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The Brown University

# Long-Term Care Quality Letter

Twice-monthly reports on total quality management and continuous quality improvement for nursing homes and related facilities.

Vol. 4, No. 20
October 30, 1992

## In This Issue:



## Administration

### Provider and Consumer Groups Clash Over HCFA Proposed Enforcement Rule

***By Herbert P. Weiss***

Provider and consumer advocacy groups are gearing up lobbying efforts to pressure the Health Care Financing Administration (HCFA) to modify key provisions in the proposed rule for nursing facility survey, certification and enforcement procedures.

The long-awaited and controversial proposed regulations will have a far-reaching impact on the operations of 16,000 Medicare and Medicaid-certified nursing facilities. They will ultimately determine how the OBRA '87 nursing facility reforms are enforced by HCFA — once the agency publishes its final rules.

Specifically, the proposed rule outlines the basic survey procedures and new enforcement measures that states and the federal government will apply against facilities out of compliance.

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## HCFA

*(Continued from page one)*

Authority to install temporary management in nursing facilities where conditions threaten the health and safety of residents and civil money penalties of up to $10,000 a day for non-compliance with federal requirements are among the enforcement tools included in the proposed regulation. The proposal also calls for a fine of up to $2,000 for an individual disclosing a scheduled inspection, notes William Toby, Jr., HCFA's acting administrator.

"We are determined to protect the integrity of the survey process, which depends on inspections being conducted without advanced notice to the nursing home," Toby says. "The surveys must reflect the actual conditions that exist in nursing homes on a day-to-day basis."

### Shook loose from OMB

For more than a year, the proposed enforcement rule was held up in the Office of Management and Budget's (OMB) regulatory approval process — consumer advocate groups blamed the nursing home industry for the regulatory delay. Many aging organizations even expected the "political hot potato" to be released well after the presidential election.

But effective lobbying efforts of consumer advocate groups, led by the Washington, DC-based National Citizens Coalition for Nursing Home Reform, (NCCNHR), combined with a Michigan lawsuit calling for the publication of the proposed rule and pressure from six key democratic congressional leaders, forced OMB to approve the proposed rule's early release in the August 28 *Federal Register.*

### Point/Counterpoint

While provider and consumer advocacy groups welcome the release of HCFA's proposed nursing home enforcement measures, they express concern over several key issues.

The proposed regulations are "seriously flawed" because they don't distinguish between poor performing providers and good ones, says Executive Vice President Paul Willging of the American Health Care Association, a trade group representing 11,000 nursing facilities.

Under the current survey process, there is no organized way to determine when a problem is called a deficiency, Willging notes.

"To distinguish between serious problems and minor observations, surveyors need to work within an established decision-making framework in exercising professional judgment," he says.

To fix the problem, Willging calls for the proposed rule to be modified to clearly define a deficiency and the establishment of identifiable standards of what constitutes compliance with the regulations. He also wants surveyors to follow a standard methodology when assessing facility compliance that includes the use of scope and severity scales when determining a deficiency.

Providers are also concerned that the proposed rule doesn't include a conflict resolution process. HCFA has failed to add simple and informational procedures to resolve disputes that arise during surveys, notes Executive Vice President Richard L. Thorpe of the American College of Health Care Administrators. "This process could quickly settle many conflicts without costly litigation," he adds.

The dispute resolution system becomes even more important with HCFA's intent to limit the rights of nursing homes to appeal deficiencies cited in error or remedies that are imposed, Thorpe tell us.

While NCCNHR, a consumer advocacy group, applauds many aspects of the proposed regulation, they differ with the provider's approach to enforcement.

"The nursing facility industry argues that scope and severity screen are necessary to assure surveyor consistency," NCCNHR says in comment to HCFA. "We believe that this is just a smoke screen to protect facilities from having to correct deficiencies and from public exposure to deficiencies."

"Every violation of the requirements should be cited as a deficiency, written in the survey report, corrected, reviewed at the survey follow-up visit, and be in the public record," NCCNHR says.

The group also calls for the state to evaluate the scope of the deficiency and its effect on residents when determining which remedies to apply in addition to requiring correction.

Finally, "Conflict resolution and other delaying tactics should not be permitted in the proposed regulations," NCCNHR says, supporting HCFA's position to require that remedies be imposed immediately, even during a facility's appeal."

NCCNHR notes that this is fully in accordance with federal statute requirements that enforcement systems "minimize the time between identification of violations and final imposition of the remedies."

A copy of the HCFA Enforcement Rule is available from us for $10.00. To order, call 1-800-333-7771. For further information about HCFA rule, contact Irene Gibson, HCFA (410) 966-6768.

Herbert Weiss is a Maryland-based writer covering health care issues.

