angry at the reporter – but challenge any attempt to put words in your mouth.

Set the record straight

Despite your best efforts, the result may still be an unflattering article about your facility. Most journalists try to be accurate and fair, but they are human too. Sometimes they have a questionable bias or agenda. Other times, they simply don't have their facts straight. Many administrators decide to ignore incorrect or excruciatingly biased coverage, fearing that to rebut the article will only invite more trouble.

But such silence can have a high price. In effect, you are letting something that is incorrect about your facility become part of historical record. As future writers do research, they will have no way to know that an article about your facility was incorrect – unless you take action.

If you find that a story published about your facility contains a technical inaccuracy, contact the reporter who wrote the piece and ask for a correction. If stonewalled, go to the reporter's editor with the facts. Still no response? Write a strongly worded letter to the editor or an opinion/editorial piece. Most newspapers will publish your concerns.

Do your homework

Long-term care providers are busier than ever. But you also owe it to yourself and your industry to reach out to the media – and to stay informed. One of the easiest ways to do the latter is to read the industry publications that come to your facility.

These periodicals will help you become better informed about the changes that are affecting your industry. They will also help you speak as an authority when you interact with the media. ❍

Herbert P. Weiss is a health care consultant and free-lance writer based in Pawtucket, RI. He is also a member of **McKnight's Long-Term Care News'** *editorial advisory board.*

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