

NURSING HOME CARE IN THE UNITED
STATES: FAILURE IN PUBLIC POLICY

INTRODUCTORY REPORT

PREPARED BY THE
SUBCOMMITTEE ON LONG-TERM CARE
OF THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE



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PREFACE

Federal support of long-term care for the elderly has, within a decade, climbed from millions to billions of dollars.

What is the Nation receiving for this money?

This report explores that, and related, questions.

It concludes that public policy has failed to produce satisfactory institutional care—or alternatives—for chronically ill older Americans.

Furthermore, this document—and other documents to follow—declare that today's entire population of the elderly, *and their offspring*, suffer severe emotional damage because of dread and despair associated with nursing home care in the United States today.

This policy, or lack thereof, may not be solely responsible for producing such anxiety. Deep-rooted attitudes toward aging and death also play major roles.

But the actions of the Congress and of States, as expressed through the Medicare and Medicaid programs, have in many ways intensified old problems and have created new ones.

Efforts have been made to deal with the most severe of those problems. Laws have been passed; national commitments have been made; declarations of high purpose have been uttered at national conferences and by representatives of the nursing home industry.

But for all of that, long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system.

It is costly and growing costlier.

It is increasing in numbers, already providing more beds than there are beds in general hospitals.

And there is every reason to believe that many more beds will be needed because the population of old persons in this Nation continues to grow faster than any other age group.

Nursing home care is associated with scandal and abuse, even though the best of its leaders have helped develop vitally needed new methods of care and concern for the elderly, and even though—day in and day out—underpaid, but compassionate, aides in many homes attempt to provide a touch of humanity and tender care to patients who, though mute or confused and helpless, nevertheless feel and appreciate kindness and skill.

This industry, which has grown very rapidly in just a few decades—and most markedly since 1965, when Medicare and Medicaid were enacted—could now take one of three courses:

It could continue to grow as it has in the past, spurred on by sheer need, but marred by scandal, negativism, and murkiness about its fundamental mission.

It could be mandated to transform itself from a predominantly proprietary industry into a nonprofit system, or into one which takes on the attributes of a quasi-public utility.

Or it could—with the informed help of Government and the general public—move to overcome present difficulties, to improve standards of performance, and to fit itself more successfully into a comprehensive health care system in which institutionalization is kept to essential minimums.

Whatever course is taken, it is certain that the demand for improvement will become more and more insistent.

Within the Congress, that demand has been clearly expressed in recent years. But often congressional enactments have been thwarted by reluctant administration, or simply have been ignored. Now, facing the prospect of early action upon a national health program for all age groups, the Congress must certainly consider long-term care a major part of the total package. Wisely used, the momentum for a total health care package could be used to insure better nursing home care.

Within the administration, there has been drift and unresponsiveness to congressional mandate since 1965. There are signs, however, that rising costs and rising public concern have aroused certain members of the executive branch to see the need for long-term care reform more clearly than before. Their actions and initiatives are welcome, but it is essential that the Department of Health, Education, and Welfare, take far more effective, well-placed action than it has thus far.

Everywhere, the demand for reform is intensifying. People know that a nursing home could be in everyone's future.

They ask why placement in such a home should be the occasion for despair and desperation, when it should be simply a sensible accommodation to need.

The Subcommittee on Long-Term Care of the Senate Special Committee on Aging continually has asked the same question.

Care for older persons in need of long-term attention should be one of the most tender and effective services a society can offer to its people. It will be needed more and more as the number of elders increases and as the number of very old among them rises even faster.

What is needed now? As already indicated, the forthcoming debate over a national health program will offer opportunity for building good long-term care into a comprehensive program for all Americans.

But the issues related to the care of the chronically ill are far from simple. Tangled and sometimes obscure, technical questions related to such matters as reimbursement, establishment of standards, enforcement, and recordkeeping, often attract the attention of policy-makers, to the exclusion of other questions, such as:

Could nursing homes be avoided for some, if other services were available?

What assurance is there that the right number of nursing homes are being built where they are most needed?

What measures can Government take to encourage providers themselves to take action to improve the quality of nursing home care?

What can be done to encourage citizen action and patient advocacy at the local level?

Such questions intrude even when the best of care is given. In other settings, however, scandal and calamity enter the picture; and dark new questions emerge.

The subcommittee, in this report and succeeding Supporting Papers, recognizes the importance of the nursing home industry; and it pledges every effort to continue communication with representatives of the industry and with members of the executive branch.

For these reasons, the subcommittee has devised an unusual format: After publication of this Introductory Report, a series of follow-up papers on individual issues will follow; then we will publish a compendium of statements invited from outside observers; after this will come our final report. In this way, the subcommittee can deal with the many parts needed to view long-term care as a whole.

Testimony from many, many days of hearings and other research have been tapped for this report, which is extensive and heartfelt. Concern about people has been at the heart of this effort. The subcommittee has, therefore, been especially dependent upon responsive staff effort. Mr. Val Halamandaris, associate counsel for the Senate Special Committee on Aging, deserves specific mention for his role in assuring that subcommittee inquiries remained directed at their real target: to wit, people in need of good care. Mr. Halamandaris has had the primary responsibility for directing the subcommittee's hearings; he is responsible for the excellent research on data and for writing this report. He is more than a skilled and attentive attorney; his investigatory skills are rooted in concern and, when necessary, outrage. He has made it possible for this subcommittee to compile and offer more information and insights into the nursing home industry than the Congress has ever had before.

He has been helped considerably by other committee personnel. Staff Director William Oriol has provided guidance and consultation leading to the design and special points of emphasis in this report. Committee Counsel David Affeldt has given generously of his legislative expertise, as well as painstaking attention to detail.

Particularly fortunate for the subcommittee was the fact that a professional staff member, John Edie, had special qualifications for making a substantial contribution to this effort. Mr. Edie, an attorney, formerly served as counsel to a program on aging in Minneapolis, Minn. When the subcommittee went to that city for intensive hearings on scandalous shortcomings in nursing home care there, Mr. Edie testified and then continued his efforts on behalf of reform. In the preparation of this report, he has worked closely and at length with Mr. Halamandaris and his associates.

The subcommittee also stands in debt to a select group in the nursing home industry and within the executive branch. Usually without much attention or encouragement, these public servants have stubbornly refused to compromise their goal, seeking high, but reasonable, standards of care.

With the publication of this Introductory Report, the subcommittee begins a final exploration of issues. We will publish responsible comments on findings expressed in this document and the Supporting Papers which will follow. And we will, in our final report, perhaps 8

to 10 months from now, make every effort to absorb new ideas or challenges to our findings. The care of chronically ill older Americans is too serious a topic for stubborn insistence upon fixed positions. Obviously, changes are needed. Obviously, those changes will occur only when public understanding and private conscience are stirred far more than is now the case.

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

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NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

INTRODUCTORY REPORT

DECEMBER 19, 1974.—Ordered to be printed

Mr. Moss, from the Special Committee on Aging,

ABOUT THIS REPORT

Nursing home care in the United States is a relatively young industry. It did not really begin until enactment of Social Security in 1935; it began to grow substantially after World War II; it accelerated tremendously after Medicare and Medicaid were enacted in 1965.

To the Senate Committee on Aging and in particular to its Subcommittee on Long-Term Care, the growth of the industry has been a source of satisfaction. Quite clearly, nursing home care is an essential element in what should be a continuum of care for older Americans. In this regard, the Federal dollar has been a major factor in stimulating the availability of nursing home services. But the subcommittee is also deeply concerned that Federal funds are now used to support substandard care in far too many cases.

On the one hand, the subcommittee recognizes that long-term care is needed now and will be needed even more in the future, particularly as the number of elderly over age 75 continues to increase. Impressive gains in providing such treatment have been made; the brick-and-mortar structures needed for beds and for rehabilitation have been, to a large degree, provided. Impressive and encouraging methods of treatment have been developed to restore health where possible or to make chronic illness as tolerable as possible in cases where it is truly irreversible.

On the other hand, the subcommittee must reluctantly subscribe to the major finding of this survey: a coherent, constructive, and progressive national policy has not yet been developed to meet the long-term care needs of the elderly.

As a result, millions of older Americans who have already received care in nursing homes have not received maximum help. In many cases they have not even received humane treatment. And in an alarming number of known cases, they have actually encountered abuse and

physical danger, including unsanitary conditions, fire hazards, poor or unwholesome food, infections, adverse drug reactions, overtranquillization, and frequent medication errors. In addition, they have been exposed to negligence on the part of nursing home personnel. The net impact is that far too many patients have needlessly sustained injury and, in some cases, death.

This failure in public policy is not only intolerable but also costly. In order to describe the full dimensions of this failure in public policy, the subcommittee has developed an unusual plan of action to present the facts about nursing home care in the United States to the Congress, to the executive branch, and, primarily, to the American public.

To deal with the intricate circumstances and governmental actions which have resulted in the present situation, the subcommittee will begin this analysis with the overall view incorporated in the document published today, the "Introductory Report." On the pages which follow a substantial part of the story is told.

But to provide full information and documentation on other parts of the story, a series of "SUPPORTING PAPERS" will be published at approximately monthly intervals over the next few months. Each will deal with a fairly specific issue; and each of those issues will be examined in the detail needed for adequate understanding, not only by legislative and health specialists, but by laymen.

A study of this magnitude would be incomplete without the reaction of the nursing home industry and representatives of the executive branch. Accordingly, national organizations¹ will be invited to submit statements within 2 months after the publication of the final "SUPPORTING PAPER." These statements will, within reason, appear in full. This response by the industry and the executive branch is not necessarily intended to provide an opportunity for rebuttal, unless such rebuttal is deemed necessary. Rather, the papers are intended to provide an opportunity for full discussion of the issues developed in the initial report and "SUPPORTING PAPERS."

Finally, the subcommittee will issue a concluding report analyzing the response from national organizations and administration spokesmen. In addition, the report will include final conclusions and final recommendations for action.

The format is unusual, perhaps unprecedented. But—as the following pages will make clear—the nursing home industry requires intense attention. That industry could be at the end of its controversial beginning. It could be on the verge of a second stage of growth combined with maturity and effectiveness of treatment. Or it could go through a very different type of stage two: a period marked by further failures in policy and the absence of clearcut goals.

¹ American Association of Retired Persons-National Retired Teachers Association; American Association of Homes for the Aging; American College of Nursing Home Administrators; American Nursing Home Association; Gerontological Society; National Council on the Aging; National Council of Health Care Services; National Council of Senior Citizens; American Medical Association; American Nurse's Association; and others.

The United States—and particularly its older citizens—cannot afford more failure in our nursing homes. We have already paid too much in dollars, and our elders have paid too high a price in despair and suffering.

THE FACTUAL UNDERPINNING OF THIS STUDY

Fifteen years of fact-gathering preceded publication of this report. In 1959, the Senate Committee on Labor and Public Welfare established a Subcommittee on Problems of the Aged and Aging. Its mission was to undertake the first comprehensive congressional evaluation of the quality of life enjoyed or endured by older Americans. That subcommittee gave major attention to nursing home care in its hearings in and outside Washington, D.C. Its findings were summed up in a study² which declared that the average nursing home promotes passivity, immobility, and even total disability.

It also summed up the very poignant set of circumstances encountered by so many persons then, and by so many persons since:

Every troubled son or daughter, anxious to find a good nursing home for a father or mother, is dismayed, and often shocked, by the inadequacy, the hopelessness, inherent in most nursing homes. Those who have wandered from home to home seeking decent facilities, a therapeutic environment, and a life-restoring force pulsing through its system too often have given up in frustration. Or with no other solution feasible or possible, they may consign a parent or relative to an inadequate nursing home, but with troubled conscience and feelings of guilt.

The subcommittee also acknowledged in 1960, as this report acknowledges in 1974, that the general picture of despair and shortcomings of treatment is contradicted by those nursing homes which provide quality nursing care, occupational and recreational therapy, and good medical services.

But the subcommittee concluded, as this report must also conclude, that such homes are in the minority.

Shortly after the report on nursing homes, the subcommittee issued a more general report³ which strongly recommended establishment of a Senate Special Committee on Aging. The report also urged that this new committee should give early attention to several key health problems affecting the elderly. Established on February 1, 1961, the committee first considered nursing home issues through its Health Subcommittee.

In 1963 and 1964, however, the subcommittees on health and housing joined forces for hearings,⁴ leading to the establishment of a Subcommittee on Long-Term Care by a committee resolution in February 1965. Senator Frank Moss, who had chaired the earlier hearings, was

² *The Condition of American Nursing Homes*: February 1960.

³ *Action for the Aged and Aging*, March 28, 1961.

⁴ *Long-Term Institutional Care for the Aged (Federal Programs)* Washington, D.C., Dec. 17-18, 1963.

named subcommittee chairman; and he conducted seven hearings in 1965, taking a total of 1,300 pages of testimony.

As is so often the case in matters related to long-term care, events occurred which required immediate action while precluding publication of a report. But data taken at the 1965 hearings served to make the case for legislative reforms known as the Moss and Kennedy Amendments of 1967.⁵

Another phase of subcommittee activity began with hearings on "Trends in Long-Term Care" in 1969. Some 3,000 pages of testimony were taken by the time the last of these hearings was held in October 1973. Once again the subcommittee reviewed the overall effectiveness of long-term care, but this time against the backdrop of several years of experience with the Medicare and Medicaid programs. Emergency situations, such as fatal nursing home fires or a food poisoning epidemic, received prompt attention. Nursing home administrators or spokesmen for the industry were far and away the most numerous witnesses, making 70 appearances. Representatives of State and local health departments were second with 22 appearances. Persons who worked directly with the elderly in nursing homes also appeared, providing some of the most illuminating testimony. Nursing home profits were examined, along with the quality of nursing home care. Testimony at individual hearings focused on such matters as access of minority groups to nursing homes and positive trends in nursing home care.

For this report, the primary source of data is the 1969-73 hearing transcripts and several supplementary studies by subcommittee staff, the General Accounting Office, and private groups such as Ralph Nader's Study Group on Nursing Homes in 1971. The Library of Congress, other congressional committees, and professional organizations, including the American Nursing Home Association, have also been helpful. Finally, much of the information for this report was provided by the Department of Health, Education, and Welfare and other administrative or independent agencies such as the Securities and Exchange Commission. The assistance of State officials, so many of whom must struggle with shifts or contradictions in Federal policy, proved especially helpful. The assistance of so many persons is gratefully acknowledged.

In the course of examining hearing transcripts and other studies, careful attention has been paid to selection of excerpts. No statement appearing in quotations has been used in this study unless the principle illustrated is still valid at the present time. Any exceptions will be noted in a footnote or explanatory discussion.

⁵ For additional information, see pp. 65-71 of this report.

INTRODUCTORY REPORT AND SUPPORTING PAPERS

Despite the plan to divide the subject matter of this study into an introductory report and supporting papers, an early statement on the extent of major findings is needed for an informed impression of the magnitude and substance of the entire effort. That summary follows.

MAJOR FINDINGS*

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

(Introductory Report)

Medicaid now pays about 50 percent of the Nation's more than \$7.5 billion nursing home bill, and Medicare pays another 3 percent. Thus, more than \$1 of every \$2 in nursing home revenues is publicly financed.¹

There are now more nursing home beds (1.2 million) in the United States today than general and surgical hospital beds (1 million).

In 1972, for the first time, Medicaid expenditures for nursing home care exceeded payments for surgical and general hospitals: 34 percent as compared to 31 percent for hospitals.

Medicaid is essential for growing numbers of elderly, particularly since Medicare nursing home benefits have dropped sharply since 1969. Average Social Security benefits for a retired couple now amount to \$310 a month compared to the average nursing home cost of \$600. Medicaid (a welfare program) must be called upon to make up the difference.

The growth of the industry has been impressive. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and expenditures for care by 465 percent. Measured from 1960 through 1974, expenditures increased 1,400 percent.

¹ The Committee's Introductory Report, as released on November 19, 1974, incorporating the latest statistics from HEW reported that total revenues for the nursing home industry in 1972 were \$3.2 billion and \$3.7 billion for 1973. Subsequent to publication of this report the Social Security Administration released new estimates for 1974. Total expenditures are estimated at \$7.5 billion. This change reflects spending for the Intermediate Care program, which until recently was a cash grant program to old age assistance recipients. With its change to a vendor payments program such expenses are properly countable as nursing home expenditures. Consequently, changes were made in this report. For complete details, see appendix 10.

*For recommendations, see p. 109, this Report and each "SUPPORTING PAPER."

Despite the heavy Federal commitment to long-term care, a coherent policy on goals and methods has yet to be shaped. Thousands of seniors go without the care they need. Others are in facilities inappropriate to their needs. Perhaps most unfortunate, institutionalization could have been postponed or prevented for thousands of current nursing home residents if viable home health care and supportive services existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients—as well as substantially less expensive—the Department of HEW has given only token support for such programs.

Despite the sizable commitment in Federal funds, HEW has been reluctant to issue forthright standards to provide patients with minimum protection. Congress in 1972 mandated the merger of Medicare and Medicaid standards, with the retention of the highest standard in every case. However, HEW then watered down the prior standards. Most leading authorities concluded at subcommittee hearings that the new standards are so vague as to defy enforcement.

There is no direct Federal enforcement of these and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the enforcement system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.

The President's program for "nursing home reform" has had only minimal effect since it was first announced in 1971 and actions in 1974 fall far short of a serious effort to regulate the industry.

The victims of Federal policy failures have been Americans who are desperately in need of help. The average age of nursing home patients is 82; 95 percent are over 65 and 70 percent are over 70; only 10 percent are married; almost 50 percent have no direct relationship with a close relative. Most can expect to be in a nursing home over 2 years. And most will die in the nursing home. These patients generally have four or more chronic or crippling disabilities.

Most national health insurance proposals largely ignore the long-term care needs of older Americans. Immediate action is required by the Congress and executive branch to improve past policies and programs which have been piecemeal, inappropriate, illusory, and short-lived.

MAJOR POINTS

Supporting Paper No. 1

"THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY"

Abuses of patients in nursing homes have been well publicized and well documented. And yet they persist, perhaps because of the belief that they are exceptions to the rule. However, subcommittee transcripts are replete with examples of cruelty, negligence, danger from fires, food poisoning, virulent infections, lack of human dignity, callousness and unnecessary regimentation, and kickbacks to nursing home operators from suppliers.

Estimates on the number of substandard nursing homes in the United States vary widely, but the overwhelming evidence indicates that a majority of the nursing homes fail to meet standards of acceptability.

Nursing home placement often is a bitter confirmation of the fears of a lifetime. Seniors fear change and uncertainty; they fear poor care and abuse; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and "going on welfare." To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

Supporting Paper No. 2

"DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS"

According to most studies, the average nursing home patient takes 4.2 different medications each day. However, more recent studies reveal that the average may be seven medications, or perhaps even higher. Prescriptions for nursing home patients typically total \$300 per year, more than three times the cost for the noninstitutionalized elderly. In 1972, drugs accounted for 10 percent of all nursing home expenditures—\$300 million in all.

And yet, the flow of drugs through many of America's 23,000

nursing homes is largely without controls. It is haphazard; it is inefficient; and it does not help the patient desperately dependent upon others for protection when put in a state of semisleep or outright unconsciousness.

Supporting Paper No. 3

“DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY”

Physicians have, to a large degree, shunned the responsibility for personal attention to nursing home patients. One of the reasons for their lack of concern is inadequate training at schools of medicine. Another is the negative attitude toward care of the chronically ill in this Nation. Medical directors are needed in U.S. nursing homes and will be required in HEW regulations effective January 1976. The subcommittee's May 1974 questionnaire to the 101 U.S. schools of medicine indicates a serious lack of emphasis on geriatrics and long-term care:

Eighty-seven percent of the schools indicated that geriatrics was not now a specialty and that they were not contemplating making it one; 74 percent of the schools had no program by which students, interns, or residents could fulfill requirements by working in nursing homes; and 53 percent stated they had no contact at all with the elderly in nursing homes.

Supporting Paper No. 4

“NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)”

Of the 815,000 registered nurses in this Nation, only 56,235 are found in nursing homes, and much of their time is devoted to administrative duties. From 80 to 90 percent of the care is provided by more than 280,000 aides and orderlies, a few of them well trained, but most literally hired off the streets. Most are grossly overworked and paid at, or near, the minimum wage. With such working conditions, it is understandable that their turnover rate is 75 percent a year.

One reason for the small number of registered nurses in nursing homes is that present staffing standards are unrealistic. The present Federal standard calls for one registered nurse coverage only on the day shift, 7 days a week, regardless of the size of the nursing home. By comparison, Connecticut requires one registered nurse for each 30 patients on the day shift, one for every 45 in the afternoon; and one each 60 in the evening.

A serious national shortage of nurses still persists, despite training programs.

Supporting Paper No. 5

“THE CONTINUING CHRONICLE OF NURSING HOME FIRES”

In 1971, there were 4,800 nursing home fires; 38 persons were killed in multiple death fires and some 500 more in single death fires. An estimated \$3.5 million loss was directly attributable to nursing home fires.

Nursing home patients are especially vulnerable to fires. Many are under sedation or bound with restraints. Physical infirmities and confusion often cause resistance to rescue.

There is reason to believe the number of nursing homes failing to meet fire safety standards is actually increasing.

In 1971, the General Accounting Office reported that 50 percent of U.S. nursing homes were deficient in regard to fire safety. A January 1974 study by the U.S. Office on Nursing Home Affairs said that 59 percent of skilled nursing facilities are certified with deficiencies. HEW spokesmen indicated that in excess of 60 percent of intermediate facilities do not comply with existing standards. The requirements are on the books, but they are not heeded. Even more dramatically, the GAO 1974 study indicates 72 percent of U.S. nursing homes have one or more major fire deficiencies.

Supporting Paper No. 6

“WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS IN LONG-TERM CARE”

It is unjust to condemn the entire nursing home industry. There are many fine homes in America. A growing number of administrators are insisting upon positive approaches to therapy and rehabilitation, innovations in physical structure of the physical plant; employee sensitivity training and cooperative agreements with local schools of nursing; and even self-government and other activities for the patients.

“Ombudsmen” programs have been established by Presidential direction and are making some headway. In some States, the nursing home industry has launched an effort to upgrade its facilities by establishing directories, rating systems, and a “peer review” mechanism. These efforts offer the prospect of improving nursing home conditions if conducted in a vigorous and effective manner. In Chicago, nursing homes have a “cool line” telephone number for relatives, visitors, or patients who have complaints.

Supporting Paper No. 7

**"THE ROLE OF NURSING HOMES IN CARING FOR
DISCHARGED MENTAL PATIENTS"**

Thousands of elderly patients have been transferred from State mental institutions to nursing homes. The number of aged in State mental hospitals decreased 40 percent between 1969 and 1973, according to subcommittee data, dropping from 133,264 to 81,912. This trend is caused partially by progressive thinking intended to reduce patient populations in large impersonal institutions. Another powerful reason, however, may be cost and the desire to substitute Federal for State dollars. It costs the States an average of \$800 per patient per month to care for mental patients in State hospitals while these same individuals can be placed in boarding homes at a substantially reduced cost. Charges of "wholesale dumping" of patients have been made in several States. Acute problems have been reported, most notably in California, Illinois, and New York.

Supporting Paper No. 8

"ACCESS TO NURSING HOMES BY U.S. MINORITIES"

Only 4 percent of the 1 million nursing home patients in the United States are members of minority groups, even though their health needs are proportionately greater. Part of the problem is caused by cost obstacles or lack of information about Medicaid. Discrimination is the greatest obstacle to greater utilization by blacks. But discrimination need not be overt; often relatives are made to feel that their parent or grandparent would not be made comfortable. In the case of Asian-Americans and Spanish-speaking Americans, language barriers often cause insurmountable difficulties. Cultural and other problems, including rural isolation, cause problems to American Indians.

Members of minority groups at subcommittee hearings have been sharply critical of the Nixon administration's nursing home "reforms." They protested the "arbitrary and punitive" closing of a few minority owned nursing homes that do exist and the absence of assistance to help upgrade standards.

Supporting Paper No. 9

**"PROFITS AND THE NURSING HOME: INCENTIVES IN
FAVOR OF POOR CARE"**

Profits by nursing homes have occasioned serious and persistent controversy. Nursing home administrators say that Medicaid reimbursement rates are low and that they can hardly become

the basis for profiteering. Critics say that the economics of nursing home operation, supported in such large measure by public funds, should be examined more closely and publicly than they now are.

On the basis of available evidence, including a subcommittee survey made in 1973-74, the subcommittee has found that the 106 publicly held corporations controlled 18 percent of the industry's beds and accounted for one-third of the industry's \$3.2 billion in revenue (as of 1972). Between 1969 and 1972, these corporations experienced the following growth:

- 122.6 percent in total assets;
- 149.5 percent in gross revenues; and
- 116 percent in average net income.

One recent HEW study, however, shows marginal rates of return in a sample of 228 nursing homes. Thus, the issue is far from settled. But a joint study—conducted by the General Accounting Office and the subcommittee—suggests significant increases in total assets, revenues, and profits for individual operators as well.

Two final documents will be issued as part of this study: A compendium of statements by the industry and administration spokesmen, and a final report by the Subcommittee on Long-Term Care.

GENERAL CONCLUSIONS

There is every reason to believe that the need for high quality long-term care facilities will continue to increase. One of the major reasons is that more and more people are living longer and longer. Individuals with multiple disabilities and advanced age are likely candidates for institutionalization.

Any interpretation of these facts inevitably concludes that the thousands of seniors needing nursing home care but suffering at home will multiply rapidly in future years, unless significant changes in present practices are made.

It is time then for the Congress and the executive branch to create a comprehensive national policy with respect to treatment of the infirm elderly.

It is time also for the Congress and the executive branch to improve the quality of life for the 1 million Americans *presently residing* in U.S. long-term care facilities.

It is time for providers of care to rise above mere public relations campaigns and join with senior citizens' spokesmen and Government officials in working for more positive improvements.

It is time that nursing homes began realizing their full potential as full and legitimate partners in the American health care system.

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

INTRODUCTION

As has already been explained in "About this Report," the report which follows is the introductory statement in a far-reaching inquiry. It can touch only glancingly upon several issues which will be discussed at greater length in supplementary papers.

It does, however: (1) Report on the dimensions of the nursing home industry and the amount of public support; (2) explore in some detail the impact of Medicare and Medicaid on long-term care; and (3) examine the present U.S. policy on nursing home care, including its shortcomings, contradictions, and unsteady and occasionally retrogressive evolution within recent years.

PART I

THE PEOPLE IN NURSING HOMES

Of necessity, congressional discussion of nursing home care in the United States today often turns to methods of reimbursement, and statutory or regulatory standards of service.

And yet, the key questions in any such discussion are: how many people need long-term care and then, what kind of treatment do they actually receive?

The most prevalent feelings about a nursing home today are fear and dread. For many elderly, the nursing home will be their last home. Most of the patients in such facilities are very old and have a number of illnesses. Even the best of care cannot work miracles.

But often, partial or even full rehabilitation is possible with proper care—care which all too often has not been forthcoming. Recovery from an illness and rehabilitation should not be limited to the young. The hope of recovery should not be denied to the elderly. Victories are possible in nursing homes; they should be more frequent.

And this is what this report is all about: the expression (and implementation of) a policy expressing the deep-rooted conviction that the residents in long-term care institutions are fellow human beings worthy of full dignity and expert care, assured of recovery when recovery is feasible and assured of equally tender and skilled care when recovery is no longer possible.

We are far from that goal; and the situation will intensify because the demand for nursing home care is accelerating since the number of "old" elderly are increasing faster than their younger counterparts.

I. OLDER AMERICANS IN NEED OF LONG-TERM CARE

The average lifespan at the height of the Roman Empire was 23 years. At the turn of the century in the United States, it reached 47 years. Today, life expectancy at birth is 70 years for the average American child. Those who reach their 65th birthday can expect, on the average, 15 additional years of life. In 1900, only 4 percent of the population, or 3 million people were age 65 and over. Today, that age group makes up 10 percent of the population and numbers about 21 million.

In short, the number of 65-plus persons in the United States has increased 600 percent in just 74 years. About one-third of these people are past 75. During the 1960's, the number of the over-75 group increased 37.1 percent, compared with a rate of 13 percent for those between 65 and 75. The over-75's are the fastest growing of all population groups.

A. THOSE NOW IN INSTITUTIONS

At the end of 1971, a little over 5 percent of the elderly were in institutions. Some 1,106,103 were in nursing homes and about 100,000 were in mental institutions.¹ (The aged constitute almost 30 percent of mental hospital inpatients.)