## Interview

# Strengthened Ombudsman Program in Older American Act Will Protect Vulnerable Seniors

*by Herbert P. Weiss*

***Editor's Note:*** *The Senate approved its version of the Older American Act (OAA) on September 10 by voice vote. After House approval on September 22, the OAA reauthorization bill was signed into law (P.L. 102-375) by President Bush on September 30.*

*In a July interview, Senator Brock Adams (D-Wash.), Chairman of the Subcommittee on Aging of the Senate and Labor Relations Committee, a subcommittee with jurisdiction over the OAA, discussed highlights of the legislation — the provisions are now incorporated into the newly enacted federal law. This interview was first published in the August/September 1992 issue of the* Long-Term Care Administrator, *a publication of the American College of Health Care Administrators (ACHCA) and is reprinted below with their permission. Herbert Weiss is a Maryland-based writer who specializes in aging and health care issues.*

**Weiss**: 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 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.

**Weiss**: 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 followup a complaint that a guardian is not performing 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 of 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 compromise.

**Weiss**: In light of current fiscal constraints regarding appropriations for OAA Title III services, how can you justify the creation of an association 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 was the agency's lack of support of the ombudsman program. AOA could tell us little about this program, and we heard from ombudsmen in the field that they were getting little support from the Bush Administration.

As to cost, I believe it is well worth the expense to protect America's most vulnerable population — the elderly. A federal official responsible for the ombudsman program would become a champion for nursing facility residents by representing them in interagency policy discussions and ensuring adequate representation for the program. The costs associated with the new position will be minimal at best. If this person is effective, he or she could become a powerful force in assisting the ombudsman program obtain additional resources.

**Weiss**: OBRA regulations mandate states to develop nurse aide registries to gather demographic information. The OAA Reauthorization Bill would direct the National Center for Health Statistics to collect and prepare a report on nurse aides' demographic information by March 1, 1994. Why create another survey for nursing facilities to fill out? Could OBRA be expanded to gather the information required by your legislation?

**Sen. Adams**: The 1992 OAA Reauthorization Bill includes provisions from a bill that I introduced last year that mandates the development of an ongoing data base to collect information about nursing home and home health care aides. The rationale for my bill was obvious. While these workers play a key role in providing direct hands-on patient care, we just don't know enough about them to develop good public policy. The federal government has done a poor job in anticipating, much less planning, for a work force which must take care of an aging population.

I've taken great pains with Sen. Cochran, the ranking Republican on my subcommittee, to ensure that we are not duplicating the efforts of other federal agencies in collecting data on nursing home and home health aides. Data obtained by the National Center for Health Statistics and the Bureau of Labor Statistics would build upon existing data bases and add to them where necessary. This will be easier to accomplish with nursing homes. However, it will be more difficult for us to collect data on home health aides. The Bureau of Labor Statistics will have to develop a new survey instrument. I am pleased that the nursing home and home health industry are supportive of these provisions. 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.

A copy of the Older Americans Act (OAA) is available from us for $10. To order, call 1-800-333-7771.

Reprinted with permission from *Long-Term Care Administrator*, September 22, 1992. For more information, contact the American College of Health Care Administrators, 325 South Patrick Street, Alexandria, VA 22314; (713) 549-5822.

## Ideas? Comments? Suggestions?

Let us know what you think! Send your learning experiences, ideas, questions or suggestions to *The Brown University Long-Term Care Quality Letter,* Manisses Communications Group, Inc., P.O. Box 3357, Providence, RI 02906; 401/831-6020, FAX 401/863-6370.

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# Long-Term Care Quality Letter

Twice-monthly reports on total quality management and continuous quality improvement for nursing homes and related facilities.

Vol. 5, No. 16
August 30, 1993

## In This Issue



## Public Policy

### Aging Groups Rally for LTC Coverage; Clinton Administration Listens

*by Herbert P. Weiss, N.H.A.*

The repeatedly delayed health care reform package has immediately replaced the federal budget on center stage in Washington and the nation, as the Clinton administration is targeting late September for the release of its long-awaited proposal.

The package had been placed on the back burner while Congress was lobbied by the administration to gain support for its 5-year budget reconciliation package. (The budget battle proved to be one of the most hotly contested on record. Conferees finally reached agreement on a compromise budget plan that, through tax increases and restrained spending, purportedly would slash the deficit by $496 billion over the next five years). As fiercely fought as it was, however, the budget battle could end up looking like a Sunday afternoon picnic when compared with the upcoming fireworks over health care reform.

Although unveiling is slated for next month, interested observers are advised to temper their expectations. "Don't expect to

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*Public Policy*
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see the plan in detail," advises Edward Howard, executive vice president of the Washington, D.C.-based Alliance for Health Care Reform. He speculates that the administration will want to sit down with Congress to draft acceptable legislative language.

### Support is growing for long-term care coverage

National opinion polls make it extremely clear to White House officials and Congress that the American public wants reform to include a long-term care (LTC) component. Support for health care reform increases when LTC coverage is included, according to a recent poll conducted for the American Association of Retired Persons. The poll also found that about 46.5 percent of those surveyed said they would be willing to pay $50 a month in higher taxes for national health insurance coverage of hospital, physician and LTC services.

To highlight its support for LTC insurance as a viable solution to paying for nursing-facility care, the American Health Care Association (AHCA) has announced the results of its Gallup poll. Three out of four Americans believe that the federal government should pay for LTC services only when people cannot afford their own coverage.

### Different strategies for LTC coverage

The Leadership Council on Aging (LCoA), representing 17 national aging groups, has urged administration officials to include LTC in national health care reform. The group has called for the establishment of a national health plan that incorporates comprehensive LTC protection for people of all ages. Such a plan could be financed through a progressive, broad-based financing mechanism by which older Americans would pay their fair share along with the working population, the LCoA proposal suggests.

To have their specific prescriptions for LTC financing included in reform, nursing-facility groups are flexing their political muscles through PAC contributions and grassroots lobbying efforts directed at White House officials and Congress. Similar reform proposals have been hammered out by the boards of directors of the AHCA ("Quality Care for Life") and the American Association of Homes for the Aging ("A Partnership in Caring"). Both proposals call for a public/private partnership that encourages people to purchase LTC insurance to plan ahead for nursing-facility care needs; a tightening of transfer-of-asset laws to close Medicaid loopholes; and development of federal consumer protection and tax incentives to encourage people to buy LTC insurance. (Expect some new LTC coverage, but coverage of nursing-facility care is unlikely.)

### Expect minimal coverage for LTC services

Although Clinton administration officials previously expressed doubts that costly LTC benefits (estimated to be $5 billion to $15 billion) would be included in a health care reform package, new signals of support are now emerging, especially after positive poll results and intense lobbying by consumer and provider groups.

Ira Magaziner, a senior White House advisor who is playing a pivotal role in heading the reform effort, told health specialists and lobbyists at a Families USA-sponsored May 11 meeting that they should expect limited LTC benefits that would emphasize home- and community-based care. The plan also would reduce the amount a person must spend down before becoming Medicaid-eligible. The LTC benefits would be set outside the basic benefit package to keep costs down, Magaziner noted. In addition, prescription drugs would be covered under the existing Medicaid program, he said.

The President's Task Force on Health Care Reform completed its work on May 30 and presented Clinton with drafted options. Although no final decisions have been made yet as to specifics, look for more trial balloons to fly over Capitol Hill before Clinton's plan is released. Even if he makes his self-imposed

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# Long-Term Care Quality Letter

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## Also In This Issue

### Point



### Counterpoint



### Perspective



### Washington Update



### Briefly Noted



## Health Care Reform

***Editors' Note:*** *We are doing something unusual this issue by focusing exclusively on health care reform. Although we generally strive to give you variety, we believe these concerns are so compelling for providers that it was worth devoting the space to these diverse and comprehensive views on reform as it relates to long-term care financing. We encourage readers to follow through with this information. Thus, we have provided specifics about the various proposals and contact addresses and phone numbers so you can find out more or take some action. Whatever the outcome, there is much to be gained — and lost.*

## Public and Congress Grapple with Long-Term Care Coverage

*by Herbert P. Weiss, N.H.A.*

National opinion polls indicate that the American public would like the health care reform process to address long-term care. In fact, support for reform increases when long-term care coverage increases, according to a recent poll conducted for the American Association of Retired Persons. The poll also found that 46.5 percent of those surveyed said they would be willing to pay $50 a month in higher taxes for national health insurance coverage that includes long-term care services.

Even with public support growing for long-term care reform, it is one of the least discussed and most costly new benefits being considered. Five prominent health care proposals with long-term care components currently are being circulated in Congress. (See a comparison of long-term care proposals in the January 5, 1994 issue of the *Brown University Long-Term Care Quality Letter*).

### President Clinton's plan

Virtually all five proposals put the brakes on rising health care costs by slowing the growth of Medicare and Medicaid, then using the savings to finance the reforms. But unlike most of the other proposals, President Clinton's plan (S. 1757/H.R. 3600) reinvests the money into new benefits for seniors and the disabled.

Projected savings would phase in funding for a new home and community based long-term care program for severely impaired individuals regardless of age and income. The Clinton proposal also addresses the problem of residents "spending down" assets to become Medicaid eligible by increasing the asset protection limit.