The 5 percent figure is roughly comparable to the percentage of institutionalized elderly in other industrialized nations.²

And yet the 5 percent figure is deceptive. The number of people actually in institutions is not a definitive measure of the number of people who may have chronic illness and may need treatment. The 5 percent figure represents only the number of elderly in nursing homes and related facilities on any given day. Recent studies indicate an 80 percent or higher turnover rate.³

A widely published study by Dr. Robert Kastenbaum of Wayne State University notes: "While one in 20 seniors is in a nursing home or related facility on any given day, one out of five seniors will spend some time in a nursing home during a lifetime."⁴

B. ESTIMATES OF REAL NEED

How many older Americans need nursing home care? As indicated above, the 5 percent figure can be misleading. The most persuasive estimates mirror Dr. Kastenbaum's finding that one senior in five will spend some time in a nursing home prior to his death. A recent working paper by Burton Dunlop of the Urban Institute estimates that 25 percent of the total aged population (or about 5 million people) require some type of care for chronic illness. Two million receive care in nursing homes or elsewhere. Among the remaining 3 million requiring care according to Dunlop, the breakdown would be as follows: nursing homes, 600,000; home health care, 1.3 million; congregate living facilities or help in preparing their meals, another 1.1 million.⁵

It appears evident that if the 2.4 million elderly in the community do not have their needs for home health, supportive service and meal services met, they will deteriorate to the point where institutionalization will be necessary, or they will die.

C. WHO CAN AFFORD LONG-TERM CARE?

It is a simple fact that most older Americans cannot afford the long-term care they require.

The financial chasm between need and ability to pay can be readily summed up:

Average nursing home charges in the United States are about \$600 a month, and average Social Security benefits for a retired couple amount to \$310 a month.

¹ See reference No. 1, p. 397, reference No. 12, p. 3, and results of Subcommittee Questionnaire to State Departments of Mental Health in Supporting Paper Number 7. (See p. 27 for references mentioned in footnotes.)

² Shanas, Ethel, "Measuring the Home Health Needs of the Aged in Five Countries," *Journal of Gerontology*, Vol. 26, No. 1 (1971), pp. 37-40.

³ See reference No. 13, p. 16-17. A figure of 86 percent per year is offered by reference No. 12, p. 4.

⁴ Kastenbaum, Robert, "The Four Percent Fallacy", presented to the 1972 Annual Meeting of the Gerontological Society, as printed in *Aging and Human Development*, Vol. 4, No. 1, 1973.

⁵ See reference No. 19, pp. 2, 11, 19.

Moreover, Medicare is of little help, paying for the care of only 70,000⁶ persons on any given day out of the 1 million in long-term care facilities. It is only Medicaid—a Federal-State program requiring a means test—which is extensively used.

Many are too proud to seek welfare. Asset limitations constitute another barrier. Some elderly persons, who would otherwise qualify, refuse to participate because of their reluctance to lower their assets by (1) accepting a lien on their homes, or (2) reducing their savings.

D. A PORTRAIT OF THE NURSING HOME POPULATION

One million older Americans are in nursing homes. What are they like? The following summary discusses facts which must be considered in any evaluation of long-term care in this Nation:

They are very old.—The average age of patients is 82; 95 percent are over 65 and 70 percent over 70.⁷

Most of them are female.—Women outnumber men two to one in pre-1970 studies and three to one in more recent tabulations.⁸

Most of them are widows.—Sixty-three percent are widowed; 22 percent never married; about 5 percent were divorced and only 10 percent are married.⁹

They are alone.—Since most nursing home patients are in their 70's and 80's they may well have outlived their own children. Almost 50 percent have no viable relationship with a close relative, and another 30 percent have only collateral relatives near their own age.¹⁰

The great majority are white.—96 percent of nursing home patients are white, with blacks accounting for an additional 2 percent. The remainder includes diverse groups such as Mexican-Americans, elderly Asians or Indians, etc.¹¹

Most of them come to the nursing home from their private homes.—More than 55 percent of patients came to the long-term care facility from their own or relatives homes; 32 percent came from hospitals (22 percent from general and 10 percent from State mental hospitals); 13 percent came from other nursing homes or homes for the aged, boarding homes, or other housing.¹²

Most of them could expect to be in a nursing home well over a year.—But many studies indicate that the length of stay in a nursing home is 2 or more years.¹³

Most patients entering a nursing home will die there.—There is great variation in statistics on this subject. Some studies indicate that

⁶ "Trends in Long-Term Care", Part 18, hearing by the Subcommittee on Long-Term Care, Washington, D.C., October 28, 1971, p. 2006.

⁷ See reference No. 25; reference No. 15, p. 17; reference No. 23, p. 8; reference No. 8, p. 3. These sources and others indicate an average age from 79 to 83.

⁸ There is a consensus of opinion concerning this figure. See reference No. 12, p. 3; reference No. 15, p. 17.

⁹ See reference No. 25; reference No. 17, p. 13.

¹⁰ See reference No. 25; reference No. 17, p. 13; reference No. 22, p. 32.

¹¹ See reference 8, pp. 3-4. See also "Trends in Long-Term Care", Part 20, hearing by the Subcommittee on Long-Term Care, Washington, D.C., August 10, 1972, p. 2439.

¹² See reference No. 17, p. 15. See also "Selected Institutional Characteristics of Long-Term Care Facilities", George Washington University, Department of Health Care Administration, Long-Term Care Monograph Series, No. 4 (1970).

¹³ Measuring length of stay in long-term care facilities is difficult and subject to considerable error. Complicating this measurement is the fact that patients may move from nursing home to nursing home, or from nursing home to hospital and back again several times in one year. However, four sources indicate a length of stay of over two years. See reference No. 21, p. 25; reference No. 25, p. 4; reference No. 23, p. 11; reference No. 17, p. 17; and reference No. 22, p. 33.

87 percent of patients died in the nursing home; others reveal that only 4 percent of nursing home patients can ever be returned to the community. The more conservative figures indicate that 50 percent of nursing home patients die in nursing homes; 21 percent are returned to hospitals; 19 percent are sent home (or to their relatives homes) and 10 percent are placed in other accommodations.¹⁴

Nursing home patients generally have about four chronic or crippling disabilities.—Authoritative studies reveal that nursing home patients have 3.8 disabilities. Cardiovascular disease ranks first, experienced by 65 percent of the patients. What is loosely termed senility is generally found among 20 percent of the patients; fractures are third most prevalent at 11 percent, followed by arthritis at 10 percent.¹⁵

A majority of patients are mentally impaired.—Widely supported data establishes that 55 percent or more of long-term care patients are mentally impaired. One study, however, put the figure at 80 percent.¹⁶

Less than half of the patients can walk.—About 55 percent require assistance in bathing; 47 percent need help in dressing; 11 percent in eating and 33 percent are incontinent.¹⁷

They take large quantities of drugs.—The average nursing home patient takes 4.4 different drugs per day, some taken 2 and 3 times; 70 percent take five or more drugs per day. Some recent studies average seven different drugs a day. The average cost of drugs per patient is \$300 per year.¹⁸

They regard the nursing home with fear and hostility, and there are sharp increases in the death rate associated with transfer to nursing homes.—Much evidence clearly indicates that old people look upon a nursing home with fear and hostility. It has been documented that old people believe entry into a home is a prelude to death, and that there is a negative relationship between survival and institutionalization. Substantially higher death rates were recorded among those admitted to nursing homes than among control groups, generally those on a list waiting admission.

This phenomenon has been termed "transplantation shock" by one researcher, who recorded a 42 percent death rate for those admitted to institutional facilities and 28 percent for those waiting admission.

¹⁴ See reference No. 17, p. 25; reference No. 22, p. 34; "Trends in Long-Term Care", Part 1, hearing by the Subcommittee on Long-Term Care, Washington, D.C., July 30, 1969, testimony of Joseph Hunt, Commissioner, Rehabilitation Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, p. 18; and Reference No. 12, p. 4.

¹⁵ See reference No. 23, pp. 12-13; reference No. 22, pp. 37 and 41; reference No. 10, p. 11.

¹⁶ *Mental Health Care and the Elderly: Shortcomings in Public Policy*, report of the Special Committee on Aging, November 1971, p. 8; Fisch, M., Shaninlan, S., and Goldfarb, A., "Early brain damage in the aged: a community and clinical study," Office of Consultant on Services for the Aged, State of New York Department of Mental Hygiene, duplicated (1962); Goldfarb, A., "Prevalence of psychiatric disorder in metropolitan old age and nursing homes," *Journal of American Geriatric Society* (1962), pp. 77-84; Goldfarb, Alvin L., "The Senile Older Person in Selected Papers," 5th Annual Conf. of State Executives on Aging, U.S. Department of Health, Education, and Welfare, Washington, D.C. 1965; Lowenthal, M., "Social isolation and mental illness in old age," *Amer. Soc. Rev.*, 29, 1964, pp. 54-70; National Center for Health Statistics, 1965, "Characteristics of residents in institutions for the aged and chronically ill—United States," April-June 1963, Public Health Service Publication No. 1000—Serial 12—No. 2. Washington: Government Printing Office.

¹⁷ See reference No. 17, p. 20; reference No. 21, pp. 23-24; reference No. 26, p. 5.

¹⁸ See reference No. 23, p. 16; reference No. 22, p. 42; letter of November 19, 1973 from pharmacist John Rawlings (of Nampa, Idaho) to Senator Frank Church citing an average of 5.6 drugs per patient per day; "A Prospective Study of Drug Preparation and Administration in Extended Care Facilities" by Allan Cheung, Pharm. D. M.P.H., Assistant Professor of Clinical Pharmacy, School of Pharmacy, University of Southern California, Los Angeles, California January 31, 1973 unpublished monograph in Committee files. For more details, see Supporting Paper 2.

Some experts charge that the shock of the uprooting is the cause, and others emphasize attitudes associated with the move.¹⁹

Most nursing home patients are placed in facilities close to their homes.—Five out of six nursing home patients are housed in facilities less than 25 miles away from their community home. Proximity is the major consideration to families of nursing home patients.²⁰

Some have visitors, but most do not.—Estimates vary, but there is agreement that most nursing home patients do not have visitors. This is because a third or more have no relatives. A comprehensive New Hampshire study disclosed that 42 percent had visitors weekly.²¹

There is little evidence to support the theory that families "dump" their aged into nursing homes.—Most studies indicate that institutionalization is the last, not the first resort, of families. Elaine Brody of the Philadelphia Geriatrics Center has written about families facing this question:

In general they have exhausted all other alternatives, endured severe personal, social and economic stress in the process, and made the final decision with utmost reluctance. This has ceased to be an issue in gerontology.²²

E. THE SIGNIFICANCE OF THE "FIVE PERCENT"

Many studies and news stories make much of the fact that "only 5 percent of the elderly are in nursing homes."

As has been stated, however, the 5 percent total neither reflects total patient population or overall need for care of chronic illnesses.

The significance of this figure goes far beyond the numbers directly affected.—The quality of care in the latter years of life is important for those in the early years of life, because (1) there is a strong likelihood that their own parents or grandparents will need such care, and (2) the odds are good that they will also need a nursing home at some time in their lives.

Emotions now run strong when a decision must be made about nursing home placement. Part of that emotional reaction is one

¹⁹ Blenker, Margaret, "Environmental Change and the Aging Individual", *The Gerontologist*, Vol. 7, No. 2, June 1967, pp. 101-105; Whittier and Williams, "The Coincidence-Constancy of Mortality Figures for Aged Psychotic Patients Admitted to State Hospitals", *Journal of Nervous and Mental Diseases* Vol. 124: pp. 618-620, 1956; Kay, Norris and Post, "Prognosis in Psychiatric Disorders of the Elderly", *Journal of Mental Science*, Vol. 102: pp. 129-140, 1956; Carmargo and Preston, "What Happens to Patients Who Have Been Hospitalized for the First Time When Over 65?", *American Journal of Psychiatry*, Vol. 102: pp. 168-183, 1945; Lieberman, M. A., "Relationship of Mortality Rates to Entrance to a Home for the Aged", *Geriatrics* Vol. 16: No. 10: pp. 515-519, 1961; Lieberman, M. A., "Institutionalization of the Aged: Effects on Behavior", *Journal of Gerontology*, July 1969; Ferrari, N., *Institutionalization and Attitude Change in an Aged Population, A Field Test of the Dissenace Theory*, Doctoral Dissertation, Western Reserve University, June 1960; Aldrich and Mendkoff, "Relocation of the Aged and Disabled: A Mortality Study", *Journal of the American Geriatrics Society*, Vol. 11: No. 3: pp. 185-194, 1963; Jasnau, K. F.: "Individualized versus mass transfer of nonpsychotic geriatric patients from mental hospitals to nursing homes, with special reference to the death rate," *J. Am. Geriatrics Soc.* Vol. 15: 280-284, 1967; Novick, L. J.: "Easing the stress of moving day," *Hospitals*, Chicago, Aug. 16, 1967.

²⁰ See reference No. 8, p. 5; reference No. 21, p. 43.

²¹ See reference No. 17, p. 20; reference No. 21, p. 45; reference No. 25, p. 4.

²² Brody, Elaine, "Institutional Settings: Nursing Homes and Other Congregate Living Facilities," Lecture, July 16, 1969, University of Southern California; Friedsam, H. J. and H. R. Dick, "Decisions Leading to Institutionalization of the Aged", Final Report, Social Security Administration Cooperative Research and Demonstration Grant Program, Project 037 (CI) 20-031, unpublished 1963; Kent, Donald P., "Aging—Fact or Fancy," *The Gerontologist*, Vol. 5, No. 2, June, 1965; Pincus, Allen, "Toward a Developmental Viewing of Aging for Social Work," *Social Work*, Vol. 12, No. 3, July, 1967; Lowenthal, Marjorie, *Lives in Distress*, Basic Books, Inc., N.Y. 1964; and Shanas, Ethel, "Family Responsibility and the Health of Older People," *Journal of Gerontology*, XV, 1960.

of possible guilt: "Have we done everything we could?" But part of the reaction is because the nursing home industry has taken its present shape in a very few years. The industry is still young and has made mistakes.

It should be an objective of public policy to insist that mistakes be corrected and that positive advances be made in the quality of care, especially since demand is increasing. The growth of the industry, therefore, is a prime element in any consideration of nursing home care in the United States today.

PART 2

GROWTH OF THE NURSING HOME INDUSTRY

One of the first inventories of the Nation's nursing home industry was a 1939 study on institutional mortality by the Bureau of the Census, which counted 1,200 facilities and 25,000 beds. By 1960, there were 9,582 homes and 33,000 beds. Between 1960 and 1970, the number of nursing homes and related facilities increased 140 percent to 23,000.

The number of beds more than tripled, to 1.1 million.¹

Nursing homes can be classified by the level of care they provide. In 1972, there were 9,244 skilled nursing facilities with 643,403 beds; there were 4,455 intermediate care facilities with 217,922 beds and 9,292 related facilities with 238,087 beds.²

In 1974, some 7,300 facilities qualified for Medicaid benefits as skilled nursing facilities. About 4,000 were also certified to participate as extended care facilities under Medicare. A few hundred qualified only for Medicare. About 8,500 participate in the Medicaid intermediate care program. The 1972 Social Security amendments unified Medicare and Medicaid standards so that a facility qualifying for one program was automatically eligible for the other.

Mere numbers of institutions do not adequately measure the growth of the nursing home industry. An even more informative indicator of their growing importance can be shaped from the following new and not generally known facts:

- There are more nursing home beds (1,235,404) in the United States than general and surgical hospital beds (1,006,951).³
- There are more than three times as many nursing homes (23,000) than hospitals (6,630).⁴
- More in-patient days of care were given in long-term care facilities (384.2 million) than in short-term general hospitals (262.7 million).⁵
- Expenditures for long-term care increased 1,400 percent from \$500 million in 1960 to \$7.5 billion in 1974.⁶
- For the first time, Medicaid expenditures in 1972 for nursing home care exceeded payments to general and surgical hospitals 34 percent as compared to 31 percent for hospitals.⁷

¹ See table 1, p. 21.

² "Study of Health Facilities Construction Costs," U.S. General Accounting Office, November 28, 1972, p. 793.

³ See reference No. 1, pp. 356 and 385. See p. 27 for references mentioned in footnotes.

⁴ See reference No. 1, pp. 356 and 385.

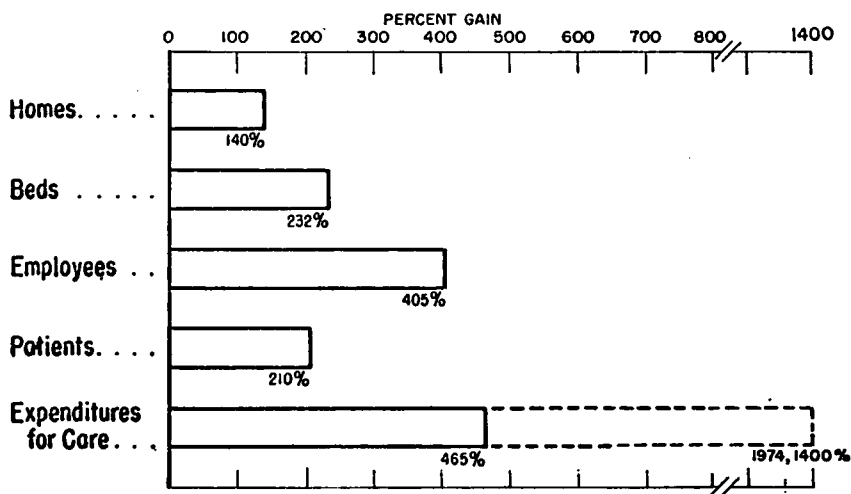
⁵ See reference No. 13, p. 2.

⁶ See appendix 10, p. 162.

⁷ See reference No. 3, p. 150.

TABLE 1

Estimated Gains in Number of U.S. Nursing Homes, Number of Beds, Employees and Expenditures for Care, By Percent 1960-1970



	1960	1970	1974
Homes	9,582	23,000	
Beds	331,000	1,099,412	
Employees	100,000	505,031	
Patients	290,000	900,000	
Expenditures (millions)	\$500	\$2,827	\$7,500

Source: February 1960 Report of the Subcommittee on Problems of the Aged and Aging, U.S. Senate Labor and Welfare Committee; White House Facts Sheet, Aug. 6, 1971; Developments in Aging, 1970, U.S. Senate Special Committee on Aging, p. 42; American Nursing Home Association 1970, and earlier Fact Books

I. CHARACTERISTICS OF THE INDUSTRY

In many ways the nursing home industry in this Nation is unlike any other in the world. Part of it was established by church groups and philanthropic institutions, but these nonprofit facilities could not keep up with the burgeoning number of the chronically ill elderly. By far and away the greatest growth of the industry came after the enactment of Medicare and Medicaid, as the availability of public funds helped fuel the tremendous expansion of the industry. Public funds account

for about \$1 out of every \$2 in nursing home revenues. There are few industries so dependent on government.

What are the characteristics of this growth industry?

Average size: In 1971, 53 beds; 59 percent had fewer than 50 beds.⁸

Seventy-seven percent of the nursing homes in the United States are operated for profit: and these proprietary homes control 67 percent of the beds. Fifteen percent of the U.S. nursing homes are philanthropic, accounting for 25 percent of the beds. Eight percent of the homes and beds are government controlled.⁹

There is very little agreement as to the average cost of nursing home care in the United States: There are great variations from study to study. The range is \$200 to \$1,200 per month. HEW studies are underway to determine more definitive cost data.

Many studies confuse average charges with costs. Charges reflect what nursing homes bill private paying patients. There is some agreement that the average monthly charge for U.S. nursing homes is now about \$600. Cost relates to how much operators must spend to provide quality care; many provide it for far less than \$600 a month.¹⁰

There is also very little agreement as to the number of nursing home beds that are needed: No firm national data are available. The few studies available indicate a national vacancy rate of 13.2 percent. Others suggest a need of 173,797 beds in 1973. Many locales will have a relatively high number of empty beds, but an acute shortage of beds for welfare or Medicaid patients.¹¹

The growth in both size and number of nursing homes is startling: It can be seen in the increase in the number of patients. There were 290,000 patients in 1960 and 900,000 in 1970, for a 210 percent increase. By 1973 there were more than 1 million patients.¹²

II. AN INVENTORY OF NURSING HOME PERSONNEL

The number of nursing home employees increased by 405 percent from 1960 to 1970. In 1970, some 215,000, or 43 percent were aides and orderlies (280,000 in 1972); 7 percent were professional nurses; and 8 percent were licensed practical nurses. Table 2 provides a precise percentage breakdown. Nursing home employees have an average yearly turnover rate of 60 percent.¹³

⁸ See reference No. 1, p. 395.

⁹ See reference No. 2, p. 2.

¹⁰ See reference No. 12, p. 5; reference No. 8, p. 5; *Survey in Nursing Homes*, August 1971, p. 6; reference No. 13, p. 8.

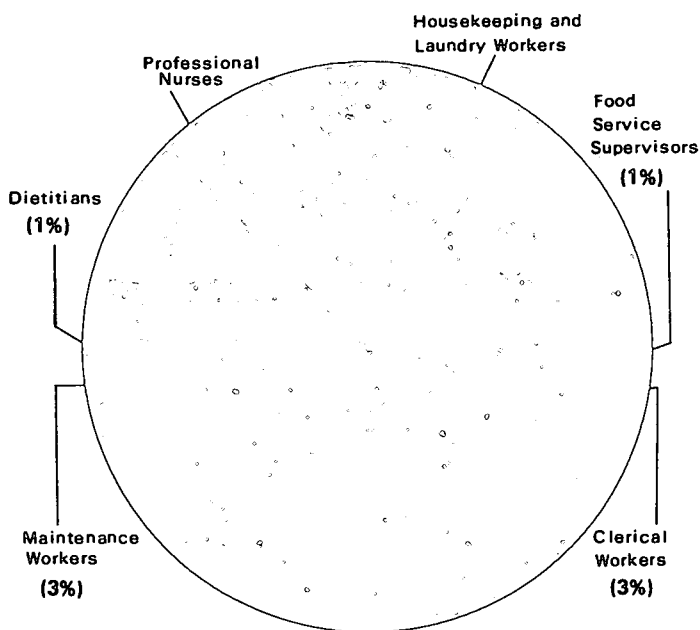
¹¹ See reference No. 8, pp. 2-3; reference No. 9, table 11; "Trends in Long-Term Care", part 6, hearing by the Subcommittee on Long-Term Care, San Francisco, California, February 12, 1970, p. 504.

¹² See reference No. 12, p. 4; reference No. 13, p. 1; see also table 1 on p. 21 of this report.

¹³ See reference No. 2, p. 2; reference No. 7, pp. 3-6; reference No. 1 projects 583,974 full-time employees in 1971, p. 401; reference No. 13 projects 722,200 full-time equivalent employees working in nursing homes in 1973-74.

TABLE 2

Occupational Composition of Employment in Surveyed Nursing Homes and Related Health Care Facilities.



Note: Percents do not add due to rounding.

Source: U.S. Department of Labor, Manpower Administration.

ADMINISTRATORS

In 1969, there were about 18,390 nursing home administrators in the United States. Their median age was 53. Some 47 percent were employees; 44 percent were self employed; and 9 percent were both owners and administrators.

Some 91 percent were administrators of only one facility. Median experience for these individuals was 8 years in a hospital or nursing home, and many had been at their current jobs for 5 years or less.

About 79 percent had completed high school, and 51 percent had some training thereafter. However, 72 percent had no undergraduate or graduate degree, and 65 percent had never taken a course in nursing Home administration.¹⁴

Sources conflict as to the number of female administrators. Older studies show a higher incidence of females. Best current estimates show 60 percent of administrators are male.¹⁵ Salaries are even more uncertain. Studies show \$8,500 in 1969 and \$15,000 at present. Committee inquiries support the latter finding for 1972.¹⁶

All administrative personnel had a turnover rate of 21 percent in 1970.

¹⁴ See reference No. 14, pp. 2-4.

¹⁵ See reference No. 17, p. 46, and Stone, Eric, "Characteristics of the Nursing Home Administrator in New Hampshire—1972", *Nursing Homes*, December 1972, pp. 7-10.

¹⁶ See Supporting Paper No. 9 on Profits.

PROFESSIONAL NURSES

In 1973, 56,235 registered nurses were in nursing homes. They made up 20 percent of all personnel in Connecticut and 3 percent in Oklahoma and Arkansas.

Registered nurses received \$3.75 an hour on the average in 1970.

They show a vacancy rate of 8 percent and a turnover rate of 71 percent a year.¹⁷

LICENSED PRACTICAL NURSES

There were some 40,000 licensed practical nurses employed in nursing homes in the United States in 1970. Twenty-five percent were licensed by waiver (that is, by past experience rather than on the basis of formal education). Licensed practical nurses received about \$2.60 an hour for their work. They had a vacancy rate of 14 percent and a turnover rate of 35 percent.¹⁸

AIDES AND ORDERLIES

Unlicensed personnel comprise 43 percent of the staff, and most are women. The 215,000 aides and orderlies received an average of \$1.70 an hour in 1970 for their work. They had a job vacancy rate of 4 percent and a turnover rate of 75 percent a year.¹⁹

RATIO OF EMPLOYEES TO PATIENTS

All in all, there were 5.3 nursing home employees for every 10 nursing home patients in 1971. General and surgical hospitals by contrast average 26 employees for every 10 patients.²⁰

III. FUNDING AN INDUSTRY: THE SUBSTANTIAL PUBLIC SHARE

In recent years, public funds for nursing home care have increased sharply.

Total revenues for the industry in 1960 were \$500 million. By 1970, they had increased 460 percent to \$2.8 billion. In 1974, revenues from all sources had reached an estimated \$7.5 billion which is a full 1,400 percent increase from 1960.²¹

Nursing homes have an increased share of the total Nation's health dollar. In 1960, they accounted for more than 1 percent, growing to 4 percent in 1970 and to about 7 percent in 1974.²²

¹⁷ See reference No. 7, p. 8. See also: "Facts About Nursing," p. 7, American Nurses Association.

¹⁸ See reference No. 7, pp. 10-11.

¹⁹ See reference No. 7, p. 13. There were 280,000 aides and orderlies employed in 1972. Aides today average \$2.00 per hour—the minimum wage.

²⁰ Assuming there are 1.1 million nursing home patients and 583,974 full-time employees in 1971, the ratio would be .53 employees per patient. Reference No. 2, p. 2, indicates 900,000 patients in 1970 and 505,031 employees for a ratio of .67 for 1970. See also February 16, 1971, *New York Times*, pp. A1 and 27. HEW advises that there were 6.6 full time equivalent (FTE) employees for every 10 nursing home patients in 1973, while hospitals average 32.3 (FTE) employees for every 10 patients.

²¹ See reference No. 3, pp. 149-50; reference No. 12, p. 3; *Nursing Homes*, January 1972, p. 12; Statement of Wiley M. Crittenden, Jr., President, American Nursing Home Association before the National Conference on Inflation, Washington, D.C. September 19, 1974; also August 15, 1974 letter from Frank E. Moss to the Honorable Wilbur Mills, Chairman, House Ways and Means Committee, app. 9, p. 158.

²² *Fortune Magazine*, January 1970; see reference No. 11, pp. 24-25.

In 1974, more than \$1 out of every \$2 in nursing home revenues came from the public funds. Medicare contributed only \$3.5 million, but Medicaid paid out about \$3.7 billion. Private patients paid \$3.5 billion. Other sources, including Social Security benefits, accounted for a sizable amount, although the exact magnitude is not known. As noted previously, less conservative estimates place the value of such "other" contributions much higher.²³

But perhaps the impact of Medicare and Medicaid can best be seen by a comparison of per capita figures. In fiscal year 1967, nursing home care stood at \$81.45 per capita. In fiscal 1971, it was almost double at \$150.87.²⁴

In 1970 the Federal share of Medicaid amounted to \$4.9 billion. In 1973 this amount was raised to \$5.2 billion. About 39 percent of total Medicaid funds in 1970 were paid for hospital care and 28 percent for nursing home care.

As has already been reported in 1972, Medicaid expenditures for nursing home care exceeded expenditures for surgical and general hospitals for the first time.²⁵

OTHER GOVERNMENT ASSISTANCE TO NURSING HOMES

The Department of Health, Education, and Welfare has aided nursing homes with some training of nursing home personnel, in addition to contributing research projects under the auspices of the Administration on Aging.