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***Health Care Reform***
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Only the Clinton plan and the McDermott/Wellstone plan propose a comprehensive solution to the often severe impact of high prescription drug costs on our nation's elderly. (Elderly persons pay almost two-thirds of their prescription drug costs out of pocket, reports Families USA, a Washington, D.C. based consumer watchdog group.)

Under the Clinton plan, starting January 1, 1996, Medicare beneficiaries would be eligible for a new outpatient prescription drug benefit under Medicare Part B. After paying an annual deductible of $250 per person, beneficiaries would pay only 20 percent of prescription drug costs up to an annual maximum of $1,000. After 1996, the deductible and copayment limits would increase only for inflation.

## Alternative proposals

The Republican reform proposal (S. 1770), introduced by Senator John Chafee (R-R.I.), cuts about $200 billion from Medicare and Medicaid, but earmarks the savings to supply vouchers for the poor, instead of new long-term care benefits. The Chafee plan keeps the existing long-term care delivery system in place, even with its problems. It does allow a personal tax deduction of long-term care expenditures as medical expenses (as does the Clinton proposal); however, this provision generally would provide little benefit to low income seniors.

Spending cuts and increased Medicare premiums are the focus of Rep. Jim Cooper's (D.-Tenn.) health care plan (H.R. 3222). No new prescription drug or long-term care benefits would be added. If Cooper's bill becomes law, long-term care spending currently shared by the state and federal governments would be shifted entirely to the states by 1999.

Rep. Robert Michel's (R.-Ill.) proposal (H.R. 3080) caps Medicaid spending, giving states a per person amount and no more, regardless of how much long-term care services actually cost. States also would have the option to cut back on long-term care services, reducing access to the needed service.

The comprehensive "single-payer" proposal offered by Rep. Jim McDermott (D-Wash.) and Sen. Paul Wellstone (D-Minn.) would abolish Medicare and provide universal prescription drug benefits. Under the McDermott/Wellstone proposal, seniors would pay a premium for a new basic benefit that includes home and community based long-term care, personal care services, and nursing facility care.

## In the eyes of the beholder

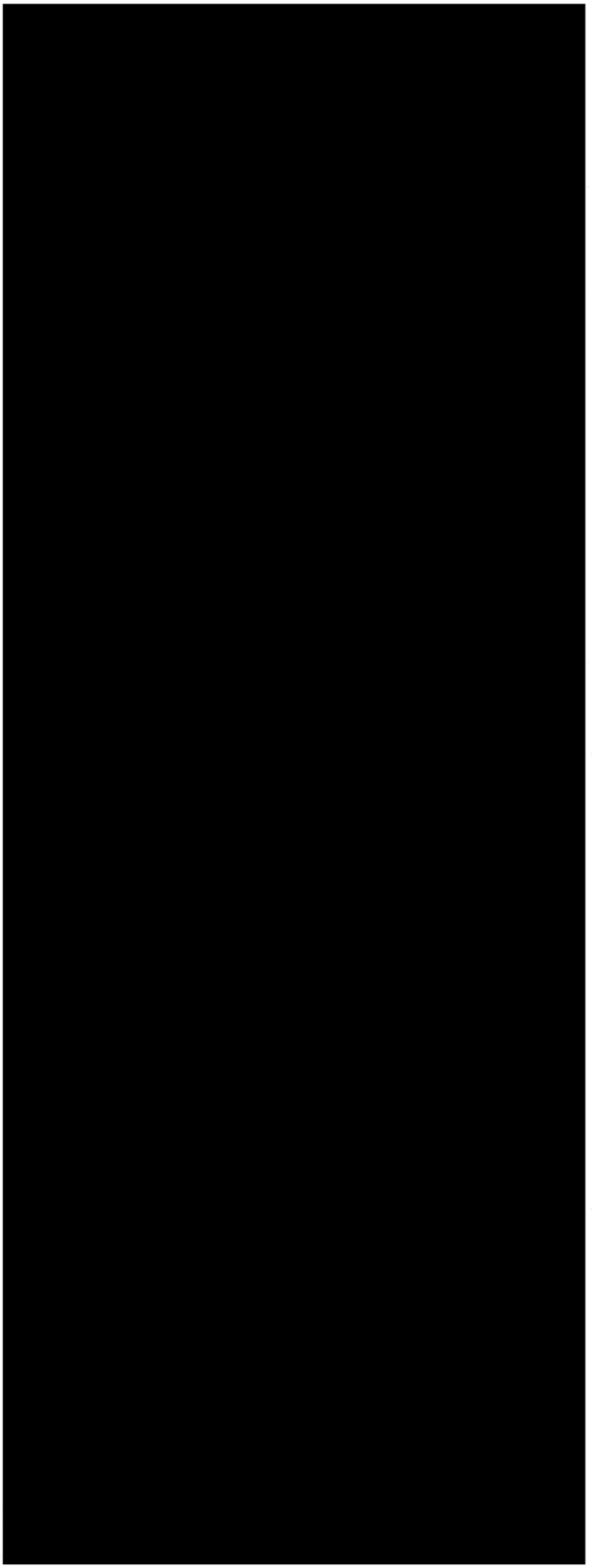
Critics of long-term care reform charge that its expense would derail congressional attempts to pass broader health care reforms. Some aging groups are concerned that new long-term care benefits may be "traded" to fund other worthy causes such as greater support for low income women with children and other at-risk groups.

To recast the debate, 35 prominent health care and consumer groups rated the five major proposals on how they would affect families needing long-term care services. The coalition's "report card" offered a passing grade only to the Clinton and McDermott/Wellstone proposals. The groups charged that the current system discriminates against people with chronic diseases and disabilities. Health insurance policies typically only pay for costly surgeries and treatments in physician offices and hospitals — not for long-term care provided in patients' homes. By paying for community based services, the Clinton and McDermott/Wellstone proposals would remedy this reimbursement problem.

With the American public demanding action, not gridlock, the Administration and Congress are poised to make up the complex issue of health reform. Many Washington insiders don't expect a comprehensive reform package to emerge intact. But a less detailed proposal may emerge with a growing number of Representatives and Senators cosponsoring more than one plan, and a President who has expressed a willingness to compromise.

For copies of the Senate bills, send a stamped, self-addressed envelope to Senate Document Room, Hart Senate Office Bldg., Room B-04, Washington, DC 20510. For House bills, call the House Document Room at (202) 226-3456. Copies of President Clinton's Health Security Act are available through the NARD Legislative Defense Fund by calling (800) 544-7447.

*Herbert P. Weiss, a licensed nursing home administrator, is a freelance writer covering health care and aging issues, and a member of the editorial advisory board for the* Brown University Long-Term Care Quality Letter. *This article was reprinted with permission from the* Long-Term Care Pharmacist *2(12), January 1994, a publication of NARD.*



*Diversification of Services*

## Offering Respiratory Services as Home Care a Good Move

*by Herbert P. Weiss*

As the health care industry goes through major changes, providers will need to stretch their own areas of service to survive and thrive in the 21st century. Home respiratory care service is a natural fit for long-term care providers, according to Patrick Dunne, who spoke at a home health care workshop at NARD's Rx Expo '94. Being competitive in the 1990s means that providers must examine carefully how they do business, identify who their customers are, and become more efficient, says Dunne, a respiratory therapist and former president of the American Association of Respiratory Care.

The need for home respiratory care will intensify in the future because of the growing number of patients who will require the service. Dunne notes that many chronic respiratory conditions requiring in-home respiratory services rank among the top 10 discharge diagnoses among Medicare patients. As the population ages, the numbers needing this type of care will go up significantly.

Dunne also predicts that the AIDS epidemic will create a greater demand for home services, because many persons with AIDS develop respiratory infections. Other potential candidates for home respiratory services include an estimated 15 million asthma patients, 16 million chronic obstructive pulmonary disease patients, and 30 million people suffering from chronic sleep disorders.

Dunne cautions that Medicare reimbursement for home respiratory services is equipment based, rather than service based. If repeated patient visits become necessary to service the equipment or because of difficulties with patient compliance, providers can lose money under Medicare reimbursement. Keeping a close eye on delivery costs is one of the most important steps a provider can take to keep its respiratory operation profitable, he says.

Whatever the reimbursement structure, in-home respiratory care is service intensive. For example, staff must perform initial and ongoing assessments to determine whether the equipment is appropriate for the patient. "There is a significant amount of patient and caregiver training that must be given," says Dunne. Patients need to be taught how to

clean the parts of their oxygen system, and most importantly, how to comply with their physician's orders.

Because of the technical nature of respiratory equipment, staff need to perform monthly follow-up visits with patients to maintain the equipment, do quality checks, and monitor the patient's condition. Under Medicare, all of these services must be provided with no additional reimbursement. "They are part of the reimbursement for equipment," Dunne says.

## How to succeed

Dunne offers the following tips to providers on how to provide home respiratory services successfully:

- **Keep it simple.** Provide patient education materials that are simple, to-the-point, and written in plain language in order to help to ease the concerns of physicians, patients and caregivers alike.
- **Carefully select patients.** Clearly define your scope of service. Remember that once you accept a patient, you are that patient's respiratory care provider. If your facility is unable to provide the appropriate level of care, the patient should be referred to another provider.
- **Provide thorough demonstrations.** Using high tech equipment can be intimidating, particularly for the elderly. You can increase your patients' comfort level by teaching them, thoroughly and sensitively, how to operate their equipment. Always provide a 24-hour emergency number for the patient to call if the equipment malfunctions.
- **Keep your patients happy.** Monitor your patients' satisfaction to help ensure that your patients are pleased with your service. When your patients give you positive feedback, always send it along to the referring physicians.