The Department of Agriculture has aided nursing homes through its commodities program. Some 2,019 institutions benefited. An estimated \$2.5 million was spent in fiscal year 1972 for food to nursing homes and similar residential institutions for the elderly.²⁶

HEW's Hill-Burton program has provided funds for the construction of nonprofit nursing homes. In 1970, the totals were 1,598 projects built (89,313 beds) at a cost of \$455 million.²⁷

The Department of Housing and Urban Development insures loans for the construction of nursing homes under section 232 of the National Housing Act. In 1970, the inventory revealed 759 projects and 75,435 beds at a cost of \$573 million.²⁸

The Small Business Administration is authorized to issue loans to proprietary nursing homes. Through 1971 it had extended 1,185 loans at a cost of \$103.7 million.²⁹

The Veterans Administration provides skilled nursing care to veterans through its own facilities, by contracting with private nursing homes and through contracts with the States in the form of subsidy payments or grants to build nursing homes. The VA program accounts for about 19,311 skilled beds today for a total cost of \$121 million

²³ See reference No. 13, p. 2, which details that "more than \$6.2 billion was expended on [nursing home] resources and inputs in 1972".

²⁴ See reference No. 5, pp. 80-90.

²⁵ See reference No. 3, p. 150.

²⁶ July 12, 1973, report to Senator Moss from Edward J. Heckman, Administrator of the Food and Nutrition Service.

²⁷ Data supplied to the subcommittee by Hill-Burton program staff at the U.S. Department of Health, Education, and Welfare.

²⁸ See *Developments in Aging, 1970*, report of the Special Committee on Aging, Report No. 92-46, March 24, Leg. Day, March 23, 1971, p. 203; also materials supplied to the Subcommittee by Mrs. Helen Holt, Director, Nursing Homes Branch, Federal Housing Administration.

²⁹ Report to the subcommittee from the Small Business Administration, Office of Reports, August 3, 1971.

yearly. There were approximately 4,600 veterans in community nursing homes at any given day at a cost of \$36.5 million annually to the VA. In addition, the VA has about 17,000 domiciliary beds, 11,130 of its own and about 6,080 under contract in the States at a yearly cost of \$40.1 million.³⁰

All in all, the Federal Government aids nursing homes through more than 50 programs. It is impossible to calculate with precision the exact extent of this Federal commitment; however it is substantial. In fact, few industries are so wedded to the Federal Government and are therefore so solicitous and attentive to the Congress and Federal bureaucracy.

³⁰ Materials supplied by the Veterans Administration compiled by Chris Smith for the Special Committee on Aging.

REFERENCES

The references listed below are the primary sources of statistical information for Parts 1 and 2. Nursing home statistics are as controversial as the industry itself. There has been an absence of universally accepted data. The subcommittee has made every attempt to use the most accurate offerings. In many cases there is a consensus on important statistics, and where there are minor conflicts, preference is given to national and HEW studies. Where great differences exist, a range of statistics is presented. Some 26 major primary sources are used, as listed below. Other sources are identified individually in the footnotes.

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2. *White House Fact Sheet* issued on August 16, 1971. This reference is reprinted in "Trends in Long-Term Care," Part 18, hearing by the Subcommittee on Long-Term Care, Washington, D.C., October 28, 1971, pp. 2017-19.
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4. "Basic Facts on the Health Industry," prepared for the use of the House Committee on Ways and Means, June 28, 1971.
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15. *Nursing Home Fact Book 1970-1971*, American Nursing Home Administration.
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17. "A Study of Non-Profit Homes for the Elderly in the State of New Hampshire," Levison Gerontological Policy Institute, The Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University (May 1972).
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21. "Survey of Nursing Home and Retirement Homes in the State of Delaware," prepared by Suzanne R. Day for the Bureau of Aging, State of Delaware, Division of Urban Affairs, University of Delaware (June 1972).
22. "The Problems of Nursing Home Patients—Implications for Improving Nursing Care," Boston College School of Nursing (1968).
23. "The Resident-Patient Profile," New York State Department of Health, 1971.
24. "Aged Patients and Nursing Home Services: Design and Methodology," Norman Bourestom, Ph. D., and L. E. Gottesman, Ph. D., presented at the Annual Meeting of the American Public Health Association, Mental Health Section, November 15, 1972.
25. "Nursing Home Performance as Related to Resident Traits, Ownership, Size, and Source of Payment," Leonard E. Gottesman, Ph. D., Philadelphia Geriatric Center, presented to Annual Meeting of the American Public Health Association, Mental Health Section, November 15, 1972.
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PART 3

THE FEDERAL RESPONSE

Medicare and Medicaid are now under close examination, as health planners and legislators consider plans which offer partial or comprehensive national health insurance coverage.

These two programs, shaped after extended debate in the early 1960's, emerged as compromises which offered a great deal more protection than had been previously available. However, they did not provide as much as advocates of more far-reaching action had sought since the 1930's, and again, with great force, under President Harry S Truman.

Together, Medicare and Medicaid encompass the great bulk of Federal and State support for long-term care. For the most part, these programs do not develop or manage long-term care resources; they merely pay for services provided by proprietary and nonprofit long-term care institutions.

Far from becoming "socialized medicine"—as anticipated by some of the critics a decade ago—Medicare has buttressed many of the long-standing practices of physicians and hospitals.

Far from giving progressive health care to the aged, blind, and disabled, Medicaid has become a spotty and sometimes endangered program, as State legislatures and the U.S. Department of Health, Education, and Welfare, seek to cut expenditures by cutting back on covered services.

Long-term care, in particular, has suffered under Medicare and is a source of considerable concern under Medicaid.

As a blue-ribbon task force said in a 1970 report:¹

Long-term care is a neglected and underdeveloped area. Medicaid and Medicare are not efficient and effective mechanisms for dealing with the problem. Major attention has been focused on the problems of medical care at one end of the spectrum and of income maintenance on the other. Overlooked is the special need for long-term care, which is something less than one and something more than the other. Neither Medicare nor Medicaid was designed to deal with it, and the failure to address the problem directly distorts the operations and inflates the cost of the medical-care programs.

This section discusses the declining role of Medicare in long-term care and the ways the administration and Congress are reshaping Medicaid with the avowed purposes of cutting costs and improving services. In the discussion of Medicare, attention is paid

¹ *Task Force Report on Medicaid and Related Programs* (1970), Walter J. McNerny, Chairman, HEW, p. 83.

to the declarations of need for "alternatives to institutionalization"; and special attention is given to the difficulties placed in the path of one of the major alternatives, home-health care. In the discussion of Medicaid, the emergence of the intermediate care facility, or ICF, is examined in some detail, largely because it represents a major Federal effort to reduce costs through means of reimbursement practices that depend upon a precise definition of care. The success of this effort is still far from certain, and critics say that ICF's could cause further deterioration of care without reducing costs to any great degree, when total costs are accurately considered.

Questions about the elements of the Federal response discussed above are raised in this chapter and buttress a central declaration of this report: the Federal policy on long-term care is still poorly defined, hampered by confused objectives of the two major programs now providing reimbursement for long-term care, and hindered—as will be seen in part—by a failure of the executive branch to carry out congressional intent through its enforcement responsibilities.

I. AN EVALUATION OF MEDICARE

Medicare's contribution to the needs of the infirm elderly in nursing homes is not very great. About \$180 million was spent in 1972 and nearly \$207 million in 1973.² On any given day, approximately 70,000 individuals out of the 1 million in the Nation's 23,000 nursing homes have their care paid by Medicare.³

In 1968 and 1969, Medicare's contribution was much more significant, reaching about \$340 million in 1968. If the average rate of growth in these allotments were projected forward from 1969, then, Medicare's present contribution should be about \$600 million this year.⁴

The obvious question is: Why isn't it at that level?

The answer is complex. It involves an administration shift in policy in 1969, and judgments about where and how to allocate funds. It also involves questions of congressional intent at the time Medicare was enacted. Finally, it involves the reaction by the Congress and administration against some abuses of the program by providers.

A. EARLY BEGINNINGS UNDER MEDICARE

When the Congress passed Medicare in 1965, the question of whether to provide a "nursing home" benefit was debated. Congress feared adding new and prohibitive costs to a potentially expensive program. But at the same time, some members of the Congress realized that the existence of a nursing home benefit of some description would enable some individuals to be shifted from hospitals to less expensive facilities for all or part of the convalescence.

In short, the enactment of an "extended care benefit" as part of Medicare was an effort by the Congress to meet limited objectives. Nursing homes could participate in the Medicare program if they could meet

² Special Analyses—Budget of the United States Government—Fiscal Year 1974, p. 149.

³ "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 18, p. 2006.

⁴ In 1969, Medicare expenditures for nursing homes constituted 5 percent of total Medicare costs. Five percent of Medicare's \$12.1 billion outlay in 1974 would be \$600 million.

high standards and provide "skilled nursing care." In employing these two crucial terms, the Congress attempted to make it clear that it drew the line at custodial care. Custodial care was *not* to be covered; only "skilled care" patients were compensable.

For this same reason, Congress sedulously avoided using the term "nursing home." Qualifying nursing homes were to be known as "extended care facilities" (ECF's). Moreover, the Congress took other steps to insure that the Medicare program would help to decrease hospital stays, thus effecting great cost savings.

To qualify for "extended care," a Medicare beneficiary was required to: (1) Be hospitalized for at least three consecutive days; (2) be transferred to a Medicare certified facility within 14 days of discharge from the hospital; and (3) be certified by a physician as needing "skilled nursing" care for further treatment of a condition which caused hospitalization.

It is obvious that many providers misunderstood the nature of this Medicare benefit, or chose to resolve the question in a manner most advantageous to themselves.

Senator Frank E. Moss, chairman of the subcommittee, sought to warn providers of their delusion. In an October 1966 speech before the American Nursing Home Association, he described the need for a true nursing home benefit under Medicare and emphasized that what had been created was something different:

The Medicare program is a short-term, acute-care program which does not even include financing of nursing home care. But despite the fact that Congress deliberately avoided the use of the term "nursing home"—the notion seems to be widespread that Congress intended to finance nursing home care but apparently did not know what to call it. This is in part wishful. Many people have looked to Medicare for too much in the way of relief from problems that it was never intended to solve.

Despite these warnings, the Medicare ECF program flourished in 1967 and 1968, providing many Americans with care. The high-water mark was 1968, with Medicare ECF payments totaling \$340 million. Nursing home stocks became one of the most attractive issues on the New York Stock Exchange.

This was possible because the Bureau of Health Insurance (BHI) allowed thousands of substandard nursing homes to participate. As a concession for the tremendous demand for nursing home care, facilities with deficiencies were certified if they were "in substantial compliance" with standards.^{4a}

^{4a} HEW's October 24, 1974 letter to Senator Moss: "contends that there were other factors that entered into the certification of extended care facilities during the period from July 1966 through 1967. For example:

"1. There was lack of a clear understanding of what an extended care facility was or the services it provided. The ECF was an entirely new concept, a new kind of facility, created by statute and not well defined. It was not a hospital and it was not a nursing home. It was more nearly related to a convalescent facility. Since few or none of these kinds of facilities existed and hospitals did not have convalescent wards, it was natural to consider nursing homes as ECF's. That only 5,000 ECF's were certified out of 23,000 nursing homes and 7,500 hospitals in the Nation, attests to how well the certification was carried out.

"2. The demand for certification of ECF's came from many sources, including the public, the nursing home and hospital industry, from Government officials at all levels and from professional health associations.

"3. States hired individuals with varying backgrounds, mostly with absolutely no inspecting experience, to make surveys. As a result, a number of ECF's initially were improperly certified. Later considerable effort was made by States and the Department to terminate ECF's that could not meet the conditions."

B. 1969: BENEFITS CUT BACK SHARPLY

The market boom and the growth in the nursing home industry slowed considerably in early 1969. There were two reasons for this:

- (1) A decision by the Nixon administration to reduce costs, which took the form of new retroactive regulations for Medicare providers; and
- (2) Hearings and a followup report by the Senate Finance Committee called attention to excessive costs, profiteering, abuses, and inefficiency in the Medicare program.

Regulations imposed on the Medicare ECF program by the Nixon administration were announced in April 1969. Former requirements were continued: prehospitalization for 3 days, transfer within 14 days to a certified facility, and physician's verification of the need for "skilled nursing" in continuation of care.

But a new condition was added requiring a patient to have "rehabilitative potential," effectively excluding coverage for terminal patients.

The second part of these April directives was the most devastating. It was a revised and narrowed definition of the term "skilled nursing," which by statute was a precondition to coverage.

BHI regulations spelled out with great specificity which medical and nursing services were covered. Despite elaborate steps to eliminate ambiguities, the administration of the new regulations resulted in confusion for patients, providers, fiscal intermediaries, and Government officials. Identical claims submitted to an intermediary insurance company were returned with some paid and some rejected. To providers, the only consistency was that most of their patients were being denied coverage. To make matters worse, these denials were given retroactive effect.

"Retroactive denials," a term that strikes deep concern in the hearts of physicians and other providers, spring from the Nixon administration April 1969 directives. In other words, a claim approved and paid in 1968 could be disallowed in 1969—with the nursing home or the patient required to make repayment.

In February 1970, the Senate Finance Committee issued its report, "Medicare and Medicaid: Problems, Issues, and Alternatives." The committee quoted 1967 estimates that the Medicare nursing home program would cost the Government \$1.80 per beneficiary per year. However, the report revealed that the actual cost was \$18 per beneficiary, or 10 times the earlier estimate.⁵ The committee report also incorporated Bureau of Health Insurance (BHI) intermediary letter No. 370 of April 1969, and its definition of covered care under the Medicare program.

This action on the part of the Senate Finance Committee gave strong support to the cutbacks initiated by the administration in April 1969.

At the same time, the committee was highly critical of the Bureau of Health Insurance for its "wholesale certification of nursing homes as extended care facilities." The report noted that 2,000 nursing homes were originally thought to be eligible to participate in the Medicare

⁵ "Medicare and Medicaid," hearings by the Committee on Finance, Washington, D.C., July 1 and 2, 1969, pp. 22-23.

program. However, BHI allowed almost 5,000 to be certified, the great majority being only "in substantial compliance," rather than in full compliance with standards.⁶ The Finance Committee called for an end to certification of facilities which did not fully conform to standards.

Because of the tremendous demand for nursing home care and the acquiescence of the Bureau of Health Insurance, the Medicare ECF programs provided broadly defined traditional nursing home care rather than narrowly defined posthospital, postoperative care. Unfortunately, the administration chose to announce new eligibility regulations which were applied retroactively.

In January 1970, the Associated Press reported that 500 facilities had withdrawn from the Medicare program because of retroactive denials and general discontent with Medicare.⁷

In October 1971, the Department of HEW placed the number at 2,000 who had quit the program for some reason.⁸

On August 13, 1972, a *New York Times* article quoted a General Accounting Office audit which announced that 3 out of every 10 U.S. hospitals and nursing homes had dropped out of the program.

According to the GAO, some 5,000 hospitals and nursing homes had withdrawn from the program by the end of 1971.⁹

Evidently many administrators shared the sentiments of Lee Dalabout, executive director of the Utah Nursing Home Association, who claimed operators were: "glad that in spite of Medicare they have survived . . . and are sorry that they ever heard of it."¹⁰

C. IMPACT UPON PATIENTS AND PROVIDERS

What does all of this mean to the patients? Very simply, necessary nursing home care is not available. Recent statistics from Maryland and Pennsylvania note that Medicare patients make up only 5 percent of their patients. Iowa reports less than 5 percent of its patients received Medicare reimbursement.

CRITICISMS OF RETROACTIVE DENIAL

Hearings by the Subcommittee on Long-Term Care in 1969 and 1970 brought numerous criticisms of the retroactive application of the HEW regulations.¹¹

Physicians, such as Dr. L. L. Long of Perry, Iowa, and Dr. Frederick Offenkrantz, medical director of the Cranford (N.J.) Health and Extended Care Center, testified. Providers were forced to seek repay-

⁶ *Medicare and Medicaid—Problems, Issues and Alternatives*, Report of the Staff to the Committee on Finance, February 9, 1970, pp. 97-99.

⁷ *Washington Evening Star*, January 22, 1970. The January 20, 1971, press release from the American Nursing Home Association denounced "the hoax perpetrated on the elderly by the Medicare program", and reported that the ANHA Executive Board "urged the more than 7,000 nursing homes across the country, who are members of ANHA, to reassess their current participation in Medicare".

⁸ Page 2005, part 18, hearings cited in footnote 3.

⁹ See *Sizable Amounts Due the Government by Institutions That Terminated Their Participation in the Medicare Program*, GAO report, August 4, 1972; and *Problems Associated With Reimbursement to Hospitals for Services Furnished Under Medicare*, GAO report, August 3, 1972. See also, *New York Times*, August 13, 1972.

¹⁰ Page 612, part 7, hearings cited in footnote 3.

¹¹ See *Developments in Aging: 1969*, Special Committee on Aging, May 15, 1970, pp. 80-90; see also appendix 1, p. 113, this report.

ment from patients or their families. In many cases the patients had died and providers had no recourse. Beneficiaries were hard-pressed to understand such arbitrary and capricious policies.

Other physicians, such as Dr. Michael B. Miller of the White Plains Center for Nursing Care, objected to the overruling of the judgments by the nursing home's medical director and utilization committee by insurance company clerks who never saw the patient or the patient's chart.¹²

Senator Moss, who earlier warned that Medicare had not created a traditional nursing home benefit, watched with concern. He agreed that the Nixon administration had the legal right to return the program to its narrow post-hospital, post-operative stance contemplated by the law.

However, he took sharp exception with *methods* employed by the Social Security Administration in early 1969. Specifically, he requested that new regulations be given prospective and not retroactive effect.

Senator Moss summed up :

Nursing home administrators have complained to me that accepting a Medicare patient is as unpredictable as putting a quarter in a slot machine. I have received heavy mail decrying this lack of predictability and the retroactive denial of claims. The problem has reached extremes in the State of Georgia, where the Georgia State Nursing Home Association has recommended that its members not participate in the Medicare program.

In the face of the resistance of nursing home administrators receiving Medicare patients, physicians have had little choice but to retain patients in the hospital. Again a paradox ; the Medicare machinery seems willing to pay hospital costs for patients who could be housed in a nursing home for about one-third of the hospital price. In an effort to cut back on the the number of days patients spent in extended care nursing homes, the Social Security Administration has significantly increased the burdens on the hospital. Small wonder the administration felt the need to increase dramatically Medicare premiums.

In the final analysis, it is the consumer of the service that suffers. I find it most regrettable that Medicare is beginning to take on the color of another broken promise. I can empathize with the nursing home patient who has it on the authority of his Medicare handbook that he has the guarantee of 100 days in a nursing home. I can sympathize with the nursing home administrator who must break these bubbles of misconception and often suffer a financial loss as well.¹³

Senator Harrison Williams, then chairman of this committee, charged that the dismantling of the ECF benefit was contrary to the intent of Congress :

¹² Page 305, part 3, hearings cited in footnote 3.

¹³ Page 150, part 2, hearings cited in footnote 3.

The net effect is to increase hospital stays and to reduce days of nursing home care, although this care may cost the Government only one-third of the amount for hospitalization. Many [doctors] believe that it is preferable to leave the patient in a hospital for convalescence rather than to submit him to such uncertainty. *However, shaving one hospital day from Medicare's national average could result in a savings of \$400 million.*¹⁴ (Emphasis added.)

Senator Williams found support for this view in studies by the General Accounting Office¹⁵ and from the direct testimony of witnesses, including David Mosher, then president of the American Nursing Home Association,¹⁶ and Francis P. Dellaferra, president of the Connecticut Association for Extended Care Facilities.¹⁷

Senator Frank Church, present chairman of the Senate Committee on Aging, had grave concerns in 1971 about the fairness of the retroactive regulations. He introduced legislation (S. 1827) in 1971, to ban retroactive denials. (A similar provision was to become law as part of the 1972 Social Security Amendments.)

D. THE EFFECT OF H.R. 1 ON MEDICARE: SOME GAINS AND SOME LOSSES

Congress, in 1972, passed what was known at the time as H.R. 1, a major bill encompassing a wide variety of changes in Social Security, Medicare, and Medicaid law. Signed on October 30, 1972, it became Public Law 92-603, but it will be referred to in this report as H.R. 1.

With respect to the Medicare nursing home program there were some gains:

- From the standpoint of nursing home owners, the provision to prevent retroactive denials was the most important amendment.¹⁸ It authorized the Secretary of HEW to establish "presumptive periods of coverage." Individuals with certain diagnoses upon discharge from the hospital are "presumed" eligible for care in a Medicare nursing home for a specific period.
- Provider reimbursement review boards were authorized to hear cases when the amount of controversy is \$10,000 or more, giving administrators some access to the appeals procedure.¹⁹
- Medicare coverage was extended to the disabled (i.e., persons entitled to Social Security disability benefits for not less than 24 consecutive months).²⁰
- To strengthen enforcement of Medicare, the Secretary of HEW was authorized to terminate payments to providers who abuse the system.²¹ Additionally, penalties were prescribed for bribes, kickbacks, or converting benefit payments to improper use.²²

¹⁴ Page 625, part 8, hearings cited in footnote 3.

¹⁵ "Study of Health Facilities Construction Costs", United States General Accounting Office, November 20, 1972, Enclosure 3, p. 25 and following.

¹⁶ Page 204, part 2, hearings cited in footnote 3.

¹⁷ Page 276, part 3, hearings cited in footnote 3.

¹⁸ Public Law 92-603, Section 228.

¹⁹ Public Law 92-603, Section 243.

²⁰ Public Law 92-603, Section 201.

²¹ Public Law 92-603, Section 229.

²² Public Law 92-603, Section 242.

- Standards for skilled nursing facilities under Medicare and Medicaid were unified²³ and HEW was required to develop uniform definitions for levels of care.²⁴
- Reimbursement for skilled nursing homes must be on a cost-related basis by January of 1977.²⁵
- Medicare inspection reports are to be made available to the public.²⁶

But there are also some losses:

- Staffing requirements for skilled nursing homes in rural areas were reduced, now requiring registered nurse coverage only 5 days a week instead of 7 days a week.²⁷
- The previous Medicare provision requiring nursing homes to have the services of a social worker was eliminated.²⁸
- Nursing home operators with 3 years prior experience were exempted from State licensure requirements.²⁹

In addition, States were required to establish a new mechanism to review the appropriateness of hospital and nursing home placement and the quality of nursing home care. The required organizations are called (PSRO's) Professional Standards Review Organizations.³⁰

PSRO's are considered elsewhere in this report (Supporting Paper No. 3), and it is still too early to determine what their impact will be. It is sufficient to note here that there has been substantial criticism of PSRO's for their failure to include representatives of other health and consumer groups, as well as physicians. And then, too, PSRO's are thought to duplicate much of the functions of existing utilization review and medical review committees; PSRO's add yet a third layer of patient review. As Art Jarvis, deputy director of the Connecticut Department of Health, commented:

These self-audit committees take several forms but operate in much the same manner; namely, the medical record of a discharged patient is reviewed by a peer group of physicians appointed to that committee by the chairman of the medical staff. The scope of the review is essentially to match up the diagnosis made by the attending physician with what pre-diagnostic examinations he ordered and following confirmation of diagnosis, what drugs and treatment he ordered. Included in this, of course, the committee evaluates the effectiveness of the treatment ordered and the attempt here is to adjudge that this particular patient received the proper care and achieved the amount of "cure" possible in relationship to the patient's diagnosis and prognosis.

While medical peer groups and self-audit committees go back to the teens and the twenties of the century . . . these committees did, and still have, the built-in weakness of a subjective, if not honest, difference of opinion between a physician on an audit committee reviewing the medical record of another physician. In other words, physician "A" who is

²³ Public Law 92-603, Section 246.

²⁴ Public Law 92-603, Section 247.

²⁵ Public Law 92-603, Section 249.

²⁶ Public Law 92-603, Section 249C.

²⁷ Public Law 92-603, Section 267.

²⁸ Public Law 92-603, Section 265.

²⁹ Public Law 92-603, Section 269.

³⁰ Public Law 92-603, Section 249F.

reviewing the chart may make the decision that such and such a decision, or procedure, was not the appropriate treatment or service that should have been ordered in view of the diagnosis.

On the other hand, physician "B"—the attending physician responsible for the medical record and his patient, may disagree and say, "I am sorry, but in my judgment, this was the best way to handle the case." Thus it is that, while we in the hospital field and our colleagues in the physician community have been able to take pride that such peer group self-evaluation is going on, and has been for some years, the problem of medically subjective disagreement between the "reviewer" and the "reviewed" has been a recognized weakness in this audit program from its inception.³¹

REGRESSIONS

Some provisions of H.R. 1 are truly unfortunate. The former Medicare standard for required nursing staffing was anything but stringent. Testimony before the Subcommittee on Long-Term Care confirmed that good nursing homes have no difficulty locating nurses, even in rural areas. Moreover, the subcommittee received testimony describing a tremendous pool of retired nurses who could be brought back into service if nursing homes would offer adequate pay and working conditions.³²

The watering down of requirements for State licensure of nursing home administrators is equally discouraging. This retreat threw existing laws into confusion. Significantly, this action was taken against the wishes of the American College of Nursing Home Administrators, which stated:

It must be realized that an individual's exposure to an administrative position alone is an insufficient measure of his ability to provide proper patient care. Education and demonstrated ability, in addition to the successful passing of a specifically designed process, must also be required.³³

Senator Abraham Ribicoff was unsuccessful in his efforts to delete provisions to weaken staffing and licensure requirements. An attempt was also unsuccessful in retaining the existing Medicare language requiring nursing homes to have social workers. Senator Ribicoff commented about this amendment:

The aging patient entering a nursing home has left his home, his friends and his family behind. He is likely to be confused, frightened, and alone and needs personal attention which doctors cannot provide. The social workers can alleviate this suffering and fright by providing counseling, letterwriting assistance, consultation with the family, and companionship. The social worker in the nursing home assures the patient that there is someone to care for his personal and emotional needs.

³¹ Page 289, part 3, hearings cited in footnote 3. HEW states that PSRO will replace utilization review and medical review committees and that there will be no duplication.

³² Page 87, part 1, hearings cited in footnote 3.

³³ *Congressional Record*, February 29, 1972, Vol. 118, No. 29, p. 2792.

Most extended care facilities currently licensed by Medicare are privately owned and operated for profit. They tend to meet only the minimum requirements set by Medicare and do not, as a rule, provide optional, extra services for their patients. If section 265 were enacted, many facilities would therefore eliminate social services. Figures in December 1969 showed that the highest number of nursing home deficiencies, 37 percent, occurred under the social services requirement for extended care facilities.³⁴

E. SUMMARY: THE MEDICARE NURSING HOME PROGRAM TODAY

In the early years, Medicare provided significant assistance to the Nation's infirm elderly. The escalating cost of meeting the nursing home needs of older Americans soon forced a reassessment, and cutbacks were inevitably instituted. Regrettably, these cutbacks were applied retroactively and thousands of providers and patients suffered as a result.

In 1972, H.R. 1 brought some gains and some losses, but on balance, it had very little effect on eligibility for care. Today, Medicare still pays for only 6.7 percent of the Nation's total nursing home bill. Only 70,000 patients on any given day out of the 1 million who are in U.S. nursing homes have their care paid by Medicare. Of the \$12.1 billion in Medicare reimbursement, only 1.67 percent or \$200 million, went for nursing home care in 1973. Moreover, Medicare remains tied to a narrow and restrictive definition of skilled care which greatly limits coverage for the elderly. In short, Medicare is of little help to those who need nursing home care; those who need assistance must look elsewhere.

II. MEDICAID'S GROWING ROLE

Medicaid, a welfare program, remains virtually the only hope for most older Americans needing nursing home care. Medicare is of little help because its coverage is limited to "skilled nursing" which is narrowly defined. Since very few can afford to pay for their own care, senior citizens are left with no choice but to turn to welfare and apply for Medicaid.

In its early years, Medicaid, like Medicare, paid only for "skilled nursing care." But as thousands of elderly were forced to turn to Medicaid for assistance, the cost of the program skyrocketed. Critics of the program then emphasized that many patients did not need the intensive nursing services characterized as "skilled care." Consequently, Congress authorized a second, less intensive level of nursing home services, known as intermediate care. Consumer advocates, while conceding the need for a second level of care, expressed grave concern about possible consequences. They predicted that cost considerations would override patient needs, leading to:

- (1) A restrictive definition of "skilled care."
- (2) Widespread reclassification of both facilities and patients into intermediate care.

³⁴ *Congressional Record*, February 29, 1972, Vol. 118, No. 29, p. S 2792.

- (3) An increase in the mortality rate of the relocated patients; and
 (4) Weak intermediate care standards which would leave patients substantially unprotected.

All these fears have been realized, as well as one unhealthy consequence which had not been predicted. The pressure causing the downward movement of patients did not end at the intermediate care level. Increasing numbers of patients were moved into boarding homes or unlicensed "bootleg" nursing homes. (See Supporting Paper No. 7 to be published in early 1975.)

A. LEVELS OF MEDICAID REIMBURSEMENT

Medicaid is a Federal grants-in-aid program administered by HEW in which the Federal Government pays from 50 to 83 percent of the costs incurred by the States in providing medical assistance to the indigent, including nursing home care for qualifying individuals.³⁵

There has been no uniform reimbursement formula. Some States have paid nursing homes a flat fee, perhaps \$14 per patient per day for skilled care. Other States reimburse nursing homes for reasonable costs expended. Section 249 of H.R. 1 mandates that all States reimburse nursing homes on a reasonable cost-related basis by January 1977.

SKILLED NURSING

Until 1972, Medicaid provided only "skilled nursing," or that level of nursing home care nearest to hospital care. The definition of "skilled nursing" varied widely among the States. Some States employed the Medicare definition of "skilled nursing," but most did not. Today, this is changed because section 246 of H.R. 1 unifies Medicare and Medicaid standards, and section 247 mandates a single definition of "skilled nursing care" for facilities in both programs.

INTERMEDIATE CARE

Intermediate care facilities (ICF's) are—as the name suggests—intended to help those who do not need around-the-clock nursing care and other mandatory services provided by a "skilled" nursing home.

The demand for ICF's arose when surveys indicated that many patients in nursing homes did not need such high-level care. They needed, first, a roof over their heads, and, second, some help from medical and other personnel to get them through each day. They were not well enough for "independent living"; they were not ill enough for expensive, around-the-clock nursing care.

During the debate over the 1967 Social Security amendments, many witnesses pointed out that Federal financing was available for only one level of nursing home care, namely skilled nursing. The Senate Finance Committee accepted an amendment to create a second level of care. The committee's 1967 report said that this lower care level would:

- (1) Lead to an overall reduction in costs, and
- (2) Enable institutions which could not qualify as skilled nursing homes to participate as intermediate care facilities (ICF's).

³⁵ The exact percentage for each State depends on the average per capita income of the residents of that State.

Accordingly, Congress passed the "Miller amendment" in 1967.³⁶ This legislation did not amend the Medicaid law. Instead, it made possible direct payments to recipients in the adult categorical assistance programs (aid for the aged, blind, and disabled) for the care of persons in ICF's.

Several controversies complicated the first few years of ICF's. Regulations were proposed in June 1969 which required minimum Federal standards. Under pressure from State health departments, HEW re-evaluated these regulations and the 1967 Miller amendment. With this second look, HEW ruled that the statute, as passed, did not provide the basis for Federal regulation. Accordingly, the new regulations published in June 1970, allowed the States to promulgate their own standards. In short, ICF regulation became totally a State responsibility.

The Senate Finance Committee had voiced its concern about the administration of the ICF program as early as February 1970, when it condemned the "wholesale transfer" of patients to the lower level of ICF care.

The Finance Committee then proposed to transfer the ICF program from its cash grant status under title XVI of the Social Security Act into XIX (Medicaid), thus providing a base for adequate Federal regulation. The committee wanted to require the Secretary of HEW to set minimum Federal standards. After several unsuccessful attempts, this plan was finally adopted as Public Law 92-223 on December 28, 1971. Interim regulations were not issued until March 5, 1973, and final regulations on January 17, 1974.

B. HOW LARGE IS THE MEDICAID NURSING HOME PROGRAM?

In 1970, Medicaid outlays reached \$4.9 billion, with 39 percent allocated for hospital care and 28 percent for nursing homes.

Medicaid payments in 1972 reached \$5.2 billion; expenditures for nursing home care 34 percent exceeded expenditures for general and surgical hospital care 31 percent. About 50 percent of the Nation's nursing home bill is now paid by Medicaid.³⁷

C. CONSEQUENCES OF "COST-CUTTING"

In discussions leading to enactment of H.R. 1, critics of Medicaid were greatly concerned about the escalating costs, allegedly caused in part by care in excess of patient needs.

To be sure, many studies indicate that a large number of the patients receiving Medicaid skilled nursing care do not need this level of care. Notable in this regard is the May 28, 1971, General Accounting Office audit of New York, Oklahoma, and Michigan. When one definition of skilled nursing was applied in Michigan, the General Accounting Office reported that 40 percent of the patients did not need skilled nursing. When another definition was employed, 79 percent of the patients did not need skilled nursing. The primary target of the audit was not

³⁶ Public Law 90-248, Section 250. Introduced by former Senator Jack Miller of Iowa.

³⁷ Page 150, Budget Analyses cited in footnote 2.

overutilization, as much as the lack of any uniform definition among the States as to the definition of "skilled nursing."³⁸

By no stretch of the imagination can it be said that a substantial number of patients in America's skilled nursing homes do not need care. What can be stated is that some need a different level of care. In turn, the number of people who fall into each category will be determined by the definitions employed for each level of care.

Consumer advocates who recognized the validity of these arguments opposed direct cuts. Instead, they argued for implementation of "medical review"—a patient-by-patient evaluation of the quality of care—as the means of matching patients with the appropriate level of care and saving dollars. H.R. 1 was enacted to resolve these conflicting positions. But on balance, it gave greater emphasis to cost consideration over patient need.³⁹

In February 1970, President Nixon announced in his budget message that he would seek to abolish 57 agencies of the Government which had outlived their usefulness. His message included a request to trim \$235 million in Medicaid costs.⁴⁰

The Presidential request passed the House of Representatives as an amendment to the Medicare and Social Security reform bill.⁴¹ The House version proposed to cut costs by requiring the following:

(1) A one-third reduction in Federal Medicaid matching money paid to nursing homes after an individual had received 90 days of care.

(2) A complete cutoff of Federal funds after a mental hospital patient received a lifetime total of 375 days of care.

(3) A one-third reduction in Federal funds after an individual received 60 days of care in a tuberculosis hospital.

THE CONGRESSIONAL RESPONSE

In a bipartisan rebuttal, five members of the U.S. Senate Special Committee on Aging opposed this amendment as unfair, problematic and certainly not the way to end the alleged overutilization of Medicaid facilities.⁴² Senator Harrison Williams, then chairman of the Committee on Aging, stated:

. . . What is puzzling is that in the early 1960's our hearings were replete with testimony that the States were having difficulty with the financing of long-term or institutional care. . . . The States are hard pressed to raise revenues. . . . I must say it is a curious kind of revenue "sharing" which the President is proposing in this amendment . . . the Federal Government intends to cut back support of the program to such an extent that the States again will have to bear the huge financial burden of caring for a segment of the population that has no resources of its own and is in desperate need of shelter, treatment, and care.

³⁸ "Problems in Providing Care to Medicaid Patients in Skilled Nursing Homes," U.S. General Accounting Office, May 28, 1971.

³⁹ HEW estimated a reduction in Medicaid costs under P.L. 92-603 of \$790 million. For detailed breakdown of this reduction see table in Appendix 2, p. 117.

⁴⁰ *Washington Report on Medicine and Health*, February 9, 1970, No. 1180, p. 1.

⁴¹ H.R. 17550, Section 225(a).

⁴² August 4, 1970, press release from the Senate Special Committee on Aging, and *Congressional Record* of the same day, p. S12705-09.

Senator Winston Prouty, ranking minority member, said :

The House-passed cutoff provision is based on an erroneous premise that patients in nursing homes do not require inpatient care after 90 days but may be cared for at home. Such a sweeping and general judgment cannot be made by lawmakers; it can only be made on a case-by-case basis by the physician.

Senator Vance Hartke, a member of the Committee on Finance, as well as the Committee on Aging, added :

It is estimated that New York will lose \$105 million; California \$20.4 million; and my own State of Indiana estimates a loss of over a million. Compared to the large losses that will be sustained by New York and California, this loss may seem small, but when one considers the condition of most State budgets these days, it means a great deal in terms of services to older people who have no resources of their own.

Senator Frank E. Moss and Senator Edmund S. Muskie also joined in the colloquy.⁴³ Because of this discussion, the Senate modified the House provision. This modified version⁴⁴ mandates a one-third reduction in the Federal matching for payments to inpatient hospitals, tuberculosis hospitals, skilled nursing facilities and intermediate care facilities, only if States do not have effective utilization review programs in force. The Federal matching to mental hospitals is reduced by one-third after 90 days. Additionally, this modification requires that intermediate care rates be lower than skilled nursing rates.

Accordingly, the compromise version of this amendment had the following effects :

(1) Medicaid cutbacks—instead of being applied automatically as in the House measure—were to be applied only in States which failed to provide effective utilization review.

(2) By HEW estimates, Medicaid costs were reduced by \$162 million annually.

In theory, utilization review should have a dual purpose: to protect the integrity of Federal and State budgets and to insure that the individual receives the level and quality of care he needs. There is great fear, however, among patient advocates that the first need is being served, but at the exclusion of the second.

Some advocates see the effect of this part of H.R. 1 as funneling skilled nursing patients into intermediate care facilities (which are required by law to be less expensive) without regard to questions of their well-being.

Ideally, placement of individuals should be dictated by their needs, not by the economic inconvenience of States and the Federal Government.

Other sections of H.R. 1 also discourage utilization and reduce State-Federal Medicaid expenditures. Section 208 required States to establish premiums for Medicaid enrollees and allows the States

⁴³ August 4, 1970, press release from the Senate Special Committee on Aging, and *Congressional Record* of the same day, p. S12705-09.

⁴⁴ P.L. 92-603, Section 207.

to charge copayment and deductibles if such supplementations are "nominal." Some people suggest that there is no such word as "nominal" when applied to the income of Medicaid recipients. HEW projected a savings of \$89 million a year because of this proposal.⁴⁵

Another provision, section 231, was strongly challenged on the Senate floor by Senators Kennedy and Moss. It called for removal of the requirement that States maintain their current level of expenditures under Medicaid. Senator Moss argued that this would open the door for States to back out of their commitment to Medicaid. HEW in fact had projected a \$640 million savings in the Federal share because of this amendment. Efforts to delete section 231 were defeated.

D. WHOLESALE RECLASSIFICATION OF PATIENTS TO LOWER LEVELS OF CARE

As already noted, H.R. 1 unified Medicare and Medicaid standards. In every case where there was to be a reconciliation, the law requires the higher Medicare standards to be retained.

This change was hailed as a major step forward because (1) standards would be raised, and (2) there would be only a single set of inspections.

But even as the new standards were being promulgated, the question arose: Would the imposition of the higher Medicare standard, with its restrictive definition of skilled nursing, mean wholesale transfers of patients from Medicaid skilled nursing homes into ICF's?

To date, HEW has not acted to clarify the definition of "skilled care." Because of this absence of direction, the States have applied the Medicare definition to their Medicaid programs.

The urgency of this question may be measured by the estimates of the number of Medicaid skilled nursing patients who could not meet the present Medicare definition. *Those estimates range from 2.5 percent to as high as 81 percent.*⁴⁶

As a result, large-scale transfers will take place, and patients will be moved to facilities where present standards require only one licensed practical nurse and "sufficient numbers of personnel."

Moreover, former mental patients and individuals with tuberculosis, cerebral palsy, or epilepsy, may be housed in these facilities with the infirm elderly. The result could have a favorable effect on State budgets but a damaging effect on the individuals.

Many of these fears are already being realized: For example, a major focus of the October 1973 hearings conducted by the Subcommittee on Long-Term Care, dealt with the effects of H.R. 1 and the application of the Medicare definition of skilled nursing to Medicaid. Former Congressman David Pryor, testifying on behalf of the American Association of Retired Persons-National Retired Teachers Association, called this change "the seeds of a devastating tragedy."⁴⁷

Elaine Brody of the Philadelphia Geriatrics Center predicted the "wholesale dumping of patients into less expensive ICF's."⁴⁸

⁴⁵ See table in Appendix 2, p. 117.

⁴⁶ "Problems in Providing Care to Medicaid Patients in Skilled Nursing Homes," May 28, 1971.

⁴⁷ Page 2556, part 21, hearings cited in footnote 3.

⁴⁸ Page 2796, part 22, hearings cited in footnote 3.

Senator Dick Clark reported that only 100 of the present 11,000 patients in his State of Iowa would continue to qualify as "skilled." He added, "According to our State officials that is less than 1 percent."⁴⁹

Dr. George Warner, of the New York Department of Health, testified that about 700,000 of the present 1 million patients in U.S. nursing homes "until now were classifiable as needing the skilled nursing facility level of care with the other 300,000 deemed in need of ICF care. Predictions this morning were that section 247 [of H.R. 1] could cause the reclassification of persons needing skilled nursing or skilled rehabilitation services from 700,000 down to 100,000 and thus cause the reclassification of 600,000 patients to the intermediate care level."⁵⁰

Both Dr. Warner and Elaine Brody reminded the committee of the sharp increase in mortality and morbidity associated with the transfer of patients from one facility to another and from one part of a facility to another. The phenomenon is commonly called "transfer shock" or "transplantation shock" (see pp. 17-18). Senator Charles Percy expressed the concern that as many as 10,000 patients might die if such large scale transfers were ordered.⁵¹

Senator Moss, in a letter to HEW Secretary Caspar Weinberger, requested that patient needs, not fiscal concerns, be the primary consideration in determining where patients were housed. At the same time, the Senator directed a questionnaire to the executive director of each State's nursing home association to determine if wholesale reclassifications were underway and if patients were being reclassified and transferred.

Questionnaire findings establish that reclassification of both patients and facilities is underway on a large scale. At least half of the States report reclassification of facilities from higher to lower levels of care; 23 States report reclassification and movement of patients. HEW has neither acknowledged this trend nor admonished the States for their action. Only aggressive action by HEW can counter the current disastrous trend.

CALIFORNIA: FORERUNNER OF DISASTER?

In California, the Medicaid program is known as Medi-Cal. California pays 50 percent of the costs of this program, and the Federal Government the remaining 50 percent.

In anticipation of the enactment of H.R. 1, Gov. Ronald Reagan, by administrative action, cut Medi-Cal nursing home payments by 10 percent.⁵² Significantly, the new regulations were applied retroactively to the beginning of the Medi-Cal program in 1966. The effect of this action was to require the nursing home industry to return about \$45 million to the State of California.

The California Superior Court ruled that the Governor's cutback was illegal and the State accordingly repealed its 10 percent cutback.⁵³

⁴⁹ Page 2755, part 22, hearings cited in footnote 3.

⁵⁰ Page 2804, part 21, hearings cited in footnote 3.

⁵¹ *Congressional Record*, July 30, 1974.

⁵² *Senior Citizens Sentinel*, March 1971, Vol. 29, No. 9, pp. 1-2.

⁵³ *Washington Report on Medicine & Health*, June 14, 1971, No. 1250.

The California situation, perhaps better than any other, shows the interplay of cost and charges of overutilization. Even before the final enactment of H.R. 1, California initiated a massive program to transfer skilled nursing patients into intermediate care facilities.

A January 31, 1973, story in the *Los Angeles Times* asserted that 1,000 patients a month were being transferred, beginning in March 1972.⁵⁴ The article quoted an earlier *Los Angeles Times* story that at least 32 patients had died, most of them within a short period after the State said they weren't sick enough to warrant treatment in skilled nursing facilities.

State Senator Anthony Beilenson, chairman of the legislature's health and welfare committee, conducted hearings to test the allegation that patients were being discharged wholesale without proper medical evaluations and against their wishes and those of their families. The hearings resulted in a 16-page report and the introduction of a resolution calling for a moratorium on the transfers, "pending the enactment of legislation to prevent precipitous and ill advised transfers."

Commenting on the *Los Angeles Times* story, Senator Beilenson stated that the 32 deaths "may be the mere tip of the iceberg,"⁵⁵ adding that the State department of health provided no data to ease his worst fears.

The *Times* article said :

The transfer of nursing home patients to intermediate care facilities is generally ordered to save State tax money—approximately \$4 to \$7 per patient per day.

With 60,000 patients now in nursing homes in California, the State estimated it could save \$13.7 million in fiscal 1972-73 by effecting such transfers:⁵⁶

In summary, the California experience confirms the many fears voiced by consumer advocates. Where two levels of nursing home care are provided, and the more expensive level can be narrowly defined, long-term care policies will be decided primarily on the basis of economics. The net impact is that wholesale reclassifications will take place, and the needs of the individual nursing home patient will receive only secondary consideration.

E. COST PRESSURES WEAKEN NURSING HOME STANDARDS

Prior to the enactment of H.R. 1, nursing homes under Medicare and Medicaid were providing "skilled nursing care." Medicaid homes were known as "skilled nursing homes" while Medicare homes were called "extended care facilities" (ECF's). Standards differed greatly. Medicare standards were the most comprehensive and were known as "the conditions for participation in an extended care facility." There was great variation between the two programs as to which medical and nursing arts were compensable under their respective definitions of

⁵⁴ *Los Angeles Times*, January 31, 1973, Part II, p. 3. See also *Los Angeles Times* article of July 5, 1972, reprinted in "Trends in Long-Term Care", hearings by the Subcommittee on Long-Term Care, Part 20, Washington, D.C., August 10, 1972, p. 2523-29.

⁵⁵ *Los Angeles Times*, January 31, 1973, Pt. II, p. 3.

⁵⁶ Reference cited, footnote 54.

"skilled nursing care." Medicare, being a Federal program, had one common definition while the Federal-State nature of Medicaid spawned numerous definitions of entitlement under the label "skilled nursing care."

H.R. 1 attempted to deal with this chaotic situation requiring HEW to provide a single definition of skilled nursing care, and a unification of Medicare and Medicaid standards. Compliance with a single set of standards and one certification procedure would allow nursing homes to participate in both Medicare and Medicaid. In this respect, the amendments in H.R. 1 were highly desirable. But Congress was adamant that standards should be raised by the unification procedure or, at the very least, that they should not be weakened below their existing levels.

HEW'S DEFAULT ON STANDARDS FOR SKILLED NURSING FACILITIES

The tragedy of the united Medicare and Medicaid standards, as proposed by regulations issued July 12, 1973 (hereafter referred to as the interim standards), is that the standards, far from being strengthened, were actually significantly weakened. Important standards were deleted, qualified, or nullified by exceptions; generalizations were substituted for specifics.

The diluted standards brought immediate and vocal opposition from consumer and senior citizen spokesmen who requested hearings by the Subcommittee on Long-Term Care. Senator Moss called hearings on October 10 and 11, 1973, to protest the weakening of existing standards and the contravention of congressional intent. He said:

The reason for these hearings is the enactment last year of Public Law 92-603 and specifically section 246. This section of Public Law 92-603 called for the unification of Medicare and Medicaid standards. Significantly, the statute spells out that the higher standard should be retained in every case. Quoting the language of the Senate Finance Committee's Summary of the Social Security Amendments of 1972:

"A single definition and set of standards (for Medicare and Medicaid nursing homes) is established. A 'skilled nursing facility' is defined as an institution meeting the prior definition of an extended care facility and which also satisfies certain other Medicaid requirements."

What appears to be clear in the minds of many nursing home spokesmen is that the standards have been significantly weakened. The proposed regulations published in the Federal Register on July 12, 1973, delete many of the requirements and specifics which were contained in the previous regulations.⁵⁷

Senator Dick Clark⁵⁸ and Senator Pete Domenici⁵⁹ echoed these sentiments, calling the new standards a retreat from good care.

Former Congressman David Pryor, on behalf of the American Association of Retired Persons-National Retired Teachers Associa-

⁵⁷ Page 2539, part 21, hearings cited in footnote 3.

⁵⁸ Page 2541, part 21, hearings cited in footnote 3.

⁵⁹ Page 2542, part 21, hearings cited in footnote 3.

tion, quoted language from the Senate Finance Committee, "The committee's amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities." He added that HEW's failure "will bring about the tragic situation where rather than being the better for Public Law 92-603, the patients . . . will be the worse for it."⁶⁰ Congressman Robert L. Steele, Chairman of the House Republican Task Force on Aging, charged the new standards "failed to guarantee adequate patient care in several major areas."⁶¹

Dr. George Warner, director of the New York Bureau of Long-Term Care, said, "The apparent watering down of nursing standards certainly is to be decried."⁶² Frederick Traill, chief of the Division of Health Facilities and Sanitation of the State of Michigan called the new standards "anything but specific, anything but clear . . . enforcing [these standards] will be a practical impossibility."⁶³

Witnesses at the hearings were just as clear as to the motives for the widespread dilution of standards. For example, Mr. Marx Leopold, general counsel for the Pennsylvania Department of Public Welfare and assistant attorney general said:

I have the strong feeling that the . . . regulations that have been proposed . . . have only one object and that is: fiscal considerations . . .

I think if we look at each one of the standards in terms of trying to save the dollar, that is where the decision has been made.⁶⁴

Mr. Don Barry, representing over 6,000 nursing homes as president of the American Nursing Home Association, reinforced this point of view:

It has become clear to us, Mr. Chairman, that the name of the game in health programs is cost containment.⁶⁵

The dominance of cost considerations over patient need was also clear to Dr. Raymond Benack, founder of the American Association of Nursing Home Physicians (AANPH); he said:

This new regulation turns back the hands of time where [a nursing home] becomes an institution of death to which we condemn the chronically ill patient.⁶⁶

HOW THE STANDARDS WERE DILUTED

Witnesses at the hearings also focused on several specific issues presented by the interim regulations, as detailed below.

Medical Direction:

Spokesmen for the American Medical Association, the American Geriatrics Society, and other organizations testified in favor of a requirement which had been inserted in earlier drafts. Under this provision, each skilled nursing home would be required to have either a medical director or an organized medical staff. Dr. J. Raymond

⁶⁰ Page 2555, part 21, hearings cited in footnote 3.

⁶¹ Page 2545, part 21, hearings cited in footnote 3.

⁶² Page 2603, part 21, hearings cited in footnote 3.

⁶³ Page 2623, part 21, hearings cited in footnote 3.

⁶⁴ Page 2621, part 21, hearings cited in footnote 3.

⁶⁵ Page 2749, part 22, hearings cited in footnote 3.

⁶⁶ Page 2778-91, part 22, hearings cited in footnote 3.

Gladue, president, AANHP, argued this provision was the best investment toward improving the quality of nursing home care, which he characterized as "either very poor or scandalous."⁶⁷

In the face of unanimous testimony, HEW witnesses announced that the Department had changed its position and promised to reinstate the medical direction requirement.

Despite this agreement, regulations issued on January 17, 1974 (hereafter referred to as the final regulations), did *not* include this requirement.

However, on May 1, 1974, HEW issued proposed regulations requiring medical direction. The standards were finalized on October 3, but compliance with respect to medical direction was postponed until 1976.

Physician Coverage:

Former Medicare and Medicaid standards required that patients in skilled nursing homes be seen by physicians at least once every 30 days. The interim standards required visits every month for the first 90 days and then at the discretion of the physician.

One of the most compelling arguments for regular physician visits was, oddly enough, made by Assistant Secretary of Health Charles Edwards, in his testimony before the subcommittee:

Experience in both the Medicare and Medicaid programs has revealed that a major source of deficiencies in long-term care facilities has occurred in the provision of physician services, e.g., too infrequent patient visits or outright abandonment, inadequate review of patients' drug regimens, incomplete records, and excessive length of patient stay. Ensuring regularly available physician services is necessary to fulfill Medicare and Medicaid requirements for adequate medical supervision and direct physician care to patients, particularly to patients institutionalized for extremely long periods and in emergencies.⁶⁸

Senior citizen and consumer spokesmen argued for retention of the 30 day requirement but received only a minor concession from HEW. Current regulations require that patients be seen monthly for the first 90 days; at the discretion of the physician thereafter but not less than 60-day intervals.

The subcommittee strongly believes that the 30-day-visits requirement should be reinstated.

Registered Nurse Coverage:

The interim regulations reduced registered nurse coverage in skilled nursing facilities from 7 days a week, to 5 days a week.

At the hearings, consumer spokesmen, including representatives of the American Association of Homes for the Aging, American Nurses' Association, National Council of Senior Citizens, and the National Retired Teachers Association-American Association of Retired Persons, unanimously supported a reinstatement of the 7-day-a-week requirement.

Under the 5-day standard, nurses will most likely be absent on Sat-

⁶⁷ Page 2725-26, part 22, hearings cited in footnote 3.

⁶⁸ Page 2720, part 22, hearings cited in footnote 3.

urday or Sunday—the two most difficult days to have full staffing of aides and orderlies.

Dr. Edwards, speaking for HEW said “. . . there are no 2 days in any given week when nursing care services are less critically needed . . .”⁶⁹

While the final regulations contained only the 5-day-a-week coverage, the May 1, 1974, proposed rules, finalized on October 3, reinstated the 7-day-a-week requirement. However, in rural areas and where there is a shortage of nurses the 5-day requirement will be the only Federal requirement.

Minimum Staffing Ratios:

Senator Moss and other advocates of long-term care have long advocated minimum nursing personnel to patient ratios as adequate insurance toward improving the quality of care. HEW has steadfastly refused to issue such ratios.

As Marilyn Schiff, director of the ombudsman project of the National Council of Senior Citizens observed :

Failure to set staffing ratios is one of the deficiencies of the current regulations that would be perpetuated if the proposed regulations are adopted. . . . As a result, a 400-bed nursing home could be staffed by one registered nurse 40 hours a week and one licensed practical nurse on each shift. The number of aides apparently would be left up to the nursing home.⁷⁰

HEW flatly refused to issue even minimum ratios for personnel per patients, describing such ratios as “a false benchmark.”⁷¹

HEW's failure to set ratios will mean that unlicensed aides and orderlies will continue to provide 80 to 90 percent of the nursing care in long-term facilities.

The disadvantages of this practice are illustrated in HEW's own testimony (in another context) :

Nursing personnel less qualified than the RN are not capable of recognizing many sudden and subtle, potentially dangerous changes that take place in an ill patient, nor are they prepared to exercise the nursing judgment necessary to respond appropriately in any number of patient crises.⁷²

HEW's Rulemaking Procedures:

The charge was made that HEW selectively leaked preliminary drafts of the regulations to the nursing home industry while consumer representatives were given only 30 days for comment after the regulations were published in the Federal Register. In response to this charge, Assistant Secretary of Health Charles Edwards acknowledged :

There was in fact a selective distribution of draft skilled nursing facility regulations to various nursing home organizations and a denial of access to other organizations, including consumer groups who requested these documents.⁷³

⁶⁹ Page 2721, part 22, hearings cited in footnote 3. In rural areas or where there is a shortage of nurses, the Secretary may waive the 7-day-a-week registered nurse coverage.

⁷⁰ Page 2759, part 22, hearings cited in footnote 3.

⁷¹ Page 2729, part 22, hearings cited in footnote 3. See appendix 8, p. 154 for more details on HEW's views.

⁷² Page 2721-22, part 22, hearings cited in footnote 3.

⁷³ Page 2782, part 22, hearings cited in footnote 3.

He added that the Secretary's office was preparing recommendations and procedures to insure equitable and timely consultation with organizations and individuals outside the department. He further promised to furnish these proposals to the committee as soon as completed.

Almost a year has passed since the promise was made. However, the committee has received no information with respect to new procedures underway at HEW to assure equitable treatment for the industry and consumers alike.

"Excess Verbiage" or Major Setbacks?

In addition to the above issues, Senator Moss expressed concern about others. He wrote to HEW Secretary Caspar Weinberger on October 30, 1973, and submitted a seven-page list of specific deletions which he characterized as "significant losses from the existing regulations."⁷⁴

As an example, the following is a list of deletions from one section of the existing Medicare skilled nursing standards (405:1127) relating to pharmaceutical services which Senator Moss asked Secretary Weinberger to reinstate:

- Medication prescribed to one patient may not be given to another patient.
- Medication errors must be promptly reported.
- Up-to-date medical reference texts must be made available to personnel.
- Each patient's medication container must clearly indicate the patient's full name, physician's name, the prescription number, the number and strength of the drug, date of issue, expiration date of all time dated drugs, the name, address, and phone number of the pharmacist.
- The medication must be kept in the containers in which it was received, and transfer from one container to the next is expressly forbidden.
- Medications having an expiration date must be removed promptly and disposed of after such date.

None of these requirements, however, were reinstated. Additionally, his suggestion that the standards be changed to bar unlicensed personnel from setting up and passing medications was disregarded.

Dr. Allen Kratz, president of the American Association of Consultant Pharmacists, underscored the importance of the above requirements. He charged that 60 percent of the patients in nursing homes received inadequate pharmaceutical services and that the rate of drugs administered in error varied from 20 to 50 percent.⁷⁵

"VAGUE GENERALIZATIONS"

Other witnesses reacted sharply to the deletions and omissions from existing standards. Frederick Traill of the Michigan Department of Health, testified that the interim regulations are so vague, so unclear, so unspecific as to be virtually unenforceable.