Adapted with permission from *Home Health Care Pharmacist*, 3(5), 1994.

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# Long-Term Care Quality Letter

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## Also In This Issue



## Health Care Reform

### Mainstream Health Care Proposal Unsatisfactory to Long-Term Care Advocates

*by Herbert P. Weiss, N.H.A.*

Lawmakers hurriedly left Capitol Hill to campaign or vacation during the 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 upcoming congressional elections in November 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 leadership health reform packages. Some believe the best chance for compromise lies with a "mainstream" proposal hammered out by a group of 20 moderate Democrats and Republicans led by Senator John Chafee (R-RI).

Advocacy groups strongly oppose the minimalist approach, however, calling for more meaningful reforms.

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*Health Care Reform*
*(continued from page 1)*

Two weeks of negotiations in Chafee's office produced a bipartisan proposal that gives priority to slashing the federal budget deficit by reducing national health care costs. The plan does not call for universal coverage.

To expand access, the proposal calls for health insurance reforms that most Democrats and Republicans agree must be undertaken. Specifically, the reforms would require that health plans not deny or limit coverage based on an applicant's health status. In addition, health care coverage would be increased through voluntary cooperatives for small businesses and individuals, adjusted community ratings, and low-income subsidies.

The politically unpopular "employer mandate" was dropped by the coalition of Senators. Instead, the plan would phase in a 100 percent tax deduction for health insurance premiums of the self-employed and those who must buy their own insurance.

## Minimal LTC benefits

Critics of the mainstream proposal charge that it has fewer benefits for the elderly than those offered by other key Senate and House proposals.

The plan creates a new capped federal program for home and community based services, limited to those with incomes below 150 percent of the poverty level. Tax deductions would be available for 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 waivers. While the plan does not include a subsidy for prescription drug coverage to Medicare recipients, it makes it easier to join managed care programs, which often include prescription drug benefits.

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

## Opposition is building

While many laud the mainstream approach as the only feasible way to move health care reform this year, others call for its defeat.

### Mainstream Proposal's Effects on LTC

- √ 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 (those with incomes below 150% of poverty);
- √ Provides no tax credit for the personal assistance services needed by persons with disabilities;
- √ Gives new tax breaks for the sale of private long-term care insurance and requires only minimal consumer protection standards for private long-term care policies; and
- √ Requires substantially weaker standards for private insurance than other key reform proposals — these standards are approved by the insurance industry.

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

In an August 24th letter to Senators, the Health Care Reform Project — a coalition of 100 diverse groups representing business, the elderly, health care providers, labor, consumers, children, people with disabilities, rural areas, civil rights, and women — urged lawmakers to reject the mainstream coalition's prescription for health care reform and consider more meaningful proposals.

The letter charges that the proposal's new employee tax deduction, the tax cap on employer contributions, subsidies, insurance reforms, and the exclusion of an employer mandate would encourage employers who now provide health insurance to drop it.

The letter also notes that millions of Medicaid beneficiaries would be forced into managed care plans that may be ill suited to provide the care they need.

The advocacy group, Long-Term Care Campaign, identified the ways that the mainstream proposal falls short in meeting the needs of older Americans and people with disabilities. See the box above for details.

This article was adapted with permission from an article in the September issue of the *Long-Term Care Administrator*. Mr. Weiss is a member of ACHCA's Rhode Island Chapter, a freelance writer and a member of the LTCQL editorial board. To respond to the proposal, contact Sen. Chafee, SD-567 Dirksen Senate Office Building, Washington, DC 20510-3902; (202) 224-2921.

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# Long-Term Care Quality Letter

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## *Also In This Issue*



## *Washington Update*

## LTC Provider Groups Support HCFA's New Enforcement Rule for Quality

*by Herbert Weiss, N.H.A.*

After more than two years in preparation, the Health Care Financing Administration (HCFA) released its 136-page final rule that provides regulators with a wider range of available penalties to enforce quality standards in the nation's 16,700 nursing facilities.

When nursing home provider groups had studied the August 28, 1992 *Federal Register*, they were disturbed by HCFA's proposed enforcement rule calling for perfect compliance with federal nursing home regulations. Many facilities could be closed down or sanctioned by the unrealistic regulations, they charged. Provider and consumer concerns over the proposed enforcement rule generated more than 28,000 comments that the agency reviewed before issuing the final rule last month.

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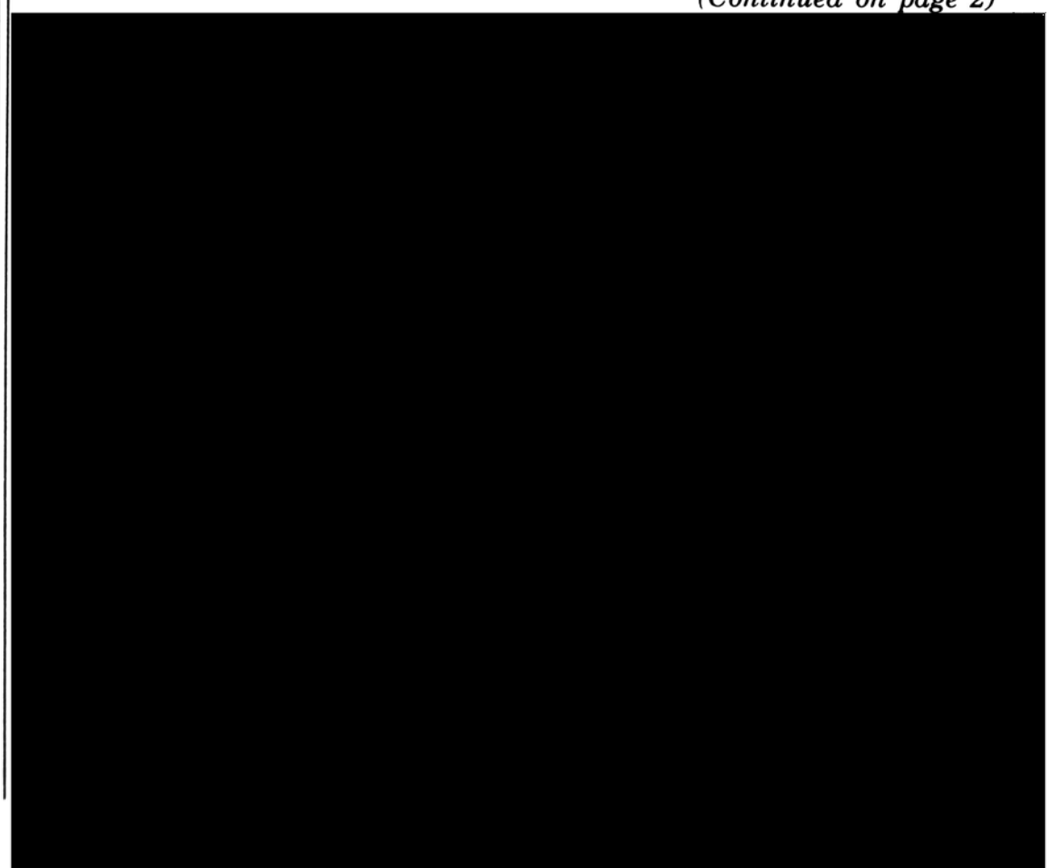

Route to: ❑ Administrator ❑ Asst. Administrator ❑ Medical Director ❑ Nursing Director ❑ Pharmacist ❑ Dietary Services ❑ Activity Director ❑ Social Services Director ❑ Physical Therapist ❑ Occupational Therapist

***Washington Update***
*(continued from page 1)*

Recent press releases issued by the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA) applauded its release.

Under the new regulation, announced in the November 10th, 1994 *Federal Register*, state regulatory agencies will have the option of levying fines to prod nursing homes into regulatory compliance. It provides for daily civil 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 danger to resident health and safety.

HCFA also defines requirements for unannounced surveys, 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 corrected.)

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

## Concerns about implementation

"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 Nursing Home Reform. Her group applauds many aspects of the final regulations, such as:

- requiring that civil monetary penalties be imposed quickly;
- prohibiting facilities from challenging the regulatory agency's selection of a remedy; and
- applying "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 rule 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 they might not feel comfortable expressing their concerns or reporting that they had been harmed for fear of retaliation.

HCFA's definitions of the terms "harm" and "minor deficiency" are key to determining whether a facility is judged in substantial compliance. Minimal deficiencies will not delay a facility's certification or result in the state imposing sanctions to force compliance, says Owen. "We're hoping that we can work with HCFA and provide them input in defining these terms and how the regulations will be implemented."

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.

## Trade groups favor new approaches

The final enforcement rule, to take effect July 1, 1995, more accurately reflects the operating conditions in the real world, says Susan Pettey, director of health policy at the American Association of Homes and Services for the Aging (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," says 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. The provision of "substantial compliance" recognizes that very seldom in our lives or in anyone's home is everything perfect, she says.