Marilyn Rose, Washington counsel of the National Health Law Program, added: "The underlying assumption of these proposed regu-

⁷⁴ For complete list of deletions, see *Developments in Aging: 1973 and January-March 1974*, Special Committee on Aging, May 13, 1974, pp. 66-71.

⁷⁵ Page 2800, part 22, hearings cited in footnote 3.

lations is that specific standards should be deleted, and in their stead generalizations be substituted. . . . We submit that the enforcement of the generalization which HEW has substituted in skilled nursing homes regulations are . . . impossible to enforce. In reality, there are no standards whatsoever."⁷⁶

Edward J. Krill, vice chairman of the committee on legal problems of the elderly for the American Bar Association, agreed: "I would agree with judicial opinion to that effect [that there are no standards at all]."⁷⁷

Former Congressman Pryor observed that far from raising standards, HEW lowered them drastically and far from being better off for the unification of Medicare and Medicaid standards, the patients in skilled nursing facilities will be the worse for them.⁷⁸

Despite the testimony of almost 30 witnesses, the final regulations failed to respond to the criticism of the specifics mentioned above.

HEW said: "The detail in the subfactors cited were deleted to be included in interpretive guidelines." Guidelines, of course, are just what the name suggests—they are a world apart from regulations which have the force of law.

Under close questioning by Senator Percy, Dr. Edwards of HEW agreed that the first priority of the regulations was higher quality patient care. Senator Percy then asked, "In what way do the omissions that have been made contribute to the objective?"⁷⁹

HEW responded that new standards were simplified to give the States more flexibility. In their view the changes amounted only to removing some of the "excess verbiage."⁸⁰

Senator Moss and Senator Percy took sharp exception to this characterization. Senator Moss stated, "Without the addition of these specifics, the proposed regulations represent an unconscionable retreat from the rudiments of proper care for the elderly."⁸¹

F. HEW'S DEFAULT ON STANDARDS FOR INTER-MEDIATE CARE FACILITIES

As has been stated, Congress authorized the participation of intermediate care facilities in the Medicaid program in December 1971 (Public Law 92-223), but preliminary standards for implementing this law were not announced until March 5, 1973. These standards, while weak in some areas, were considered acceptable by most advocates of the elderly.⁸² HEW, however, published final ICF regulations (in January 1974) which were significantly weaker.

The preface to these regulations contains a long list of deletions with HEW's rationale including the following:

⁷⁶ Page 2767-68, part 22, hearings cited in footnote 3.

⁷⁷ Pages 2808, part 22, hearings cited in footnote 3.

⁷⁸ Page 2555, part 21, hearings cited in footnote 3.

⁷⁹ Page 2736, part 22, hearings cited in footnote 3.

⁸⁰ Page 2736, part 22, hearings cited in footnote 3. HEW also said in the preamble to final regulations of 1/17/74, "The skilled nursing facility regulations are designed as performance standards; greater specificity would diminish their applicability to all facilities. Additionally, State agency surveyors have recently undergone extensive training to enhance their understanding of the program and the survey process. These performance-oriented requirements will provide these surveyors criteria on which to base their assessment of an individual facility's performance."

⁸¹ Letter of October 30, 1973, from Senator Frank E. Moss to HEW Secretary Caspar Weinberger.

⁸² For more detailed discussion of the beginnings of intermediate care facilities, see *Developments in Aging: 1972 and January-March 1973*, Special Committee on Aging, May 10, 1973, pp. 36-40.

(1) The proposed standards are too detailed to permit facilities requisite flexibility. Accordingly, requirements for administrative management, resident records, rehabilitative and restorative services, social services, activities programming, dietary services, health services, and pharmacy services have been shortened and procedural details eliminated.

(2) Professional resources to meet staffing and consultant requirements are scarce or unavailable in many areas. Consultants in the areas of social services, activities, the RN programming and meal services have been eliminated. The RN and pharmacy consultants are retained. With the exception of the licensed practical nurse, the requirement that professional individuals on the ICF staff be designated to supervise the various resident services has been deleted. The functions, stated in terms of objectives, have been retained. The professional staff rendering or supervising physical therapy, occupational therapy, speech and audiology services, social services and psychological services in an institution for the mentally retarded are no longer required to have specialized training in mental retardation or 1 year of experience in treating the mentally retarded. Master's degrees are no longer required for social workers and educators who are qualified mental retardation professionals. Specific staff-to-resident ratios in institutions for the mentally retarded have been deferred for 3 years...

(3) Environment and sanitation standards are overly detailed and impose an unnecessary burden on the facility. Physical standards have been revised to eliminate reference to special requirements for laundry facilities, food preparation areas, fire inspection reports on file, elevators, basic service areas for major subdivisions, one dayroom per floor, maintenance staff, indoor and outdoor recreational areas and access to outside exposure and corridors. Bedroom requirements are stated in terms of minimum square footage, with variations permitted by the survey agency under certain conditions. A resident call system has been added in intermediate care facilities other than institutions for the mentally retarded. Specific numbers of toilets and bathing facilities per resident in institutions for the mentally retarded have been deleted. Waiver authority for environment and sanitation standards has been modified to conform with skilled nursing facility standards.⁸³

The final standards are weak, vague, and misleading. For example, only one licensed practical nurse is required 7 days a week in ICF's plus 4 hours consultation with a registered nurse.

The vagueness of the standards for the physical environment can be illustrated in several ways. For example, the standard for toilet facilities requires that "each room be equipped with or conveniently located near toilet facilities." There is no explanation of the meaning of the words, "conveniently located near." More acceptable standards would include minimum numbers of toilets per number of patients and specifics as to their location and convenience. Similarly, the regulations re-

⁸³ *Federal Register*, January 17, 1974, Vol. 39, No. 12, Pt. II, pp. 2219-2237, "Intermediate Care Facility Regulations".

quire "bathing facilities appropriate in size and number to meet the needs of residents." Again the standard gives no indication as to the kind and bathing facilities required.

Under the new standards, ICF's must comply with the Life Safety Code of the National Fire Protection Association, but several serious exceptions are allowed:

Exception No. 1:

In the case of small homes (15 beds or less) for the mentally retarded or those with related conditions, the States may apply the residential occupancy sections of the Life Safety Code rather than the institutional occupancy sections. A State would be required to find that the individuals in such facilities are ambulatory and capable of following direction in an emergency.

Exception No. 2:

States may waive the application of the Life Safety Code entirely or separate provisions of it for such periods as they deem appropriate, if the code provisions would result in unreasonable hardship for the facility. However, the waiver must not adversely affect the health and safety of residents.

Exception No. 3:

States may waive compliance with the Life Safety Code entirely if the Secretary of HEW makes a determination that their own fire codes protect patients equally well.

Exception No. 4:

ICF's can be allowed up to 3 years to comply with Life Safety Code requirements.

Comments:

These exceptions can effectively nullify the standard. Exception No. 1 does substantial damage in exempting buildings which are often the most susceptible to fire. This exception would also be dangerous for persons afflicted with muscular dystrophy, cerebral palsy, alcoholism, and drug addiction. It is doubtful that many of these individuals will be both ambulatory and capable of following directions for self-preservation in an emergency.

Exceptions No. 2 and 3 allow the States to circumvent the provisions of the Life Safety Code. Unless such findings of "equivalency" are carefully evaluated and sparingly given by HEW, the effect will be to undercut this standard.

Exception No. 4, of course, means almost 2½ years before ICF standards will be fully enforced.

All in all, the final ICF regulations poorly serve the interests of the nursing home patients. They reflect the same pattern as the skilled nursing facility regulations in that virtually all the specifics are deleted in the name of "flexibility."

This lack of specificity (or excess flexibility) makes the standards impossible to enforce. Unhappily, the result will be deterioration in the quality of care.

There is no evidence of personnel shortages that will justify the downgrading of this standard. If, as appears likely, the motive is cost

containment, the move will prove to be "false economy" in that individuals needing care will debilitate and require transfer to the more expensive skilled nursing facility or the general hospital.

G. THE SHARP INCREASE IN BOARDING HOMES AND UNLICENSED NURSING HOMES

Medicaid, as it has been described thus far in this report, is suffering from creeping anemia in standards and purposes. Perhaps the most dramatic ailment on the Medicaid syndrome is the draining off of Medicaid patients to boarding homes and unlicensed nursing homes. Several provisions of H.R. 1, as enacted in 1972, have forced this reclassification from higher to lower levels of care. In addition, other factors have intervened. Among them:

The Life Safety Code:

H.R. 1 requires that intermediate care facilities comply with the provisions of the Life Safety Code. This amendment was added after several fires in ICF's were reported in the public press.⁸⁴ As reported earlier, full compliance with the provision of the code has been postponed for 3 years and is subject to liberal exceptions because of HEW regulations. However, when this requirement is enforced it is likely that thousands of facilities will not be able to meet the Federal standards.⁸⁵ In all likelihood, many will either go out of business or seek refuge as unlicensed "bootleg" nursing homes or boarding homes.

The Old Age Assistance Loophole and the New SSI Program:

One unanticipated result of the shift to ICF's has been the diversion of benefits paid under *other* Federal programs. The Federal Government had provided the States with matching funds under titles I, X, XIV, and XVI of the Social Security Act. Basically these are cash grants to individuals who are aged, blind, and disabled. An individual receiving such cash grant generally is free to do with it as he chooses. He can purchase his own housing, food, etc. However, in the case of individuals who are under some physical or mental disability, many States have placed such persons in specific boarding homes, rest homes, or unlicensed nursing homes. This technique or loophole allows the States to escape responsibility for these individuals and to use cheaper facilities which are required to meet State licensure requirements. These facilities are known as "bootleg" nursing homes and they are in wide use in many States.

Recent fires in Honesdale, Pa.,⁸⁶ and Rosecrans, Wis.,⁸⁷ brought this practice out into the open. In Honesdale, where 15 patients died, the State of Pennsylvania was found to be using old age assistance (title I of the Social Security Act) funds to support individuals in what the State called a "skilled nursing home." In reality, it was little more than a boarding home. Title I typically provided a cash payment to individuals who are free to find their own housing. As practiced in

⁸⁴ See Supporting Paper No. 5, to be printed early in 1975.

⁸⁵ The *Washington Post*, January 16, 1974, reported:

HEW's Director of the Office of Nursing Home Affairs, Faye Abdellah, disclosed that 59 percent of the Skilled Nursing Facilities in the U.S. did not meet minimum fire safety standards as expressed in the Code and noted that *there was an even higher rate of non-compliance among that nation's 8,500 ICFs.*

⁸⁶ October 19, 1971.

⁸⁷ April 4, 1972.

Pennsylvania, individuals were given a cash payment under title I but placed in specific facilities. A similar pattern emerged in Wisconsin where nine elderly persons died. Seven of the home's residents were supported by old age assistance funds; three actually needed skilled nursing as determined by a State nurse the day before the fire.

The January 16, 1973, editorial in the *St. Louis Globe Democrat* asserts that there are at least 755 unlicensed and substandard "boot-leg" facilities in the State of Missouri which house about 10,000 patients.⁸⁸

There is also ample evidence that States have used cash assistance and old age assistance funds to pay for the care of individuals discharged from State mental hospitals. The cost of caring for a patient in a State mental hospital is typically about \$800 a month, compared with \$146 in a foster care or boarding home.⁸⁹ Consequently, there is strong motivation for such transfers. Moreover, the provision (section 207) in H.R. 1, which reduces Federal matching by one-third to individuals with mental illness, has helped accelerate this procedure.

In 1972, the Congress moved to close this loophole with section 249D of H.R. 1. This section prohibits the use of cash assistance payments for individuals who could be cared for under the Medicaid program. Perhaps even more significant, this bill "federalized" title I, the old age assistance program and now establishes a minimum \$146 per month floor under the incomes of the needy aged. The program is called Supplementary Security Income (SSI).

The advent of SSI, unfortunately, has accelerated the transfer of patients from State hospitals to boarding homes, and has stimulated the rapid development of a for-profit boarding home "industry."

In the past, the cost of old age assistance was shared between the States and the Federal Government. Under SSI, the Federal Government pays the full amount. Therefore, the option of the State to move a patient from its mental hospital (estimated at \$800 per month in State money), is all the more tempting.

The regulations implementing SSI (section 416.1125), create a strong preference for housing individuals in proprietary boarding homes.

First, recipients are not eligible for SSI if confined to an institution (e.g., mental hospital or nursing home). However, recipients are eligible for SSI if they reside in boarding homes.

Second, if a recipient is living in a nonprofit boarding home which supplements part of the cost of care, the value of this supplementation will be cut by one-third or more because it would be counted as in-kind income in determining eligibility for SSI. The net effect is that an SSI recipient can lose all or part of his assistance payment.^{89a}

⁸⁸ On September 11, 1974, a fire in an unlicensed facility in St. Joseph, Missouri, claimed seven lives.

⁸⁹ Average costs in St. Elizabeths Hospital in Washington, D.C., for 1973 were over \$800 per month per patient. The Federal maximum for a single individual under the Supplementary Security Income (SSI) program is \$146.

^{89a} In August 1974, Senator Frank Church introduced an amendment to H.R. 13631 to relieve this inequity. The new law (P.L. 93-484), effective retroactively to January 1, 1974, provides that SSI benefits no longer be taken away to the extent that the nonprofit home subsidizes an individual's support and maintenance. HEW plans to issue regulations early in 1975.

Third, if a person lives in a for-profit boarding home with unrelated individuals he is eligible for his full SSI payment.

The increased use of boarding homes has serious implications. Most States do not license boarding homes. When States do require licenses, standards are weak and oftentimes unenforced. Nationally, the result may be what committee investigators found in New Mexico: Poor food, negligence leading to death or injury, deliberate physical punishment inflicted by operators upon their residents, poor care (for example: allowing patients to sit in their own urine, binding them to the toilet with sheets, not cutting toenails to the point where they curl up under the feet, making walking impossible), cutting back on food, electricity, water and heat to save money, and housing people in makeshift facilities, such as a former chicken coop or a rundown mobile home.⁹⁰

In short, the interaction of the skilled nursing facility and intermediate care facility regulations is forcing the downgrading of thousands of patients to lower levels of care. Few will continue to qualify for skilled nursing. Most will be ICF patients, and thousands will be relegated to boarding homes. In addition, the number of boarding home residents will increase as States continue their large-scale "dumping" from State hospitals to take advantage of SSI cost savings.

It is evident that boarding homes are the bottom line, the last repository for the elderly. Changes in Federal regulations must be effected, but until the States enact effective statutes which are regularly enforced, more and more senior citizens will be relegated to boarding homes—often the least suitable, the least qualified, the least regulated, and always the least expensive answer to their needs.

⁹⁰ Cited in report on the New Mexico Boarding Home Assn., presented to Honorable Pete Domenici from Val J. Halamandaris, Associate Counsel, U.S. Senate Special Committee on Aging, May 25, 1974, at hearing in Santa Fe, N. Mex., "Barriers to Health Care for Older Americans," Part 12.

PART 4

THE NEED FOR ALTERNATIVES TO INSTITUTIONALIZATION

Thus far, this Introductory Report has described the nursing home industry and Federal efforts—partially through Medicare and largely through Medicaid—to pay for care provided by that industry. Now this survey turns to two fundamental questions: why such heavy reliance upon long-term care institutions? If satisfactory alternatives could do a major part of the task, why are they not at work?

Overwhelmingly, testimony at subcommittee hearings charges Medicare and Medicaid with failure to encourage suitable alternatives. And yet, eminent witnesses have told the subcommittee that in-home services and other alternatives can reduce costs and serve patients better.

Other common assertions include:

- In-home services can prevent premature institutionalization;
- Large numbers of older Americans are now unnecessarily and prematurely institutionalized;
- Thousands of nursing home patients could be discharged if in-home services were more readily available; and
- Homemaker and home health care can be provided at a substantially reduced public cost than institutional care.

The first assertion has received widespread acceptance. The others, however, are subject to debate and discussion.

It is a cruel irony that more than 2.5 million people are in urgent need of home health services authorized under Medicare. But these individuals do not receive this care because very few can qualify for "skilled nursing care."

In the case of Medicaid, the situation is especially perplexing. To be eligible a patient need not qualify for "skilled nursing." Indeed, payment is authorized for preventive, skilled, and nonskilled care. Although every State participating in Medicaid is required to provide home health services, few States have provided more than token services. Clarification by HEW is needed to provide a more effective program and guidance concerning the types of service that qualify for Federal assistance.

A. BASIC FACTS ABOUT HOME HEALTH CARE

Home care, in the broadest sense, is the provision of health care and/or supportive services to the sick or disabled person in his place of residence. It may be provided through a broad range of services and organizational patterns—from nursing service under physician direction to a coordinated home care program which is centrally administered. Coordinated home care should include visiting nurse,

home aide, laboratory services; physical therapy; drugs; and sick room equipment and supplies. The purpose of such programs is to shorten the length of hospital stays, speed recovery, and bridge the gap in community health services for patients who are unable to visit a physician's office but do not need hospital care.¹

Home Health Care: The European Experience

America can learn much from Europe about the place of in-home services in an organized array of medical and social services. For example, Dr. Lionel Z. Cosin of Great Britain explained:

In America there are few community support services to help maintain the aged patient in his own environment. . . . In England each local authority health service is required to supply the following supports which the aged utilize: chiropod service, podiatry, Meals-on-Wheels, home help service, occupational therapy, recuperative holidays, residential homes for mental health, home nursing, health visiting, ambulance service, day centers and clubs, and residential accommodation. Even though such services may vary in strength from community to community, the geriatric practitioner can rely on the support being basically available.

The American family caring for an aged relative has few supports in either the community or the hospital system. The English family in the same circumstances has not only community supports but also the growing reality of flexible hospital admission . . . plans for the aged. Cowley Road Hospital has such flexible plans in practice to relieve families of heavy or sudden increasing care pressures. These are holiday admission, short-term admission, and floating beds. . . . Holiday admissions assure the family that the aged patient will be admitted to the hospital during the family's planned vacation. . . . A short-term admission program provides for intermittent two week admission of the aged patient. . . . The floating bed plan . . . is a scheduled admission every 2 weeks for either 3 days and 2 nights or 4 days and 4 nights. . . . In addition there is the Day Hospital . . . a unit combining medical and nursing care, physical, and occupational therapy with a noon meal for the aged.²

Dr. Cosin described the American system as "episodic" in which the patient only sees his physician from time to time. This point is reinforced in a committee report³ prepared by Brahma Trager in April 1972.

B. HOW MANY OLDER AMERICANS NEED SUCH SERVICES?

Agnes Brewster, consultant for the Senate Committee on Aging, estimates that 2.6 million individuals over 65 need in-home services; 300,000 in institutions and another 2.3 million in the community. This

¹ "Study of Health Facilities Construction Costs", U.S. General Accounting Office, November 20, 1972, enclosure 3, p. 25 and following.

² "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 14, pp. 1380-81.

³ *Home Health Services in the United States*, Report to the Special Committee on Aging, April 1972.

statistic is provided in the report: *Alternatives to Nursing Home Care: A Proposal*, prepared for the use of the Senate Special Committee on Aging by Dr. Robert Morris and staff specialists at the Levinson Gerontological Policy Institute of Brandeis University.⁴

Commenting on this report, Elaine Brody of the Philadelphia Geriatrics Center characterizes the 2.6 million figure as an understatement.⁵ Ethel Shanas, professor of sociology at the University of Illinois, arrived at a figure of 4 million potential home health beneficiaries by adding the institutionalized, bedfast, homebound, and those who walk with difficulty. By this estimate, one out of every five older Americans is a potential candidate for home care.⁶ In an Urban Institute working paper, Burton D. Dunlop projected that 2.5 million individuals needed home health services including meal services.⁷ He evaluated the above-mentioned studies in reaching this conclusion.

C. HOW MANY HOME HEALTH OR VISITING NURSE AGENCIES ARE THERE?

In 1970 there were 2,800 home care programs in the United States.⁸ Almost 85 percent of these had been approved for Medicare.

About 2,300 home health agencies participated in Medicare in 1971, up from 1,275 in 1966. However there were only 2,250 home health agencies participating in Medicare in 1972.⁹ About 57 percent were official health agencies, 24 percent were visiting nurse associations, 3 percent were combined Government and voluntary agencies, and 9 percent were hospital based. The remainder were based in rehabilitation facilities, extended care facilities, retirement villages, and in other types of agencies.¹⁰

Medicare specifically excludes proprietary home health agencies unless they are licensed by State law. At the present time only 10 States have passed such licensure laws: California, Hawaii, Louisiana, New York, Wisconsin, Arizona, Indiana, Kentucky, Nevada, and North Carolina.

All home health agencies, by definition, provide skilled nursing. In 75 percent of the cases the other required medical or therapeutic service is physical therapy. Most agencies provide only two services. Some 21 percent offered medically related social services.¹¹

⁴The estimates by Agnes Brewster are based on extrapolations from published surveys of the National Center for Health Statistics, National Health Center, and Social Security Administration. See *Alternatives to Nursing Home Care: A Proposal*, prepared for use by the Special Committee on Aging, October 1971, p. 3.

⁵Letter of September 7, 1971, from Elaine M. Brody, Director, Department of Social Work and Research, Philadelphia Geriatric Center, to Senator Frank E. Moss.

⁶"Measuring the Home Health Needs of the Aged in Five Countries," *Journal of Gerontology*, 1971, Vol. 26, No. 1, pp. 37-40. In fact, one out of five seniors will spend some time in a nursing home prior to death. See p. 15, supra.

⁷"The Long-Term Care: Need vs. Utilization," June 21, 1974.

⁸*Health Resource Statistics*. National Center for Health Statistics, Department of Health, Education, and Welfare (1971), pp. 377-80. For purposes of Medicare, a home health agency is defined as a public or private organization or a subdivision of such agency or organization which is primarily engaged in providing skilled nursing care and other therapeutic services to patients in their home. To be approved for Medicare the agency must provide skilled nursing and at least one other therapeutic service, such as physical therapy, speech therapy, occupational therapy, medical social services, or home health aide service. Agencies certified include visiting nurse services, health departments, hospitals, rehabilitation centers, group practice units, homes for the aged, retirement villages, religious orders, homemaking agencies, and neighborhood health centers.

⁹Pp. 14-15, report cited in footnote 3.

¹⁰Page 378, statistics cited in footnote 8.

¹¹Page 378, statistics cited in footnote 8.

D. HOME HEALTH BENEFITS UNDER MEDICARE

Home health benefits are authorized under both Part A and Part B of Medicare. Under Part A, Medicare beneficiaries are authorized up to 100 home health visits.

To be eligible the following conditions must be fulfilled:

(1) The patient must have been hospitalized for at least three consecutive days.

(2) The continuing care he needs includes part-time skilled nursing, or physical or speech therapy.

(3) The patient is confined to his home.

(4) A doctor determines that home health care is needed and establishes a plan within 14 days after the patient is discharged from a hospital or participating skilled nursing facility; and

(5) The home health care is for further treatment of a condition for which the patient received services in a hospital or skilled nursing facility.

Up to 100 visits each calendar year are also available under Part B. To qualify, five conditions must be met:

(1) The Medicare beneficiary needs part-time skilled nursing care, or physical or speech therapy.

(2) He is confined to his home.

(3) A doctor determines that the patient needs home health care.

(4) A doctor sets up and periodically reviews the home health care plan; and

(5) The home health agency participates in the Medicare program.

In fiscal year 1973, Medicare paid out \$75 million in home health benefits, down from \$115 million in fiscal year 1970.¹² Moreover, this \$75 million figure accounts for less than 1 percent of the total Medicare expenditures of \$12.1 billion.

Home health care—like the Medicare nursing home program—is tied to the definition of “skilled nursing” (see pp. 32–33 for additional discussion). When the April 1969 regulations were announced restricting the definition of skilled nursing under Medicare, the regulations fell with equal force on home health agencies. Under the new rules, thousands of individuals previously eligible were no longer compensable. Moreover, the new rules were given retroactive application.

“Retroactive denials” is a term that is familiar to coordinators of home health agencies as well as nursing home owners. Retroactive denials and the new restrictive definition of skilled nursing care are generally considered the two primary reasons for the decline of home health agencies in the United States. This is the conclusion of the report, *Home Health Services in the United States*, previously mentioned.¹³

In testimony before the Subcommittee on Long-Term Care, Mrs. Bilye Boselli, executive director for Visiting Nursing Association of Jacksonville, Fla., discussed the impact of these two problems:

¹² “Home Health Care Benefits Under Medicare and Medicaid”, audit by the U.S. General Accounting Office, July 9, 1974. As of October 18, 1974, according to HEW, the amount reimbursed for home health services under Medicare has increased from \$57 million in fiscal year 1971 to \$75 million in fiscal year 1974. In addition, the claim denial rate has decreased from 4 percent in fiscal year 1971 to 1.6 percent in fiscal year 1974 and appears to be going even lower in this fiscal year.

I enclose a copy of an analysis of this agency's case load for 1969 which was done when we [were] faced with a \$120,000 deficit because of the "new" interpretation of skilled nursing and custodial care. This agency was established in 1944 and traditionally has provided nursing care to those in need of part-time service in the home regardless of ability to pay. We have a well trained experienced staff of nurses and home health aides to provide such services. Since the advent of Medicare we have expanded our staff to meet this demand. Medicare has paid for services since 1966. Now, they will not and we find ourselves in the position of reducing staff by one-half with an increasing demand created by Medicare.¹⁴

On November 13, 1973, Senators Frank Church¹⁵ and Edmund S. Muskie¹⁶ introduced bills to liberalize Medicare home health benefits and to provide grants to assist the establishment and operation of home health agencies. Senator Muskie stated:

I have received letters from agencies all over the country detailing Medicare denials and delays of reimbursement and the subsequent effects on home health agencies. A feeling of terrible frustration and concern for their elderly patients is expressed again and again in these letters. One Indiana agency wrote:

"The abuses of Medicare on the home care level have been practically nonexistent. The on again off again policies of the Federal Government and SSA are making orderly development of home health care services practically impossible. Board, staff, and patients are confused and disgusted. Many patients go without needed care because their right to Medicare coverage of health care services has been denied them."¹⁷

Another measure of these developments was provided the committee on July 9, 1974, when the Subcommittee on Health of the Elderly received a long-awaited report of Medicare-Medicaid home health services from the General Accounting Office. A General Accounting Office survey of 11 States revealed that from 1968 to 1971:

—The number of home visits to Medicare patients decreased 42 percent.

—The number of nurses in home health programs and home health aides decreased by 41 and 49 percent.¹⁸

Senator Muskie commented:

The report shows that the facts are worse than we thought . . . patients and physicians have been confused. Physicians recommended home health care; the Medicare claim forms showed entitlement to home health visits; yet the intermediaries denied payments.¹⁹

¹⁴ Page 233, part 2, hearings cited in footnote 2.

¹⁵ S. 2695 incorporated in S. 3280 which passed the Senate, Sept. 10, 1974.

¹⁶ S. 2690. See also S. 1825, introduced by Senator Moss, May 16, 1973.

¹⁷ *Congressional Record*, November 13, 1973, p. S. 20248.

¹⁸ Page 11, audit, cited in footnote 12.

¹⁹ Opening statement of Senator Edmund S. Muskie, "Barriers to Health Care for Older Americans", hearings by the Subcommittee on Health of the Elderly, Washington, D.C., July 9, 1974, not yet in print.

E. HOME HEALTH BENEFITS UNDER MEDICAID

Medicaid provides Federal funds to States which establish a medical care program designed to meet the needs of indigents. All have now chosen to participate in the program. The law now requires each participating State to provide a minimum of eight essential services including: hospital care, physicians' services, skilled nursing home care, and X-ray and certain other laboratory services.

A State could, of course, provide additional services for which there would be Federal matching available, such as eye care and dental care. As long as the eight essential or so called mandatory services were provided, the Federal Government would provide matching funds (ranging from 50 to 83 percent of the cost of the Medicaid program), depending largely on the per capita income of the State.

In 1967, Senator Moss added a provision to the Social Security amendments (Public Law 90-248). *Section 224 of this act requires States to provide home health services as a condition to participate in Medicaid.* This requirement became effective June 30, 1970.

Medicaid home health services, unlike Medicare, are not limited by the requirement that the patient qualify for "skilled nursing care." Skilled care, unskilled (basic) care, and even preventive care are authorized. Unfortunately, HEW has failed to (1) provide clarification concerning the specific home health services eligible for Federal financial participation, (2) define these services for the States, and (3) insist on anything more than token compliance with the law.

As a consequence, few States²⁰ have developed significant home health programs. In 1972 Medicaid home health expenditures totalled \$24 million or less than 1 percent of the Medicaid \$5 billion total. Some 113,372 recipients were served nationwide.²¹

New York, which spent \$15 million for home health care for 32,800 recipients, accounted for more than 60 percent of the total expenditures. At the other end of the scale were Oregon (which served 10 recipients at a cost of \$2,160) and Wyoming (which served 12 recipients at a cost of \$3,392.)²²

F. LACK OF A POLICY ON "ALTERNATIVES"

The lack of alternatives to institutionalization was one of the major concerns of the 1961 White House Conference on Aging. In fact, the delegates said that: "The need to expand institutional facilities should not discourage noninstitutional alternatives, particularly treating the individual in his own home."²³

Some 10 years later, President Richard Nixon told the 1971 White House Conference on Aging, "The greatest need is to help more older Americans to go on living in their own homes."²⁴

New pressure for home health services has mounted because recent studies assert that large numbers of individuals in nursing homes are misplaced.

²⁰ Page iii, audit cited in footnote 12.

²¹ "Numbers of Recipients and Amounts of Payment under Medicaid 1972", U.S. Department of Health, Education, and Welfare, Social and Rehabilitative Services, Office of Information Sciences, May 23, 1974, Tables 4 and 5.

²² Page iii, audit cited in footnote 12.

²³ *Developments in Aging, 1970*, Special Committee on Aging, March 24, 1971, p. 60.

²⁴ *Bergen County Record*, April 23, 1972, p. B.6.

According to these studies many people receive excessive, insufficient, or inappropriate services.

Not long ago the General Accounting Office issued a report which said that the cheapest way to provide new hospital beds was to make better use of existing acute beds by moving individuals out of the hospital to lesser facilities and services. It suggested that wider use of "alternatives to traditional health care," could save 81.7 million short-term general hospital days, *or about \$3 billion in 1970 operating costs*. The study also argued that the reduction in the average length of stay in a hospital by one day could save 28 million short-term hospital days or 96,000 beds. GAO further said that a one day reduction in the average length of stay in hospitals could save between \$1 and \$2 billion in health care costs.²⁵

Some individuals and organizations read the GAO report to mean simply that the Government should make better use of Medicare (ECF now SNF) nursing homes since a nursing home bed costs only about one-third that of a hospital bed. But the study has much broader implications. Individuals could be discharged to their own homes as well as to nursing homes. One Michigan study noted that the average cost of an experimental home care program in 1967 amounted to \$3.96 per day, compared with \$51.34 (at that time) for in-patient hospital care. Parenthetically, nursing home costs averaged about \$15 a day. The GAO report places the cost of home care per patient per day in the \$3 to \$8 range. However, GAO did not attempt to survey the services provided to establish comparability with other forms of care.²⁶

These cost comparisons for home health services must be considered carefully. There are often great variations in the services provided. Some home health programs are computed on a per case rather than a per day or per month basis, adding to the complexity of the comparison.

The premise that large numbers of nursing home patients can be discharged and supported through home health services at a substantially reduced public cost is not fully supported by present data. An Urban Institute study, for example, reveals that most nursing home patients need some level of nursing home care.²⁷

However, if home health services are readily available prior to placement in a nursing home there is convincing evidence to conclude that such care may not only postpone but possibly prevent more costly institutionalization. What is particularly appealing from the standpoint of the elderly is that home health services can enable them to live independently in their own home, where most of them would prefer to be.

The Minneapolis Age and Opportunity Center, Inc. (M.A.O.), provided the committee with numerous case histories, illustrating the dramatic cost savings possibilities under home health care.²⁸

²⁵ Pages 51-53, study cited in footnote 1.

²⁶ Pages 51-53, study cited in footnote 1.

²⁷ "Long-Term Care: Need vs. Utilization", by Burton D. Dunlop, June 21, 1974.

²⁸ "Barriers to Health Care for Older Americans", hearings by the Subcommittee on Health of the Elderly, Washington, D.C., June 25-26, 1974. Not yet in print. See additional samples, Appendix 5, p. 133.

Supportive Services for Mrs. M. R. over 3 years by M.A.O. :	
Meals, including delivery charges (2 meals a day, 7 days a week)	\$3,385.00
Housekeeping services (3 services a month)-----	399.60
Counseling (average one a month)-----	324.00
Total Cost of M.A.O. services-----	4,008.60
Nursing Home costs for 3-year period (projected cost) :	
\$450.00 per month for 3 years-----	\$16,200.00
Less clients income of \$115/month for 3 years (client would be allowed to keep \$25.00 a month for personal needs)-----	-4,140.00
Remaining cost to be paid by Medicaid-----	12,060.00
Less cost of M.A.O. services-----	-4,008.60
Total M.A.O. saved the taxpayers over 3 years with respect to a patient ordered institutionalized-----	8,051.40

SUMMARY—"ALTERNATIVES"

In short, there is no firm national policy with respect to alternatives to institutionalization. Home health care receives a very low priority in the United States. While home health is authorized under both Medicare and Medicaid, expenditures for home health care constitutes less than 1 percent of either program. Why? Under Medicare, benefits are limited to a narrow and restrictive definition of "skilled nursing." Under Medicaid, few States have made more than a token effort to make these services available. This glaring lack of policy is all the more evident when American health delivery services are compared with some European systems where home health is a full partner in a genuine continuum of care.

One result of this failure is that the United States does not take advantage of the significant cost savings inherent in a viable home health program.

Older Americans, more so than any other group, have been adversely affected by the failure. Some 2.5 million seniors are without necessary care, which could postpone or prevent institutionalization if provided in a timely fashion. Moreover, it could allow elderly persons to live independently, in their own homes, where most would prefer to remain.

PART 5

FAILURE TO ENFORCE NURSING HOME STANDARDS

Most experts in the field of long-term care argue that nursing home standards are essential to reach the desired goal of quality care.¹ Early hearings by the Subcommittee on Long-Term Care documented that standards varied greatly from State to State as did the quality of care. Generally, the higher the nursing home standards, the better the care. Accordingly, the enactment of Federal nursing home benefits under Medicare and Federal-State benefits under Medicaid brought minimum standards for skilled nursing care.

Standards were promulgated under Medicare with relatively little controversy. But under Medicaid, because of its joint Federal-State nature, it was a different story. Senators Frank E. Moss and Edward M. Kennedy fought a long, uphill battle to bring about the enactment of legislation requiring Federal minimum standards for skilled nursing care under Medicaid. They fought an even greater battle to get the Department of Health, Education, and Welfare, to implement regulations.

I. THE BATTLE OVER NURSING HOME STANDARDS AND IMPLEMENTATION OF THE LAW

As has been described, the unification of Medicare and Medicaid standards led to the promulgation by HEW of new regulations which scuttled existing standards and substantially lowered requirements for America's nursing homes. The story of the new regulations is one of default, bureaucratic highhandedness, and indifference, if not outright neglect. A similar pattern existed in the early years of the Medicaid program. When HEW delayed effective implementation of the Moss amendments for 3 years, Ralph Nader told the subcommittee to consider "personal sanctions to officials who have, in effect, so seriously neglected their jobs or so willfully neglected enforcing the law—that their very tenure in office must be brought into question."² The inadequate regulations (then and now) and the unreasonable delay provided clearcut evidence of the lax enforcement of nursing home standards and the lack of a policy with respect to the infirm elderly.

¹ Problems of enforcement date back to the earliest days of this investigation. In its 1960 study, "The Condition of American Nursing Homes", the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare, stated at page 20: "Licensure standards differ greatly and are either too low or are not being enforced because of the problem of finding a place to put patients."

² "Trends in Long-Term Care", Part 2, hearings by the Subcommittee on Long-Term Care, Washington, D.C. December 17, 1970, p. 874.

A. DEFAULT ON THE MOSS AMENDMENTS FOR MEDICAID SKILLED NURSING FACILITIES

Prior to enactment of both Medicare and Medicaid, subcommittee hearings in 1965 disclosed great variations in State nursing home standards and great disparity in the manner and vigor of State enforcement. These findings and the Federal Government's massive infusion of Medicaid funds into nursing homes convinced Senator Moss, chairman of the Long-Term Care Subcommittee, that uniform Federal standards were necessary.

Accordingly, Senator Moss proposed new standards as part of the Social Security Amendments of 1967.³ Under this new law the Department of Health, Education, and Welfare, was charged with the responsibility of developing regulations for uniform, minimum Medicaid standards for skilled nursing facilities which the States would then enforce. The tragedy of the Moss amendments is that HEW did not act.

WHAT WERE THE MOSS AMENDMENTS?

The Moss amendments of 1967 were tailored to meet the most significant problems disclosed in the subcommittee's hearings. The new law required:

- States participating in Medicaid to offer home health services as an alternative to nursing home care.
- Agreements between State health departments (which license and certify nursing homes for participation in Medicaid) and State welfare departments (which make Medicaid payments) to insure cooperation and communication.
- Nursing homes participating in Medicaid to keep detailed records of services provided to patients.
- All individuals with a 10 percent or greater interest in nursing homes to disclose such interest to the State.
- Medicaid nursing homes to have "sufficient nursing and auxiliary personnel," including at least one full-time registered nurse in charge of nursing services 7 days a week. It also recommended minimum ratios for nursing personnel to patients and the number of nursing personnel to supervisors.
- Meals in skilled nursing homes to be planned and supervised by qualified professional personnel and special diets to be provided as prescribed by physicians.
- Standards for the maintenance of medical records, the dispensing of drugs, physician coverage, environment and sanitation.
- Nursing homes to have agreements with local hospitals for in-patients hospital care when needed.
- Medical review (an evaluation of medical care on a patient-by-patient basis with periodic inspections to determine the adequacy of care and services provided and the necessity of retaining the patient in the nursing home) with consideration being given for placing patients outside an institution.
- All Medicaid skilled nursing homes to comply with the provisions of the Life Safety Code (21st edition) of the National Fire Protection Association—an accepted fire and safety code to protect the institutional patient.

³ Public Law 90-248, Sections 224 and 234.

- The Secretary of HEW to withhold Federal funds to a nursing home which does not meet all licensing requirements.

HEW'S EFFORTS TO COMPLY WITH THE LAW

The deadline for complying with most of the Moss amendments was January 1, 1969.⁴ However, HEW did not issue regulations for the States to comply with the law. As a result, the States did not begin their enforcement activities. Instead, a protracted battle developed in which the scope and substance of the regulations were earnestly debated.

The first draft of the regulations was offered in December 1968. Advocates considered this draft to be in full compliance with the intent of the law. Unfortunately, the Medical Services Administration (MSA) Commissioner Francis Land, with advice from Harold G. Smith withdrew the first draft. Mr. Smith at this time was also serving as a consultant to the American Nursing Home Association. Mr. Smith testified before the subcommittee on July 30, 1969 saying:

The Department [HEW] requested that I serve as a consultant on an intermittent basis, sometime early in 1968. I agreed to do that with the understanding that they were aware of the fact that I also consulted with the American Nursing Home Association. When I filled out the employment papers of HEW, I so stated that I was on retainer with the American Nursing Home Association. I made no effort to conceal that fact.⁵

Strongest objection to the first draft was made regarding the personnel requirements and the ratios of personnel to patients.

A second draft of the regulations was proposed to Commissioner Land on January 10, 1969, already 10 days in default of the deadlines set by Congress for implementation of the law by HEW. Once again changes were made to placate those who had argued that standards were too high and too costly.⁶

It should be noted that at this time the Nixon administration took over and began appointing new officials at HEW.

On June 24, 1969, so called interim regulations were announced. Senator Moss said he was shocked by the inadequacy of these regulations, particularly because of their personnel requirements. He immediately called oversight hearings, which were scheduled for July 31, 1969.

The nursing requirement became the focus of the hearing. The interim regulations required 24-hour nursing service (in other words, a registered nurse as a full time director of nurses). However, the regulations did not require registered nurse coverage in the afternoon and evening shifts. At these times the regulations allowed any licensed nurse to be in charge. As a result, a licensed practical, a vocational nurse, or even a nurse licensed by waiver (a practice in some States

⁴ There were three exceptions: requiring states to provide home health services under Medicaid was effective June 30, 1970; medical review requirements were effective July 1, 1969; and the requirement to withhold funds from homes not meeting state licensure requirements was effective June 30, 1968.

⁵ "Trends in Long-Term Care", Part 1, hearing by the Subcommittee on Long-Term Care, Washington, D.C., July 30, 1969, p. 101.

⁶ "Trends in Long-Term Care", Part 8, hearing by the Subcommittee on Long-Term Care, Washington, D.C., May 7, 1970, pp. 626-30, for more detailed chronology of implementation of Moss Amendments.

of licensing nurses out of experience rather than formal training) could be in charge of the other two daily shifts. There were no specific requirements as to experience, training, or education. In sharp contrast, Connecticut requires one registered nurse for every 30 patients on the day shift, one registered nurse for every 45 patients during the afternoon, and one for every 60 patients during the night shift.⁷

At the Senate hearing, Senator Moss denounced the new regulations as lowering standards below their former level. He said :

We are left with regulations that say, in effect, that a single, untrained practical nurse on duty in a home with 200 or 300 patients or more constitutes properly supervised nursing services on the afternoon and night shifts.⁸

Sister Mary Ambrosette, then president of the American College of Nursing Home Administrators, commented :

. . . the charge nurse could conceivably be a teenager with less than a day's experience, with neither training nor education for the task. This is the absolute lowest standard ever—completely different from any previous standard.⁹

Mr. William R. Hutton, executive director of the National Council of Senior Citizens said that the regulations, when compared to the Moss amendments, show that the interests of the nursing home industry have been accommodated and the aged have been sold short.¹⁰

In answer to these charges, Mr. Thomas Laughlin testified in place of resigned MSA director Dr. Land.¹¹ He proposed grace periods because (1) there was a shortage of registered nurses and licensed practical nurses, and (2) HEW had not been given enough money to establish training programs for such nurses. Eleanor Baird, on behalf of the American Nursing Home Association, supported this view.¹²

Rev. William Eggers, president of the American Association of Homes for the Aging, and Mary E. Shaughnessey of the American Nurses' Association testified that they knew of no such shortages.¹³ Moreover, Ms. Shaughnessey argued :

The availability of qualified personnel should not be the factor which determines the standards for an establishment. Rather, the standards would be set according to the services that are to be provided.¹⁴

Senator Moss continued to call upon HEW to revise their interim regulations and issue standards more in keeping with the spirit of his amendments.

In a Senate floor speech,¹⁵ he noted that more than 2 years had passed since the law was enacted and yet HEW had not announced even one final regulation advising the States on how to proceed under the law.

"The effective dates of most of them have passed. What possible

⁷ "Trends in Long-Term Care", Part 3, hearing by the Subcommittee on Long-Term Care, Hartford, Connecticut, January 15, 1970, p. 270.

⁸ See page 1 of hearings cited in footnote 5.

⁹ See page 83 of hearings cited in footnote 5.

¹⁰ See page 46 of hearings cited in footnote 5.

¹¹ See pages 4-15 of hearings cited in footnote 5.

¹² See pages 88-91 of hearings cited in footnote 5.

¹³ See also pp. 79-80 of hearings cited in footnote 5.

¹⁴ See page 69 of hearings cited in footnote 5.

¹⁵ *Congressional Record*, April 16, 1970, p. S 5872-75.

explanation can there be for this Government debacle?" he asked. At the same time he announced hearings for May 7, 1970 to establish "Why there has been so little practical result from our legislative efforts."

At this hearing the Senator stated :

Nearly 2½ years have passed since the enactment of the Moss amendments and we still can see little practical result from our legislative efforts. Standards for skilled nursing homes were not developed by the time the amendment requiring States to use them became effective on January 1, 1969. Six months later, interim standards were published which failed in important respects to be responsive to the law. Despite widespread adverse reaction to these interim regulations, including criticism from a special task force appointed by the Department itself, almost a year went by before improved standards were issued. After months of inaction, they were issued shortly after I announced this hearing.¹⁶

Final standards implementing some of the Moss amendments were announced on April 29, 1970, just in advance of the Senate hearings. At the May 7, 1970, hearing newly appointed MSA Commissioner, Howard Newman apologized for the delay. Senator Moss noted that some of the provisions had yet to be implemented.

Mr. Newman responded that the regulations would be forthcoming "very shortly," which prompted this exchange :

Senator Moss. Twenty-eight months have elapsed since the legislation was enacted. Don't you think that is an unreasonable time ?

Mr. NEWMAN. As I said in my statement, sir, I think that it should have been done by now and I personally regret that this has not been the case. We expect to do all that we can to get it accomplished.¹⁷

Unfortunately, performance has not followed promise. The status of most of the Moss amendments is the same: regulations have been issued, but never enforced. Three provisions in particular were never effectively implemented :

1. Requirement for Medical Review

The philosophy of medical review is patient-oriented. It seeks to assure that the patient is in the right place at the right time and is receiving care appropriate for his needs. It differs from utilization review which is dollar-oriented. One of the key concerns of utilization review is to determine whether the State is paying more money than it should for this patient because he no longer needs hospitalization or skilled nursing care? It differs also from professional review which is physician-oriented, and dominated. Medical review is a team approach in which the patient's social as well as medical needs are considered. Medical review teams should be composed of educators, nurses, therapists, and social workers *in addition* to physicians.

Preliminary regulations for implementing the medical review pro-

¹⁶ See pages 623-24 of hearings cited in footnote 6.

¹⁷ See page 635 of hearings cited in footnote 6.

visions were announced on May 17, 1970, and final regulations were promulgated in February 1971. However, this provision has never been enforced. But late as October 1971, the Administrator of the Social and Rehabilitation Service, John Twiname, testified:

I think I should add to what was said that from the medical review, included in Senator Moss' amendments, we have now developed a comprehensive set of guidelines which are under final review. Next year with the issuance of those guidelines, the presence of our people in the field to set up teams to see that they actually get into nursing homes on a minimum of once a year basis to review this kind of practice will be a significant step forward for us. We welcome that opportunity.¹⁸

2. Staffing Requirements

Senator Moss emphasized in early speeches that minimum ratios were of critical importance and that "sufficient nursing and auxiliary personnel" would be inadequate if HEW failed to promulgate minimum ratios of nursing personnel to patients. Most experts agree that the States with the best nursing home care mandate how many registered nurses, licensed practical nurses and aides, there must be per number of nursing home patients. Each human being can only do so much work.

Early HEW standards in implementation of the Moss amendment were silent on this point. One witness testified:

The proper standard and one for which we should strive is a standard which would require at least 1 RN on duty at all times in both ECF's and skilled nursing homes. This is not unrealistic. Witness New York and other States. What is unrealistic is to provide low standards and then to provide waivers for those low standards.¹⁹

Others called for a more modest standard such as one registered nurse or licensed practical nurse for every 90 patients.²⁰

The final April standards included an HEW commitment to establish minimum ratios. At the May 7 hearing, HEW could give no reasonable assurances when such ratios would be announced. Despite the January 1, 1969 deadline date, ratio requirements have still not been announced in regulations.

Instead, HEW published a guideline in their Medical Assistance Manual. A guideline is just what the word suggests. It is not to be confused with regulations which have the force of law. The guideline reads:

Total Nursing Department Time: Total staff time in the nursing department should amount to an average of not less than 2.25 hours of nursing department per patient per 24 hour day.²¹

¹⁸ "Trends in Long-Term Care". Part 18, hearing by the Subcommittee on Long-Term Care. Washington, D.C., October 28, 1971, p. 1996.

¹⁹ See page 87 of hearings cited in footnote 5. On pages 31-33 of these same hearings Paul De Preaux, president, Connecticut Association of Nonprofit Homes and Hospitals for the Aged, stated: "We were amazed that an agency of the Federal Government could promulgate standards such as these and still term the result a 'Skilled Nursing Home' . . . 'It is a sad day when the laws of States such as Connecticut require more stringent standards for the care of poodles than the Federal Government proposes requiring for nursing homes caring for people'".

²⁰ See page 44 of hearings cited in footnote 5.

²¹ *Program Regulation Guide*. Medical Services Administration, Department of Health, Education and Welfare, PRG-10, November 3, 1971, p. 17.

3. HEW's Responsibility to Withhold Federal Funds from Substandard Facilities

The Secretary of HEW is required to insure that no money goes to substandard long-term care facilities, more specifically to those homes which do not fully meet state standards.²²

In response to this requirement, HEW decided to accept Medicaid certification as sufficient evidence that the certified home was in full compliance with State standards.

HEW reasoned that nursing homes must have a valid State license as a precondition to qualify for Medicaid. If a nursing home qualifies for Medicaid funds, HEW contended then the nursing home must be in conformity with State standards. With this rationale HEW did nothing to implement this amendment which had placed an affirmative burden upon the Secretary to insure that Federal funds did not go to substandard facilities.

Senator Moss described HEW's interpretation as turning a duty and requirement of the Secretary into a nonregulation.

SUMMARY

Although the Moss amendments were enacted in 1967 to improve Medicaid standards for skilled nursing care, HEW failed to develop effective regulations. More than 30 months elapsed from congressional enactment until final regulations were published. Perhaps one reason for the delay is that Medicaid was not adequately staffed. Between January 1966 and January 1967, more than 122 people and 40 man-years of labor were devoted to developing standards for the Medicare nursing home program. By contrast, between January 1968 and January 1969, standards for the much larger Medicaid nursing home program were entrusted to two people and 1½ man-years of labor.²³

When interim standards were announced they were viewed as "lowering standards below their formal level."²⁴ Only strong and continued pressure by the Congress insured that realistic standards were issued on April 29, 1970. Even then, many important provisions of the law were lost in implementation by HEW.

In short, the entire history of the Moss amendments, as implemented by HEW, is tragic. It is a history of the selective enforcement of the law and reflects a continued contempt for the mandates of Congress. Similarly, even a cursory examination of the unified Medicare-Medicaid standards promulgated by HEW in January 1974 (see pp. 45-51) reveals a grossly inadequate response for the health and well-being of thousands of nursing home patients.

II. LICENSING THE ADMINISTRATOR: ROADBLOCK TO ENFORCEMENT OF THE KENNEDY AMENDMENT

In 1965, the Subcommittee on Long-Term Care found that large numbers of nursing home administrators were untrained. Moreover, lack of licensure requirements varied markedly among the 50 States, and some States had no requirements whatsoever.

²² See Appendix 7, p. 149, for Memorandum from Elliot Richardson to President Nixon which indicates HEW's recognition of this responsibility.

²³ See pages 635-36 of hearings cited in footnote 6.

²⁴ Speech by Senator Frank E. Moss before American Association of Homes for the Aging, November 17, 1969, St. Louis, Mo.

Samuel Levy, Director of the Massachusetts State nursing home licensure program reported that "Only 18 percent had completed college, 29 percent were high school dropouts; 1 percent had no formal education at all; and of these administrators, 85 percent supervised all personnel and 56 percent supervised nursing care directly."²⁵

A report later issued by a Ralph Nader study group supplied more specifics:

The regulations of 13 States in 1967 did not even mention the administrator, and those of 10 others did nothing more than refer to him by title. Twenty-eight States had no educational training or experience requirements for the person holding this critical position. Only 14 States required the administrator be over 21 years of age, only 22 specified that he be in good physical health, and only 19 made the point that he be in good mental health. Only nine required the administrator to be at least a high school graduate or the equivalent. Only 21 mentioned that he be of good moral character and only nine indicated that he should have an interest in the welfare of the patients.²⁶

Senator Kennedy introduced legislation to require States to license nursing home administrators after hearings revealed examples of absentee ownership in many States and the possibility of criminal involvement in the ownership and operation of chain nursing homes in Massachusetts. That amendment became a companion to the Moss amendments.²⁷

The Kennedy amendment requires the appointment by the State of a licensing board to oversee the licensure process. These boards must include "representatives of professions and institutions concerned with the care of the chronically ill and the infirm aged patients."

The implementation of this section of the law brought about great controversy in the field. Nursing home administrators sought wide representation on these boards, if not outright domination and control. To nursing home administrators this was logical. Edward C. Walker, former president of the American Nursing Home Association explained: This is entirely consistent historically when one points to the predominance of physicians, pharmacists, attorneys, and dentists, and so forth, on their own State licensure boards."²⁸

On the other hand, advocates such as William R. Hutton, executive director of the National Council of Senior Citizens, charged that the attempts to dominate licensure boards "could well perpetuate abuses the nursing home licensure program was designed to eliminate."²⁹ Mr. Hutton also pointed out that the National Advisory Council on Nursing Home Administration, which was created by the Kennedy amendment, had recommended that these boards not have a majority of any one profession.

The Social and Rehabilitation Service (SRS) of HEW, at the request of Mr. Hutton, prepared a fact sheet which details that there

²⁵ Brian D. Sullivan and Robert K. Dyron, *Progress Report on Nursing Home Administrator Licensing Under Section 1908 of the Social Security Act* (Thesis for Yale Law School, March 15, 1970), p. 2-3.

²⁶ *Nursing Homes for the Aged: The Agony of One Million Americans*, Task Force Report on Nursing Homes (a Nader Task Force), 1970, p. 141-42.

²⁷ See "Conditions and Problems in the Nation's Nursing Homes", Part 6, Boston, Mass., hearing, Aug. 9, 1965, p. 704; see also Public Law 92-248, Section 236.

²⁸ *Nursing Homes*, August 1968, p. 2.

²⁹ News release from the National Council of Senior Citizens, September 21, 1970.

are 47 States which have complied with the licensure law and established advisory boards; 21 of these had a majority of nursing home administrators.

**NURSING HOME ADMINISTRATOR (NHA's) LICENSING BOARDS WITH
A MAJORITY OF NURSING HOME ADMINISTRATORS AS MEMBERS,
AS SPECIFIED IN THE LAW**

1. Alabama.....	5 NHA's of 9 members until July 1, 1975, then 7 of 11.
2. Colorado.....	5 NHA's of 9 members.
3. Connecticut.....	5 NHA's of 9 members.
4. Georgia.....	7 NHA's of 13 members.
5. Idaho.....	3 NHA's of 5 members.
6. Illinois.....	5 NHA's of 7 members.
7. Iowa.....	5 NHA's of 9 members.
8. Nevada.....	3 NHA's of 5 members.
9. New Mexico.....	4 NHA's of 5 members.
10. New York.....	6 NHA's of 11 members.
11. North Carolina.....	3 NHA's of 5 members (and nonvoting member ¹).
12. North Dakota.....	5 NHA's of 9 members.
13. Ohio.....	At least 4 NHA's of 7 members. ²
14. Oklahoma.....	7 NHA's of 9 members.
15. South Dakota.....	4 NHA's of 5 members. ²
16. Tennessee.....	6 NHA's of 9 members.
17. Texas.....	5 NHA's of 9 members.
18. Vermont.....	6 NHA's of 9 members.
19. Virginia.....	4 NHA's of 7 members.
20. Washington.....	6 NHA's of 9 members.
21. Wyoming.....	3 NHA's of 5 members.

¹ Ohio—the board as appointed has 5 nursing home administrators out of 7 members.

² South Dakota—1 nurse who is administrator or director of nursing services in a nursing home (appointed a nursing home administrator with a R.N. degree).

Source: Social and Rehabilitation Service, HEW, Aug. 29, 1970.

After surveying the data supplied by the Social and Rehabilitation Service, Mr. Hutton later charged that nursing home operators in 29 States were in a position to dominate State boards. And in another 13 States, administrators could dominate their boards with the assistance of one other member who might have a financial interest in nursing homes. In testimony before the Senate Finance Committee, he asked for a clarification amendment, emphasizing the need for public representation.³⁰

At the May 7, Trends in Long-Term Care hearing, Frank C. Frantz, then Chief of the Office of Nursing Home Programs, Medical Services Administration, was asked to give his view of congressional intent when the Kennedy amendment was enacted. He had served on the staff of the Senate Special Committee on Aging and helped to draft and guide the legislation through the Congress. He replied:

The historical context is that even at that time when the bill was in its formative stage we were hearing the argument about doctors licensing themselves and pharmacists licensing themselves and so on and why not us? We did not think that this was a valid analogy. We did not think that nursing home administration was an established body of knowledge which was the exclusive province of the practitioners. Indeed, in order to

³⁰ See source quoted in footnote 29.

establish it as a body of knowledge, it needed the contribution of a large number of other representatives of the health and health service professions.