Pettey says that AAHSA also is very pleased to see the process of formalizing the informal dispute resolution process. "The earlier you can resolve a dispute about a deficiency, the more efficient, the less costly and the better integrity of the survey process," she notes.

AHCA executive vice president Paul Willging adds: "We applaud the government's decision to include an informal process for resolving conflicts, short of the courts and administrative hearings."

According to Willging, the new rule requires government inspectors to focus on facilities that chronically provide poor care or that

actually have harmed residents. He said that under the new rule, government no longer will waste limited resources for minor oversights.

Adapted with permission from the *Long-Term Care Administrator* 28(8), December 1994. Herbert P. Weiss, N.H.A., is a freelance writer who covers health care and aging. He is a member of the *LTCQL* editorial board.

For more information about the new regulations, contact Anne Verano, Health Care Financing Administration, U.S. Department of Health and Human Services; (202) 690-6145. A copy of the final regulation is available for $8 from the Government Printing Office (GPO). Request Stock No. 069-001-00080-7 from Superintendent of Documents, GPO, Washington, DC 20402-9325; (202) 512-1530.

**Editor's Note:** The new HCFA Enforcement Rule, while an improvement over the former policy, still falls well short of the ideal. While it fines facilities for deficiencies, it offers no reward to facilities that are well above average — thus creating a situation where acceptable but mediocre care is most profitable for the nursing home. Moreover, while it directs that surveys be focused on homes with problems, it does not relieve consistently good homes from the burden of surveys.

In the future, the editors of the *LTCQL* hope that HCFA approaches survey and certification of nursing homes as the IRS does tax audits: A random sample of every facility gets audited, and screening methods based on resident outcomes and consumer complaints are used to select other homes that are strongly suspected of quality outcomes. With the developing technology of case-mix adjustment and outcomes benchmarking based on the Minimum Data Set, such an approach is feasible. Money now spent on unnecessary surveys of high quality homes would be better spent on incentives for excellence.

*-Barry S. Fogel, M.D.*

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# Long-Term Care Quality Letter

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## Also In This Issue



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## Consumers' Perspective

# LTC Delivery System Should Be More 'Person Centered'

*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. The system should allow individuals to live independently at home as long as possible, if that is their choice.

This major policy recommendation was among scores of others placed on a policy "wish list" by more than 400 seniors and aging advocates from six New England states who attended a regional White House Mini-Conference on Aging (WHCoA) held in December.

During the two-day regional conference, concurrent workshops addressed the policy issues of economic security, long-term care, and elder abuse. Next May, WHCoA delegates in Washing

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ton will consider including the New England region's WHCoA report in the final conference summary.

"The 1995 WHCoA will be the single most important forum to discuss issues affecting seniors in our country," said Phil Johnston, regional director of New England Health and Human Services. 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 said.

## Growing need for LTC services

In his keynote address, 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.

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 more than $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 acknowledged that 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 said. He pointed out that long-term care is an intergenerational issue and should not be considered just an elderly concern.

## Long-term care issues addressed

According to Anne Harrington, Ph.D., a consultant in aging and long-term care, many workshop participants called for "individual choice and preference, autonomy, dignity, independence, and personal rights" to be re-

flected 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.

Many participants said that long-term care should 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 in home and community based settings as well as in institutional settings.

Workshop participants also voiced strong concerns that the current long-term care system is confusing and overly complex for many seniors to negotiate and acquire appropriate services. To fix this access problem, they recommended a one-step shopping, single entry to long-term care information and service.

"There was strong support for a national publicly funded social insurance system that provides universal coverage for health and long-term care," said Harrington. But participants disagreed about how to implement such a system, whether there should be a single payer system, regional health alliances or some other funding approach. People were willing to supplement this system through private contributions to programs similar to Medigap insurance, she said.

Workshop participants commented that a full array of home and community based options (*e.g.*, home care, home health care, day care, transportation, respite care, and assisted living, *etc.*) are not always available in many local communities. Even when they are available, high costs, program eligibility restrictions, and limited public funding reduce access to these services. Many believed that a national social insurance system could help seniors live at home longer.

Others urged providers and policy makers to develop better ways to identify, promote, and measure quality of care and quality of life. Consistent with the ideal of a person centered long-term care system, participants said that quality indicators should include the individual's own definition of quality. This subjective assessment can be measured by customer satisfaction surveys and other techniques, Harrington said.

"The world is changing and older persons want to stay at home as long as possible," Harrington said. She concluded that facilities need to change the way they do business; they need to become active in developing alternative services to institutional care.

Reprinted with permission from the *Long-Term Care Administrator*, Jan/Feb 1995. Herbert Weiss, NHA, is a member of the editorial board of *LTCQL*.