So, in effect, this language "representative of professionals and institutions is concerned with the care of the chronically ill" represented the sponsor's (Senator Kennedy) decision on that argument.³¹

In December 1970, the Nader Task Force report was extremely critical of HEW's implementation of this amendment. Particularly, the report challenged the decision of outgoing Administrator of the Social and Rehabilitation Service, Mary Switzer, who had rejected the advice of the National Advisory Council on Nursing Home Administration and had allowed the State licensure boards to be dominated by administrators.³² The National Council of Health Care Service, representing some of the larger nursing home chains, concurred in this conclusion of the Nader report. They recommended that the Federal Government establish minimum standards for licensure, rather than leaving matters to the States. With specific Federal standards, the council contended that the question of the domination of the boards would be moot. Moreover, Federal standards would facilitate reciprocity between the various States as far as licensure of administrators.³³

In 1971, Senator Moss wrote to John Twinn, Administrator of the Social and Rehabilitation Service, restating his belief that the licensure boards should not be dominated by any one group. He recalled the admonition of Senator Stephen M. Young of Ohio who said, "Licensing of nursing homes by operators is as good as regulation of saloons by bartenders."³⁴ As a result, preliminary and corrective regulations were announced in September 1971. They specified that the boards could not be dominated by any one group.

Amid rumors that the September regulations would then be withdrawn, Senator Moss, in October 1971, informed then HEW Under Secretary John Veneman of his concern.

Final regulations were announced on May 28, 1972, requiring representation of all health professionals on the boards and no domination by any one profession.

The controversy, however, was not settled. The American Nursing Home Association threatened to sue to restore the administrator-domination pattern. The June 1972 edition of *Modern Nursing Homes* reports a May 7, 1972, meeting between Eleanor Baird, then president of the American College of Nursing Home Administrators, and a "very important" but otherwise unnamed person in HEW. The HEW representative counseled the college to "seek relief in a legal brief to HEW Secretary Richardson." The unnamed person suggested this action "might well result in the nullification of the no-majority rule."³⁵

In June 1972, a suit was brought in the U.S. District Court for Northern Florida by the American College of Nursing Home Administrators, The American Nursing Home Association, The State of

³¹ Page 641 of hearings cited in footnote 6.

³² Pages 152-53 of report cited in footnote 26.

³³ Pages 972-73 of hearing cited in footnote 2.

³⁴ "Conditions and Problems in the Nation's Nursing Homes". Part 2, hearing by the Subcommittee on Long-Term Care, Cleveland, Ohio, February 15, 1965, p. 132.

³⁵ *Modern Nursing Home*, May 1972, p. 29; and June 1972, p. 72.

Florida, the Florida board of nursing home examiners, the National Association of Boards of Examiners of Nursing Home Administrators and the Florida Nursing Home Association.

The suit against then Secretary Elliot Richardson charged that the regulations encroached on the rights of the States to determine licensure composition of the boards, and violated congressional intent. Plaintiffs objected particularly to part of the regulations which classified individuals with "direct financial interest" in a nursing home as being a nursing home representative, not a public representative.

On March 29, 1973, Senator Kennedy wrote to newly appointed HEW Secretary Caspar Weinberger explaining that congressional intent required that the boards reflect representation of all professionals and institutions concerned with the care of the aged. He felt it was essential that the public have representation on such boards and that there be no domination of these boards by the nursing home associations, their surrogates or by any other group. The following is part of the answer to his letter:

The Federal District Court granted the Secretary's motion for summary judgment but the nursing home associations filed notice of appeal. Final resolution of this issue is far from over.³⁶

SUMMARY

The chronology of the enactment of the Kennedy amendment and its implementation in regulation form are indicative of the early inaction and vacillation of HEW. Only through the most vigilant efforts were the sponsors of the amendment and other consumer advocates successful in getting appropriate regulations announced by HEW. The suit by the American Nursing Home Association may be a significant impediment to enforcement.

Still it is to HEW's credit that the Department did make a vigorous defense of its regulations in the Florida District Court. It remains to be seen whether the defense will continue as the case winds its way through the appeals process. It also remains to be seen if HEW will insist on the enforcement of this regulation.

It is clear that nursing home professionals are not content with equal representation on the licensure boards—they insist on domination. The associations are most concerned with the part of the regulations which classify anyone with a direct financial interest in a nursing home as a representative of the nursing home industry for purposes of membership on the licensure boards.

The intimate relationship of some professions with nursing homes should be sufficient to bar them from qualifying as "public representatives" on the licensure boards. But when such individuals have a direct financial interest in nursing homes as well as a professional connection, the conflict of interest is too great to permit them to represent the public. By insisting on the contrary, the nursing home profession has placed its own concerns above that of the public.

³⁶ See Appendix 3, p. 118, for letter of April 23, from HEW Acting Secretary Frank Carlucci to Senator Edward M. Kennedy.

III. NURSING HOME INSPECTIONS: "A NATIONAL FARCE"

The early hearings of the subcommittee documented the great variation in State enforcement procedures. Time and again, witnesses said that standards were not enforced for certain specific reasons:

- Enforcement meant the closure of facilities, already in short supply, with no place to put the dispossessed patients.³⁷
- States have few weapons other than the threat of license revocation to bring a home into compliance.³⁸
- The license revocation, itself, was of very little use because of protracted administrative or legal procedures required.³⁹
- Even if the revocation procedure was implemented, judges were reluctant to close a facility when the operator claimed that the deficiencies were being corrected.⁴⁰
- Nursing home inspections generally are geared to surveying the physical plant rather than assessing the quality of care.

Much the same arguments can be made today, despite the Moss amendments of 1967 and the much publicized Nixon "reforms" launched in 1971. (These reforms are discussed in detail in part 6 of this report.)

For all the talk of uniform minimum standards, enforcement is still haphazard, fragmented and generally inadequate. The States license nursing homes and inspect them in accordance with their own licensure laws; *the same State people conduct Medicaid and Medicare inspection (using Federal criteria), certifying facilities for participation in these programs.* There has always been great disparity in the manner of this enforcement, made only worse by the continued inconsistency of directions from Washington.

The degree to which standards are not enforced led former Congressman David Pryor of Arkansas to denounce the nursing home inspection system in the United States as "a national farce."⁴¹ Both Pryor and the Nader Task Force on Nursing Home Problems concluded that 80 percent of the nursing homes in the United States did not meet minimum standards.^{41a} Many other studies indicate similar conditions.

The General Accounting Office in its May 28, 1971 audit found 50 percent of the nursing homes it surveyed in Oklahoma, New York, and Michigan to be in violation of Medicaid standards for nursing staff, physician visits, and fire safety.⁴²

³⁷ "Conditions and Problems in the Nation's Nursing Homes", Part 1, hearing by the Subcommittee on Long-Term Care, Indianapolis, Indiana, February 11, 1965, p. 22, testimony of W. Dean Mason; testimony of Thomas Karsell, p. 33; testimony of Albert Kelley, p. 38.

³⁸ "Conditions and Problems in the Nation's Nursing Homes", Part 3, hearing by the Subcommittee on Long-Term Care, Los Angeles, California, February 17, 1965, p. 211.

³⁹ Testimony of Clifton Cole, see page 233 of hearing cited in footnote 38.

⁴⁰ "Conditions and Problems in the Nation's Nursing Homes, Part 5, hearing by the Subcommittee on Long-Term Care, New York, August 2-3, 1965, p. 399, testimony of Dr. Alonzo Yerby.

⁴¹ *Congressional Record*, August 3, 1970, p. H 7620.

^{41a} *Congressional Record*, August 3, 1970, p. H7620, see also "Trends in Long-Term Care", part 11, p. 878, hearings by the Subcommittee on Long-Term Care, Washington, D.C., December 17, 1970.

⁴² *Problems in Providing Proper Care to Medicaid and Medicare Patients in Skilled Nursing Homes*, report of the U.S. General Accounting Office, May 28, 1971.

The Lieutenant Governor of Wisconsin found 51 out of the 99 nursing homes in Milwaukee had serious violations of standards, confirming a previous investigation by the Milwaukee Journal.⁴³

In its hearings in Illinois, this subcommittee heard from the Chicago Board of Health that "45 percent of the nursing homes in the city would need vast improvements to conform to standards."⁴⁴ The Cook County Board of Health testified that 50 percent of its 100 nursing homes were substandard.⁴⁵ Finally, the Illinois State Department of Health testified that 50 percent of the nursing homes in the State had serious violations.⁴⁶

More recent studies show the same pattern.

The November 1, 1973, *New York Times* described the State's inspection of 104 long-term care facilities in New York City. The State health department reported "serious operating deficiencies" in nearly two-thirds (66) of the homes surveyed.⁴⁷

Late in 1971 the Department of Health, Education, and Welfare did its own survey of Medicaid nursing homes. As a result, Secretary Richardson reported to the 1971 White House Conference on Aging that 38 States were out of compliance with Federal standards and were threatened with a loss of Federal funds.

The HEW report concluded that in the majority of States Title 19 standards were not being effectively applied or enforced.⁴⁸

At an October 1971 hearing, Under Secretary of HEW, John Veneman, was questioned by Senator Moss as to the number of nursing homes in violation of standards. Mr. Veneman answered by quoting the GAO audit above to the effect that 50 percent were substandard nationally; he noted that there would be great variation from State to State and that some States would probably have a higher rate of noncompliance.⁴⁹

The subcommittee also learned that 74 percent of the nursing homes participating in Medicare programs were certified with deficiencies. HEW statistics indicate that over 70 percent of the Medicare-certified facilities had deficiencies from 1968 through 1971.⁵⁰

Under Secretary Veneman stated that the "reliance on State enforcement machinery had led to widespread nonenforcement of Federal standards."⁵¹

Further evidence of lax enforcement is illustrated by the number of nursing homes that have been formally closed by various States. The subcommittee, in its 1971 Illinois hearings, learned that three nursing homes in 10 years were closed by legal action, despite repeated violations and the admission by the health department that over 50 percent of the facilities did not meet minimum standards.⁵²

⁴³ *Nursing Home Investigation*, report by Lt. Governor Martin J. Schreiber to Governor Patrick J. Lucey, December 8, 1971.

⁴⁴ "Trends in Long-Term Care", Part 12, hearing by the Subcommittee on Long-Term Care, Chicago, Illinois, April 2, 1971, p. 1124.

⁴⁵ Pages 1037 and 1049 of hearing cited in footnote 44.

⁴⁶ Page 1058 of hearing cited in footnote 44.

⁴⁷ *New York Times*, November 1, 1973, p. 47.

⁴⁸ Page 2039 of hearing cited in footnote 18. See also pages 1977 and 2023.

⁴⁹ Page 1980 of hearing cited in footnote 18.

⁵⁰ See Chart on page 1982 of hearing cited in footnote 18.

⁵¹ Page 1976 of hearing cited in footnote 18.

⁵² Pages 1065 and 1058 of hearings cited in footnote 44.

In January 1974, HEW released the result of its study of nursing home fire safety. With respect to the Nation's 7,318 skilled nursing facilities (SNFs) the report notes: "There were 4,307 SNF's certified with deficiencies (59 percent of total). Of these, 1,199 or 27.8 percent had incomplete or no plans of correction in the file."⁵³

In part, the report concludes that there are serious administrative problems in the survey and certification process.

In Illinois and elsewhere, State officials explained that many homes closed "voluntarily" were actually closed under State pressure. Senator Moss noted that unless there was some formal public action by the State there was no available measure of State pressure. It would be impossible to distinguish between those homes closing for economic reasons or at the insistence of a local health department.

In Florida, there were 137 closings between 1964 and 1970 and 24 revocations by the State.⁵⁴ As of 1970, there were no formal revocations but about 100 voluntary closings in Maryland.⁵⁵ New York showed 210 voluntary closings, about 20 administrative hearings but only 2 direct closings as of 1970.⁵⁶ In Minnesota, there were three formal closings from 1954 to January 1972.⁵⁷

The statistics and studies just mentioned are not meant to be all inclusive, but are listed to give some dimension of the meager enforcement efforts. The following section seeks to examine why the enforcement procedure has not worked.

A. FAILURE TO ACT ON INSPECTIONS

Following the 1970 Salmonella (food poisoning) epidemic which claimed 25 lives in a Baltimore nursing home, the State of Maryland convened a blue-ribbon panel to investigate the facts and suggest improvements in the State's system of inspection. The panel—chaired by the Rev. Joseph Sellenger, dean of Loyola University in Baltimore—concluded that the inspection and enforcement system was greatly at fault. The following is taken from the panel's October 1970 report:

It has become evident from this investigation that mechanisms for licensing and inspection of nursing homes, while superficially appearing thorough and penetrating, are inadequate in Maryland.

While on paper the rules for licensure and the criteria for inspection seem reasonable and thorough, there was abundant evidence at the hearing (on the salmonella deaths) that inspections were infrequent, that nursing homes generally knew when they were to take place, that inspection reports were sometimes in conflict with one another, and that violations almost never resulted in revocation of licensure.

⁵³ See *Washington Post*, January 11, 1974, p. A9. See also: *Enforcement of Life Safety Code Requirements in Skilled Nursing Facilities*, January 1974, Report of Office of Nursing Home Affairs, P.H.S. Dept. of HEW.

⁵⁴ "Trends in Long-Term Care", Part 2, hearing by the Subcommittee on Long-Term Care, St. Petersburg, Florida, January 9, 1970, p. 178.

⁵⁵ "Trends in Long-Term Care", Part 10, hearing by the Subcommittee on Long-Term Care, Washington, D.C., December 14, 1970, p. 814-15.

⁵⁶ Memorandum of July 22, 1971 from Dr. George Warner, Director, Bureau of Long-Term Care, to Dr. Loudon, New York Department of Health.

⁵⁷ "Care Facilities Closed Following Formal License Revocation Hearings, The Scheduling of Such Hearings or Other Legal Action Involved, With the Dates of Closure or Reclassification", document provided to Subcommittee from Division of Hospital Services, Minnesota Department of Health, December 15, 1971.

Indeed our panel felt at certain points in the testimony that inspections were a bureaucratic ritual carried out in a fashion which led to a tidy series of papers which were duly filed as evidence of accomplishment rather than signals for action.⁵⁸ (Emphasis added.)

These paragraphs confirm several conclusions the subcommittee has reached about inspections throughout the country :

1. INSPECTIONS INFREQUENT

The Lieutenant Governor's report to the Governor of Wisconsin on nursing home problems declares that nursing homes sometimes go a full year without inspection.⁵⁹ Of 12 homes surveyed in Minnesota by HEW in their test of conformity with Federal and State regulations, the last date of inspection could not be found in seven homes and the fire safety inspections in four homes were a year to 4 years old.⁶⁰ It is also true that some homes are overinspected.

2. SHORTAGES IN STAFFING

Following subcommittee hearings in Illinois and Minnesota, the number of inspectors was raised from 18 to 29 in Illinois and from 8 to 38 in Minnesota. In each case, the State's health department claimed it did not have enough people to do the job.⁶¹ In 1971, there were two people assigned to visit 136 nursing homes in Utah. These same officials are in charge of monitoring care in hospitals, residential care facilities, and other health care institutions in the State.⁶²

3. ADVANCE NOTICE OF INSPECTION IS GIVEN

Advance notice prior to inspection was documented in Minnesota, Illinois, Florida, and Maryland. The practice is apparently fairly common nationwide. There is little doubt that it undermines effective inspections.⁶³

4. INSPECTIONS AS BUREAUCRATIC RITUALS

The subcommittee received evidence that inspections in many States are cursory or pro forma. Some inspectors felt their work was complete upon filling out the forms. In addition, little followup action is taken when inspectors write negative reports and recommend closings or other discipline. Friendly relationships between the inspector and the inspected, are also reported.

⁵⁸ Report of an Investigation into the Salmonella Epidemic at Gould Convalesarium in Baltimore, Maryland, by the Board of Inquiry appointed by the Secretary of Health and Mental Hygiene of Maryland, October 27, 1970, p. 23.

⁵⁹ See source cited in footnote 43.

⁶⁰ Letter of November 8, 1971, from Elwood Stenickl (writing for Social and Rehabilitation Services Regional Commissioner Donald Simpson) to Morris Hursh, Commissioner, Minnesota Department of Public Welfare. See also *St. Paul Pioneer Press*, December 2, 1971.

⁶¹ Page 1055 of hearing cited in footnote 44. See also "Trends in Long-Term Care", Part 19A, hearing by the Subcommittee on Long-Term Care, Minneapolis-St. Paul, Minnesota, November 29, 1971, p. 2173.

⁶² Dr. Bruce Walter, Deputy Director, Utah Department of Medical Services, quoted in 1970 report prepared by the Utah Nursing Home Association.

⁶³ Page 184 in hearing cited in footnote 54. See also page 2114 of hearing (Part 19A) cited in footnote 61.

5. THE RECOMMENDATIONS OF THE INSPECTORS IGNORED

However, there are many instances in subcommittee files where inspectors have recommended disciplinary action or even closing only to be overruled by home office personnel. In two cases where the inspectors told their story to a newspaper and to this subcommittee, disciplinary action was taken not against the homes but against the inspectors for "making trouble."

Following the subcommittee's hearings in Chicago, the Cook County Department of Public Health (which cooperated with the subcommittee) was stripped of all its enforcement responsibilities. This is true even though witnesses testified at subcommittee hearings that the county had been doing the most effective job of inspection in the State.⁶⁴

In Milwaukee, two nursing home inspectors had to file an appeal in the circuit court to force the State Department of Health and Social Services to restore "satisfactory" ratings to their personnel files. The two inspectors were given unsatisfactory ratings after the *Milwaukee Sentinel* carried a series on nursing home conditions. The *Sentinel* charged that 43 out of the 99 homes in Milwaukee County had serious violations that jeopardized patient safety. As previously mentioned, the Lieutenant Governor's report confirmed the *Milwaukee Sentinel* story, showing 51 out of 99 homes in the county with serious violations.

The loss of satisfactory ratings had significant effects on the inspectors, including the denial of merit increases. All this occurred, although the two inspectors had excellent past records.⁶⁵

6. THE FRAGMENTATION OF RESPONSIBILITY FOR INSPECTION

In many, if not most States, the regulatory system boils down to this: a home is licensed and inspected by one agency, paid by a second agency, and assigned residents by a third. In most cases a fourth agency institutes a legal proceeding to close a home.

This system almost insures that homes with violations can continue to operate. Lack of interdepartmental communication often results in one agency trying to close a facility while another agency is sending it more patients.⁶⁶

7. INSPECTIONS EMPHASIZE THE PHYSICAL PLANT RATHER THAN PATIENT CARE

The most common criticism of inspections received by the subcommittee is that inspectors are more concerned with the physical plant and less with the quality of patient care.⁶⁷ In reality, there are at least four major components of the inspection system, the sanitation and the

⁶⁴ "Trends in Long-Term Care", Part 15, hearing by the Subcommittee on Long-Term Care, Chicago, Illinois, September 14, 1971, p. 1476.

⁶⁵ *Milwaukee Sentinel*, November 22, 1971, Part 1, p. 24.

⁶⁶ See p. H7620 of source cited in footnote 41.

⁶⁷ See for example testimony of Dr. Neil Solomon in "Trends in Long-Term Care", Part 9, hearing by Subcommittee on Long-Term Care, Washington, D.C., August 19, 1970, p. 740, and "Grand Jury Says Inspectors Pay Too Much Attention to Details, Too Little To Care", *Modern Nursing Home*, September 1972, p. 24.

environment, meals, fire safety, and patient care. In many States, there is a separate inspector for sanitation, meal planning, fire safety, and patient care. With this approach, there would be four separate inspections during the year if standards were being enforced with each inspector concerned with different requirements.⁶⁸

8. FRAGMENTATION BY GEOGRAPHIC AND POLITICAL RESPONSIBILITY

There is yet another possible layer to this bureaucratic tangle. There may be county and city responsibility for inspection of one or several standards. State responsibility usually overlaps the other two.

9. STATE RESPONSIBILITY FOR FEDERAL INSPECTIONS

Despite Federal reimbursement for almost 50 percent of the Nation's entire nursing home bill, HEW does almost none of the inspection. The States have had the responsibility in the past and they continue to have such responsibility under the Nixon announcements of June and August 1971 and the proffered 1974 "reforms."⁶⁹

This means that on top of the bureaucratic layers evident in previous paragraphs, these same State inspectors, in addition to their own licensure and conformity inspections, will continue to conduct Federal inspections under Medicare (skilled nursing homes) and under Medicaid (both skilled homes and intermediate care facilities).

Curiously recent HEW efforts to implement President Nixon's plan to eliminate substandard nursing homes, continued full responsibility for inspections on the shoulders of the States.⁷⁰

Witnesses before the subcommittee have argued that full reliance on State enforcement will never work under the present system. They urge a program of Federal inspection and direct Federal responsibility for enforcement, in lieu of "giving the States a blank check."⁷¹

On May 10, 1970, the office of the Maryland Secretary of Health and Mental Hygiene issued a press release in which Dr. Neil Solomon forecast a Medicaid surplus of \$565,000 which he attributed to "cost-cutting" and "up-to-date techniques."⁷²

An audit later requested by Senator Moss (after the outbreak of a Salmonella epidemic in Baltimore) in December revealed that, contrary to law, only two Medicaid audits (of two Medicaid homes) had been performed by the State of Maryland from 1967 through 1969, despite the fact that Maryland uses a reasonable cost reimbursement formula for Medicaid (which means it reimburses administrators for what they spend plus a 10 percent profit up to a maximum amount of \$18 a day for skilled nursing care; hence the importance of varifying costs).⁷³

⁶⁸ See testimony of Dr. Matthew Tayback in hearing cited in footnote 55.

⁶⁹ Page 1978 of hearing cited in footnote 18.

⁷⁰ See Part 6 of this Report. HEW is required by law (title XVIII of the Social Security Act) to contract with State agencies for the performance of nursing home surveys. Under title XIX of the Act, States have the responsibility for administering their Medicaid programs of which nursing home care is a component.

⁷¹ Page 898 of hearing cited in footnote 2.

⁷² *Washington Post*, May 10, 1970.

⁷³ Page 807 of hearing cited in footnote 55. An audit by the HEW audit agency for fiscal year 1967 through fiscal year 1969 revealed that the State of Maryland overpaid Maryland nursing homes by some \$4.8 million. See *Modern Nursing Home*, September 1970, p. 24c.

10. THE "IMPOSSIBILITY" OF CLOSING A HOME AND THE LACK OF DISCIPLINARY OPTIONS

Most States cannot act against a substandard home except through lengthy (and costly) formal procedures for license revocation or for closing. Why are there no other disciplinary options? Generally, the State legislatures which write the State statutes have not provided for other enforcement tools. Several actions by the State departments of health have been challenged in court. Unsuccessful suits have even been brought challenging the right of the State to remove patients once they have been placed in a particular home or challenging the States' right's to cut off funds. Every State enforcing statute is different. Some provide for injunctive relief which can only be brought in extraordinary cases—when the State can show immediate or irreparable injury. Attempts have been made in several States to increase the courses of action available.⁷⁴

Why are so few homes closed? For one reason, State personnel are not prepared to deal with the relocation of patients. "Where will we put them?" was the common cry by State officials.⁷⁵ The refusal of many homes to accept welfare patients compounds the problem. In short, many officials rationalize that a poor nursing home is better than putting people in the street. Kenneth C. Eymann, editor of *Professional Nursing Homes* in the September 1964 issue, disagrees:

This is about the same as saying if you are starving to death, even poison is better nourishment than nothing at all. *In these enlightened times it is appalling that such a philosophy can exist.*

The Illinois Department of Health, for one, conceded that beds could be found if it decided to close down 5 percent of its nursing home beds.

The report to the Governor of Michigan on nursing home problems states the problem in another way:

This enforced wholesale movement of patients can cause great inconvenience and actual physical harm to these patients. Thus, revocation of license adversely affects the very people the Government seeks to secure. For this reason alone, revocation of license must be used only in severe situations when correction of facility inadequacies is demonstrably not forthcoming and the potential harm to the patients if allowed to stay in the facility persisting in those uncorrected deficiencies.⁷⁶

This comment provides good perspective. States need enforcement tools short of formal legal procedures which are protracted and expensive. The closure of a home should be an item of last

⁷⁴ Minnesota Statutes 1971, Chapter 144.653, provides for issuance of "correction orders" after inspection where regulations are violated. If, upon reinspection, violations are still present, a fine of up to \$250 for each deficiency can be levied. See also Minnesota Statutes 1971, Chapter 144.651 for "Patients of health care facilities: bill of rights". In late 1971, Wisconsin revised their regulations for nursing home enforcement procedures. Violations were divided into three categories with differing corrective actions called for, including immediate recommendations for court injunctions and immediate recommendation for denial of payments—see Appendix 4, p. 132 for full details. In 1973, California added Chapter 2.4 (Assembly Bill No. 1600) to Division 2 of the Health and Safety Code. Included in these provisions was a citation system dividing violations into Class "A" with a minimum civil fine of \$1000 per deficiency and Class "B" with possible civil fines of from \$50 to \$250 per violation. For more detail, see Appendix 4, p. 120.

⁷⁵ Page 162 of hearing cited in footnote 54, and page 815 of hearing cited in footnote 55.

⁷⁶ "Governor's Nursing Home Project" (Michigan), October, 1971, p. 183.

resort, after all reasonable efforts have been made to help bring about compliance. But in the face of recurrent violations, substandard facilities must be closed.

Allowing the operation of substandard facilities by some caretakers results in others not taking the regulations seriously. Equally important, substandard homes have a competitive advantage over homes providing quality care.

Other enforcement tools might be fines and penalties, power to remove welfare patients, power to refuse to permit new welfare patients referred to the facility, protective custodianship, or the appointment of a custodian by a court to bring a home into compliance.

11. THE LACK OF ACCREDITATION AND "SELF REGULATION"

Accreditation refers to the practice of certifying compliance with certain standards. At the present time there is one agency which accredits nursing homes and hospitals: the Joint Commission on the Accreditation of Hospitals. Under the law the commission's accreditation is sufficient to certify a hospital for participation in Medicare. The joint commission's nursing home standards are currently much higher than the existing Medicare-Medicaid standards (for skilled nursing facilities), and few nursing homes have sought its approval, primarily because the commission's accreditation does not guarantee participation in Medicare or Medicaid's nursing home program.

Not surprisingly, there is a controversy within the industry at the present time as to the value of accreditation. However, if the commission's certification, or that of some other accreditation group, were more widely accepted, the task of licensing and enforcement officials would be significantly reduced.

Unfortunately, some operators have exhibited their Medicare certification by the commission to the unsuspecting elderly as an example of accreditation by an authority higher than the State. The use of the term "Medicare-approved" in advertisements is common and has the effect of misleading the public.⁷⁷

Self-regulation or "peer review" is often mentioned in subcommittee hearings as a force for reform in the nursing home industry, and yet, the industry has fallen short of making any serious effort toward self-policing. Almost every other major professional organization has laws or canons of ethics and the power to discipline their members for violations. The results can be severe: Attorneys and physicians can be barred from practice.

Most associations understand that the absence of regulation from within, invites regulation from outside. The American Nursing Home Association and others respond by saying their associations are voluntary and their powers are limited. They claim only State health departments have the power to close a home.⁷⁸

A great many State officials would welcome genuine self-regulation by the industry. Most would accept findings which were the result of association administrative hearings. They would be pleased to share responsibility for disciplining nursing home owners and administrators.

⁷⁷ Page 1450 in hearing cited in footnote 64.

⁷⁸ Page 793 in hearing cited in footnote 67, and page 1519 of hearing cited in footnote 64.

There are some advocates who suggest that such self-regulation will never be effective. They assert that nursing home associations have difficulty obtaining and holding membership. Officers must constantly justify the virtues of the association to the membership. Thus it is argued: if the associations were to indulge in "self-policing" in any vigorous sense, membership might quickly decline.

There are encouraging signs in Minnesota where the Minnesota Health Facilities Association experimented with "peer-review." The program has been called a success and recommended to the membership of the entire American Nursing Home Association.

In the final analysis, self-disciplining procedures by a nursing home association must inspire public confidence. If procedures are pro forma they will only intensify regulation from the outside and preserve myths and suspicions about the nursing home profession.

12. POLITICAL INFLUENCE ASSERTED

During the subcommittee's Illinois hearing a witness with access to State health department files testified:

The 69-bed Kosary Nursing Home in Finley Park has had consistently bad reports for the past 4 years. Most inspectors have recommended the place be closed but it has remained open.

It now appears political pressure was applied in 1968. A memo found in Illinois files from Inspector F. H. Williams to the coordinator of the licensure and certification section mentions the political implications involved.

These implications apparently stem from queries by State Representative Walter Babe McAvooy to Dr. Yoder, head of the Department of Public Health, in regard to Kosary Nursing Home. A license was issued for that year.

In the following 2 years, 1969 and 1970, inspectors again found conditions bad and recommended no relicensure. The home remains open today.^{78a}

IV. TWO CASE HISTORIES IN ENFORCEMENT BREAKDOWN

To explore in more depth the problems of State enforcement the subcommittee choose two States for an intensive look: Wisconsin and Illinois.

Wisconsin

A 1971 report by Wisconsin Lieutenant Governor Martin J. Schreiber resulted in the following conclusions:⁷⁹

^{78a} Bill Recktenwald, Better Government Assn. of Chicago, page 1041 of hearings cited in footnote 44. See also the *Milwaukee Journal* of January 13-14, 1974 reports: "A White House aid and other Republican party allies of a large Milwaukee nursing home chain (National Health Enterprises, Inc.) have tried for 18 months to scuttle a Wisconsin program headed by a Democrat (Lt. Governor Martin J. Schreiber) that investigates nursing home care. The *Journal* added that Robert A. Palifito, President of National Health Enterprises, Inc. "contributed \$30,111 to the Nixon re-election campaign because, he said, 'I was told, that they were really hard up for money.'" Palifito denied he had asked for or received favors in return for his contribution. A Republican spokesman charged that Schreiber intended to use the program for political purposes.

⁷⁹ The conclusions of this report were summarized in the *Milwaukee Sentinel*, December 9, 1971, p. A1-2, and are set forth in the text.

- The filing system used by the health department was in shambles. Sanitarians' and engineers' inspection reports were in one file cabinet and nurses-inspectors' reports in another with no attempt to coordinate between the two.
- There is no single point of responsibility for the licensing regulation program and there is confusion and a lack of coordination between the various department divisions involved.
- There is an actual loss by the State department of data and information concerning individual homes.
- There is an unnecessary and confusing duplication of codes and regulation and inspection report forms, making it difficult for inspectors to identify and report all violations.
- Some homes are approved and licensed although only a partial inspection has been made.
- Procedures are used that allow inspectors to use personal discretion and not report every violation they find.
- In some inspection reports incorrect sections of the nursing home code were cited, making it difficult to decide on possible enforcement action.
- There is a lack of consistency in notifying nursing homes of violations that had been found.
- There are no guidelines used by the department to determine whether enforcement action should be taken.
- Homes have continued to operate and receive public funds although it was determined they were not providing the services for which they were being paid.
- The department is not enforcing regulations on the basis of inspection reports telling of violations.
- Whether homes are or are not inspected, they "continue to be licensed by the State on an annual basis, thereby receiving by implication the State's approval, even though the State is without real knowledge of their operations."
- Inspection reports were ignored or not analyzed effectively by officials superior to inspectors so that no action came of inspection reports.
- A number of nursing homes in the Milwaukee area have been paid Medicaid or other public funds that they were not entitled to because of violations and noncompliance with regulations.
- It was quite common to find the State giving grace periods of 40 to 44 weeks for violators to come into compliance with standards. There was no limit on the length of time that a home could be given to correct violations.
- Nursing homes are not all being inspected annually as required by law. In the last 5 years, 34 Milwaukee nursing homes have gone from 13 to 26 months without being inspected.
- There is nothing to indicate that the department of health was even aware of the constantly recurring identical violations in some homes.
- The problem is not in one area; it is the entire system—the inspection, transmittal of information, and the enforcement.

The Lieutenant Governor suggested a series of reforms including the classification of nursing home violations into three categories. In the first category, covering the most serious violations, public funds for patient care must be withheld immediately; injunctive or legal proceedings are to take place immediately; no grace period is allowed. In the second category of violations, 30 days is allowed for correction. And in the last, 60 days is allowed.

In addition, the report recommended that nursing home operators carry out comprehensive and continuing self-evaluation as adjunct to licensure procedures. The Lieutenant Governor proposed legislation making the incorrect or falsified self-evaluation surveys a criminal offense. Also proposed were simplified inspection reports, unified inspection procedures and an automated computerized filing system. (See appendix 4, p. 122.)

Illinois

In February and March of 1971, the investigators of the Better Government Association (BGA) of Chicago collaborated with the *Chicago Tribune* task force in an exposé of nursing home problems. Their investigation focused on the nursing homes in the Chicago area. The investigators testified as follows:

Working as mop boys, nurse's aides, and janitors, we saw garbage scraped from one tray to another to make meager food supplies go around. We were told to administer drugs and medication within hours after we obtained employment, using phony job references that were never checked.

We saw elderly patients struck and kicked because they dared to complain or cried out for mercy.

In one case, an investigator seeking work as a janitor was hired as a nursing home administrator by an absentee owner who was trying to get the health department off his back.⁸⁰

To prepare for the subcommittee hearings in Chicago, the BGA worked with subcommittee staff to develop data on nursing homes throughout Illinois. This investigation included an analysis of State, county and city health department records. The investigators reported that at least half the homes repeatedly had serious violations in inspection reports. They found that inspectors would recommend action against nursing homes for serious violations and nothing would be done.

In Illinois, cities or metropolitan areas with more than 1 million people may do their own inspecting of health care facilities. The State does the licensing and is responsible for the closing of substandard facilities.

The Cook County Department of Health, with responsibility for over 100 nursing homes, often reported substandard conditions. Their recommendations were not heeded, nor did the State make its own inspections. The city of Chicago has even more autonomy. In Chicago, there have been repeated violations in the same homes and administrative hearings with minimal fines. As a result, "censured" homes have continued to operate as before.

⁸⁰ Page 1012 of hearing cited in footnote 44.

Testimony by William R. Rectenwald, chief investigator, Better Government Association :

An inspection of State public health records by Bill Hood, Jim McCaffrey, and myself, shows years of callous neglect by health officials in seeking any kind of nursing home reform. Let me cite a few examples taken from the files of the State Department of Public Health :

- Largent's Nursing Home is located in south suburban Midlothian. This home, operated by a woman who is herself confined to a wheelchair, first came under criticism from health inspectors in 1950. State files show that Largent's was repeatedly found in violation of nursing home codes for the next 10 years.

Nevertheless, its license was never revoked, although inspectors had recommended such action numerous times.

In March 1967, this home was found in violation of 14 codes and was not recommended for relicensure.

It was then given 10 followup inspections, over a period of 3 years, in an effort to get a passing grade from health inspectors. Its license was finally revoked, and it lost its status as a nursing home. One month later, the license was reinstated, with no record that the owner had corrected a *single violation*.⁸¹

* * * * *

- The 69-bed Kosary Nursing Home in Finley Park has had consistently bad reports for the past 4 years. Most inspectors have recommended the place be closed but it has remained open.⁸²

These reports were confirmed by Dr. Collette Rasmussen of the Cook County Department of Health, and Myrtle Merritt, chief sanitarian for the county. With respect to the Kosary Nursing Home, Dr. Rasmussen stated :

- In the Kosary Home, the principal problem has been one in the field of sanitary engineering.

This is a home that has a *very serious sewage problem* which would potentially affect the health of the residents there very seriously and the correction of such a problem does take a certain amount of time.

This deficiency has been going on many, many years in this home and the home is continuously relicensed against the strong recommendation of our sanitarians . . .⁸³

Mr. Recktenwald provided an example from State files which was in turn confirmed by Dr. Rasmussen.

- In each of the last 5 years, inspectors have recommended the Barr Oak Nursing and Convalescent Center be closed.

In 1966, the food service was so bad the chief nutritionist of Cook County Department of Public Health asked no

⁸¹ Page 1013 of hearing cited in footnote 44.

⁸² Page 1014 of hearing cited in footnote 44.

⁸³ Page 1041 of hearing cited in footnote 44.

license be given. A 1967 survey team found a complete and utter disregard for good patient care in this facility. The report listed 29 violations and the entire team vetoes relicensing. In 1968, the fire marshal found serious violations and ordered immediate corrections.

The 1969 visit to the 38-bed facility, although announced beforehand, found diet orders for patients completely lacking, dirty food storage areas and the patients' medical record book was missing.

The three-man team investigating in 1970 found :

1. No one in charge of the patients when they arrived.
2. The condition of the patients was described as "very unclean, feet badly in need of washing and the skin on feet was dirty and hard."
3. Patient's rooms were dirty, disorderly, and floors throughout the home were unclean.
4. There was a "strong urine odor throughout the home."
5. Medicine distribution very bad and records of who got what could not be found.

In sum, the place was not recommended for relicensure. The Cook County Department of Public Health termed it as one of its worst homes. It is still in business today.⁸⁴

Investigator William R. Hood provided examples from "down-state" Illinois:

- The Daybreak Nursing Home in Elgin has never met minimum State standards in some areas since it first opened in 1959. The home operated for several years without any license at all. . . . Memos in State files indicate enforcement officials bent backward time after time to allow the place to remain open when inspectors repeatedly urged it to be closed. A quote by health department Counsel Robert Gleason typifies State policy in this case. He contended it is always "better to give a chance to shape up" than to close a home. We think 4 years is too long to wait for a place to shape up.

An attempt by inspectors to probe an alleged suicide at Daybreak Home was stifled by health department officials with the words, "What use is it to us to learn more on this situation?" That very same memo noted that bruising on patients had been found on previous visits, indicating patients were roughed up there.

Later in 1967, the former head nurse of this home made a written complaint to the health department stating she had quit and that there was "no hope for improvement" in this place.

Inspectors in the past 2 years noted incredible hostility and lack of cooperation by the owners.

Daybreak remains open today.⁸⁵

The Cook County Department of Health verified the accuracy of the BGA conclusions and the city of Chicago admitted that 45 percent of its facilities had serious violations. Moreover, the State conceded

⁸⁴ Page 1044 of hearing cited in footnote 44.

⁸⁵ Page 1019 of hearing cited in footnote 44.

that 50 percent of the nursing homes in Illinois were substandard and had serious violations which jeopardized patients lives and safety. The State was hard pressed to deny the contents of its own inspection reports. It admitted closing only three nursing homes in the previous 10 years. These admissions brought the following exchange between Senator Charles Percy and State health director Dr. Franklin Yoder :

Senator Percy. But I ask the question again : Why do you think there are so many violations ?

What is wrong with the system, as we have now established it, that we can have that many violations in 50 percent of the 600 nursing homes in the field today ?

Dr. Yoder. I suppose for one reason we haven't been there often enough, very simply and we will get there more frequently on an unannounced basis now.

Senator Percy. Why, in the past, have "we been there not so frequently" ?

Dr. Yoder. We have used the staff we had. We have reorganized our staff in the last 6 months.

We will focus our entire professional staff and get a temporary loan of people to help make this work.⁸⁶

Dr. Yoder pointed out he had only 18 inspectors. Senator Percy asked what they would say if he put them on the stand to explain why there were so many violations. That question brought this response from Dr. Yoder :

They receive a list of violations. We went back as soon as these cases were found. Why the institutions didn't make full correction, I really can't explain.⁸⁷

Later, Dr Yoder told Senator Stevenson of the difficulties inherent in formal revocation procedures with the attendant notice requirements, delay, and expense. Dr. Bruce Flashner, deputy director of the Illinois Department of Health, amplified the concern of the Department about the operation of the court system to nullify Department administrative actions :

. . . Every time a proceeding went to court, it got either thrown out, or somebody found some reason for delaying any action so that in a sense, the department, which should not be absolved from blame, got more blame than it deserved.

You cannot do anything unless the courts are going to back you.⁸⁸

Finally, Dr. Flashner added this comment :

What we are being asked to do is to regulate a program, which from both the professional point of view, and governmental point of view, does not make sense.

I do not mean this as an excuse, and I do not think many of us working in this want to excuse themselves.

We will try, and as hard as we can to regulate it, but most of us are aware of the fact that it probably cannot be done and not to raise the expectation of the public. If we had 2,000

⁸⁶ Page 1058 of hearing cited in footnote 44.

⁸⁷ Page 1063 of hearing cited in footnote 44.

⁸⁸ Page 1459 of hearing cited in footnote 64.

more nursing home inspectors, or with x amount of dollars, it will really not solve the problem unless we are willing to change the whole program.⁸⁹

Soon after the subcommittee hearings in Illinois, the State implemented a new computer inspection reporting system which is being studied by HEW for its possible applicability in other States. On a less constructive note, as reported above, the Cook County Health Department lost all inspection privileges and responsibility even though it was described at the hearing as the most active enforcement entity in the State.

Completing this look at the enforcement system's operation in Illinois is this account from Illinois State files presented by investigator Recktenwald.

Palos Hills Convalescent Center in Palos Hills and Whitehaven Acres in Glenview are both owned in substantial part by one Frank Williams, former president of the Illinois Nursing Home Association. Both these homes have been severely criticized by inspectors. Recommendations have been made that both lose their licenses. These repeated pleas have been ignored.

The attitude of the owner, Mr. Frank Williams, has been part of the problem. A State inspector wrote the following paragraph to his superiors in Springfield in April 1969, and I quote:

"I have been reliably informed, and his actions further bear out the fact, that Mr. Williams feels that he, in his position, is above the law, and feels that his homes should be overlooked. . . . The Whitehaven Acres Nursing Home is one of the most substandard homes that I have seen."

Inspection reports indicate the Palos Hills Convalescent Center is no better.⁹⁰

This example has importance for another reason beyond the reference to a nursing home official. The reference to the Palos Hills Nursing Home and to the practice on the part of the State of Illinois in ignoring the report of inspectors is contained in a Medicaid audit of the State of Illinois conducted by the HEW audit agency covering the period January 1, 1966 to June 30, 1969. The report was issued January 4, 1971.

The HEW audit language quoted below makes it clear that the Federal Government knew that Illinois was relicensing facilities even in the face of serious violations. In short, contrary to law, Federal funds were going to facilities which did not meet State standards.

The IDPH [Illinois Department of Public Health], was issuing State nursing home licenses to institutions that did not meet minimum qualifying standards. Licensure was granted to the nursing homes that were approved for local license by county health departments, without IDPH review of the results of the inspection and without regard to the inspectors recommendations to the contrary. For example, on July 7,

⁸⁹ Page 1462 of hearing cited in footnote 64.

⁹⁰ Page 1013 of hearing cited in footnote 44.

1969, an institutional nutrition consultant from the Cook County Department of Public Health surveyed the Palos Hills Convalescent Center, Palos Hills, Ill. The report recommended that the nursing home not be considered for a relicensing because (i) diet orders were inadequate, (ii) a diet manual was not available, (iii) sanitation practices were inadequate, and (iv) employee health records were not current. Despite the recommendation to the contrary, the nursing home license was renewed without any assurance that the deficiencies would be corrected. In discussion with the IDPH representatives we were advised that the inspector's recommendation was overruled by her superior for undocumented reasons, known only to him, and that her superior is no longer employed by the IDPH.

HEW's only action was to recommend to the State that it use greater care in evaluating the investigations of local health departments.

PART 6

THE NIXON NURSING HOME "REFORMS": HOW EFFECTIVE?

Presidential interest in any problem generally leads to the formulation of policy. In June 1971, nursing homes became the central topic of a major Presidential address on problems of the aged. Because of this interest from the highest level, many senior citizen and consumer advocates assumed that substantial progress would be achieved in solving many serious problems in the areas of long-term care. The assumptions, however, have not been fulfilled.

In his June 25, 1971 speech President Nixon stated: ¹

If there is any single institution in this country that symbolizes the tragic isolation and the shameful neglect of older Americans . . . it is the substandard nursing home.

The President described such facilities as unsanitary, ill-equipped, overcrowded and understaffed—"little more than warehouses for the unwanted." He asked that the White House Conference on Aging give particular attention to the nursing home problem. Finally, he stated that Medicare and Medicaid funds should not subsidize substandard facilities.

A few weeks later at the Greenbriar Nursing Home in Nashua, N.H., he again noted that many nursing homes in the United States fall short of standards and announced his eight-point plan to transform nursing homes into "shining symbols of comfort and concern."

His eight-point plan, which he announced on August 6, included:

- (1) Federal training for 2,000 State nursing home inspectors.
- (2) The establishment of 150 new positions in HEW to aid enforcement.
- (3) Federal reimbursement for 100 percent of the cost of State inspections of nursing homes.
- (4) Centralizing enforcement activities in one HEW office.
- (5) Short-term training programs for nursing personnel.
- (6) Authorization for HEW to help establish State investigative units to respond to consumer complaints.
- (7) A comprehensive study of long-term care by HEW to develop recommendations for action.
- (8) A promise to cut off Federal Medicare and Medicaid funds to facilities which did not meet standards.²

This eight-point plan must, however, be viewed in the context of other Administration policies affecting nursing home care. The most

¹ Speech of President Richard Nixon before the American Association of Retired Persons—National Retired Teachers Association in Chicago, Illinois, June 25, 1971.

² For more detail of the Nixon Plan, see White House Fact Sheet reprinted in "Trends in Long-Term Care", hearings by the Subcommittee on Long-Term Care, Part 18, Washington, D.C., October 28, 1971, pp. 2015-21.

notable in this regard was the administration's determination to reduce Federal funding for skilled nursing care under Medicaid.³

To obtain more information about the administration's eight-point plan, Senator Moss conducted a hearing on October 28, 1971. In his letter to Secretary Richardson, he stated:

I have expressed some misgivings about the direction of these new policies which I characterize as stopgap measures, believing as I do that reform will be a complex and expensive proposition.

At the same hearing, the Senator expressed pleasure that HEW had, at long last, made a commitment to enforce his legislation which had been approved in 1967. Nevertheless, he characterized the "reforms" as primarily policing in nature, and he was critical of the administration's failure to deal with root causes. He also criticized the administration for adopting an inconsistent position: Cutting Medicaid funds for nursing homes, yet trying to upgrade such facilities solely for political purposes.⁴

Dr. James C. Houghton, co-chairman of the White House Conference on Aging's Health Section, indicated that some delegates to the conference regarded the announcement "as a political ploy to divert attention from other major issues" being discussed. He explained that many thought the announcement would snare the headlines and relegate to the shadows the other major health issues of the elderly.⁵

The American Public Health Association, in its annual meeting in Minneapolis in October 1971 adopted a resolution stating that it was encouraged by the President's directives to upgrade nursing homes. The resolution reads in part:

Most of the actions requested by the President are short-range. One however, calls for the Department of HEW to make a longer range comprehensive review of the use of long-term care facilities as well as the standards and practices of nursing homes. The association urges that the Department use this opportunity to formulate general public policy priorities on long-term care of the aged . . .⁶

The American Nursing Home Association commended the President for his determination to close substandard homes.⁷ Member chapters were more critical. The Florida Nursing Home Association stressed the importance of greater financial support for nursing homes, a factor missing from the Nixon plan.⁸

³ See pages 38-40, Part 3 of this report. See also p. 83, "Trends in Long-Term Care," pt. 1, hearing of the Subcommittee on Long-Term Care, Washington, D.C., July 30, 1969.

⁴ "Trends in Long-Term Care," hearings by the Subcommittee on Long-Term Care, Part 18, Washington, D.C., October 28, 1971, p. 1973-74. For more of Senator Moss' view, see Congressional Record, July 30, 1971, p. S 12657.

⁵ *Christian Science Monitor*, "U.S. Warns Nursing Homes" (Nov. 30, 1971). For more discussion of the political implications of the Nixon plan, see transcript of NBC NEWS Washington Editor Bill Monroe's comments, Memorandum from HEW Secretary Elliot Richardson to President Nixon, and article of J. F. terHorst, "How a Nursing Homes Policy Sprang Forth," in *Washington Evening Star*, December 26, 1971. All three items are reprinted in Appendix, pp. 146-155.

⁶ Letter of October 26, 1971, from Dr. Harold R. Hunter to Senator Frank E. Moss.

⁷ Letter of June 28, 1971, from C. Robert Harberson, then Executive Vice President, American Nursing Home Association, to President Nixon with accompanying press release.

⁸ Letter of July 14, 1971, from Walter M. Johnson, Jr., President, Florida Nursing Home Association, to President Nixon.

Albert L. Hickman, president of the Washington State Health Facilities Association, charged the President with hypocrisy. He said the administration was proposing to reduce the budget for skilled nursing homes and aged mental health care by over \$500 million while the President was criticizing nursing homes for being overcrowded and understaffed. Such cuts, in his view, would shift the burden for long-term care to the States who were already in desperate financial straits.⁹

To nursing home administrators, these cuts meant less money available for long-term care. At the same time there was great pressure for reform and enforcement as a consequence of the President's "reforms."

One administrator wrote to Senator Moss: "You cannot impose costly high standards with one hand and reduce costs with the other. This is forcing nursing home administrators to become liars and cheats."¹⁰

Another operator said: "We have simply redefined patient needs to fit the standards that would justify placing them in less adequate facilities. Lower levels of need dictate lower levels of care, financing, manpower, quality concerns, and accountability."¹¹

Finally, another provider noted that the entire cost of the Nixon nursing home "reforms" was \$9.5 million. He stated: "It was a good ploy, spending \$9.5 million to cut nursing home revenues by half a billion and get a lot of good political mileage besides."¹²

I. THE NIXON NURSING HOME "REFORM": POINT-BY-POINT ANALYSIS

What follows is an analysis of each of the eight points in the Nixon "reforms." The President's exact language from the August 6, 1971 speech¹³ is followed by the statement of progress on each point, including the White House facts sheet of July 17, 1972,¹⁴ and updated by the April 16, 1973 progress report by the Office of Nursing Home Affairs to the Committee on Aging, and commentary on both.¹⁵ Finally, there is an overall analysis of the Nixon "reforms" which reflect responses to the subcommittee's questionnaire to 150 acknowledged nursing home experts.

⁹ *Nursing Homes*, August 1971, p. 8. Mr. Hickman's remarks made reference to Administration proposals incorporated in H.R. 17550, which was not enacted in the 91st Congress and which was reintroduced as H.R. 1 in the 92nd Congress. It was enacted into law (P.L. 92-603) on October of 1972.

President Nixon announced these proposed cuts in his February 26, 1970 message to the Congress. As reported in the *Washington Post* and *New York Times* on February 27, 1970, the President proposed to eliminate 57 agencies which had outlived their usefulness. In this long list of government programs to be cut was the suggestion for a \$235 million reduction for Medicaid payment to nursing homes.

The Nixon proposal became section 225 of H.R. 17550 and later Section 207 in H.R. 1 (P.L. 92-603). According to HEW estimates, this proposal saves the Federal government \$162 million. Section 208 which imposes premium, copayment and deductible requirements of Medicaid recipients also saves \$89 million. These two proposals accomplished the 1970 goal. (For more detailed description of these provisions and other measures HEW estimated would save \$790 million in Medicaid costs in H.R. 1, see Part 3, pp. 38-54. See also Appendix 2, p. 117.

¹⁰ Responses to Moss Questionnaire (Mar. 26, 1973), detailed in this report, pp. 105-106.

¹¹ See source cited in footnote 10.

¹² See source cited in footnote 10.

¹³ Weekly Compilation of Presidential Documents, August 16, 1971, Vol. 7, Number 33, pp. 1148-50.

¹⁴ Press release, July 19, 1972, White House Fact Sheet on Nursing Home Program.

¹⁵ See *Developments in Aging: 1972 and January-March 1973*, Report of the Special Committee on Aging, May 10, 1973, pp. 219-25.

ACTION ANNOUNCED BY THE PRESIDENT, PROGRESS CLAIMED, AND COMMENTARY

1. FEDERAL TRAINING FOR 2,000 STATE NURSING HOME INSPECTORS

What the President said:

"I am ordering that the Federal program for training State nursing home inspectors be expanded so that an additional 2,000 inspectors will be trained over the next 18-month period. The major responsibility for surveillance and regulation in the field is now carried out by State governments and this action will enable them to increase their effectiveness most significantly.

"One of three places in the country where such training is now provided is the W. K. Kellogg Center for Continuing Education at the University of New Hampshire in Durham. This program trains people not only to inspect nursing homes but also to provide technical assistance and consultative services which can help improve these facilities. This New Hampshire program is funded through a grant from the Department of Health, Education, and Welfare, and it is our intention to establish similar programs in other areas of the country. This expansion effort will cost approximately \$3 million."

Action:

HEW contracted with two additional universities—the University of Maryland (\$204,546) and the University of Colorado (\$185,146)—for the training of State nursing home inspectors. About 1,100 health surveyors had been trained by July 1972. The remaining 900 were scheduled to complete their 4 weeks training by July 1973. The actual cost was \$1.2 million.

In addition to the training planned by HEW headquarters, there is now a coordinator in each region responsible for the Health Facility Surveyor Improvement Program, and funds allocated so that special needs identified in States in that area can be met.

Comment:

Undoubtedly, the training programs will be helpful. If all that is accomplished is the education of State inspectors in the essentials of Federal requirements which they can then apply in certifying nursing homes to participate in Medicare and Medicaid, the program will be constructive.

Critics, however, suggest that inspectors in the States should not be given total blame for the existence of substandard facilities. Their point has some value, particularly in Illinois where inspectors time and again pleaded with the State to take action against chronic violators but to no avail.¹⁶

It is also suggested that a training program a month long cannot be of much value. Moreover critics suggest that it would be less costly to the Government to transport instructors to the States rather than to bring students to the three universities providing the training.

Finally, some argue that the money could be better spent for the direct training of personnel rather than for facilitating greater policing.

¹⁶ See Part 5, p. 80.

2. 100 PERCENT FEDERAL FINANCING OF STATE INSPECTIONS

What the President said:

"I am asking the Congress to authorize the Federal Government to assume 100 percent of the necessary costs of these State inspection teams under the Medicaid program. This will bring the Medicaid law, which now requires the States to pay from 25 to 50 percent of these costs, into line with the Medicare law, under which the Federal Government pays the entire costs for such inspections. Again, State enforcement efforts would be significantly enhanced by this procedure."

Action:

This proposal was enacted as section 249(b) of H.R. 1, P.L. 92.603.

Comment:

In H.R. 1, the Federal government agreed to assume 100 percent of the cost of State Medicare and Medicaid inspections through June 1, 1974. At the administration's request, the provision was recently extended by action of Senator Wallace Bennett, ranking Republican member of the Senate Finance Committee.¹⁷

Full Federal 100 percent financing should enable the States to add muscle to their inspection and enforcement teams. Unfortunately, the funding carries no preconditions or standards. There have been many complaints about untrained and inexperienced people being hired by the States for enforcement purposes.¹⁸

These charges, however, only serve to distract from the major criticism. There continues to be heavy reliance upon State enforcement machinery. The Federal Government essentially offers a blank check. In addition to State licensure functions the States have responsibility to insure that (1) facilities conform to Federal and State standards, and (2) quality care is provided. This is taking too much for granted. A stronger Federal role is necessary.

3. CONSOLIDATION OF RESPONSIBILITY FOR ENFORCEMENT

What the President said:

"I am ordering that all activities relating to the enforcement of such standards—activities which are now scattered in various branches of the Department of Health, Education, and Welfare—be consolidated within the Department into a single, highly efficient program. This means that all enforcement responsibility will be focused at a single point—that a single official will be accountable for success or failure in this endeavor. I am confident that this step alone will enormously improve the efficiency and the consistency of our enforcement activities."

¹⁷ S. 3622 introduced June 11, 1974, Congressional Record, p. S 10242. Later added as an amendment to P.L. 93-368.

¹⁸ *Washington Report on Long-Term Care*, May 5, 1974, reveals report of Faye Abdellah, Director, Department of Health, Education, and Welfare, Office of Nursing Home Affairs, indicating bartenders performing inspections in Pennsylvania.

Action:

The Office of Nursing Home Affairs was established at HEW and Dr. Marie Callender was appointed as Special Assistant for Nursing Home Affairs. The new office was charged with coordinating enforcement programs of the Social and Rehabilitation Service, Medical Services Administration, Social Security Administration, and Health Services and Mental Health Administration. (In late 1973 Mrs. Callender accepted new responsibilities in AoA and was replaced by Dr. Faye Abdellah.)

Comment:

The creation of the Office of Nursing Home Affairs and the selection of Dr. Callender and later Dr. Abdellah was widely praised. In this respect, the move was positive and helpful.

However, the duties and powers of the Office of Nursing Home Affairs (ONHA) have not been well defined. There continues to be confusion. Under Secretary John Veneman in October 1971 told the Moss subcommittee that Dr. Merlin K. Duval, and specifically, his office of Assistant Secretary for Health and Scientific Affairs, was to be responsible for the coordination of nursing home enforcement activity. But it was never clear who had the responsibility.

It is evident that given the lack of clarification of this role the director of ONHA is not in a position to coordinate activities between the Social and Rehabilitation Service and the Social Security Administration, which administer Medicaid and Medicare respectively.

The Office of Nursing Home Affairs has no direct authority over any other HEW unit. The director serves at the pleasure of the Secretary and Assistant Secretary. With the departure of Secretary Elliot Richardson and Under Secretary John Veneman, Dr. Callender's ability to influence policy appeared to wane. (See page 107 of this part for details of HEW reorganization giving the Office of Nursing Home Affairs more enforcement authority.)

In short, the reality is far from the rhetoric of August 1971, wherein the President promised a nursing home "czar." The term "czar" was used by the White House to symbolize centralization of authority in one person. This hasn't happened. Responsibility for nursing homes within HEW is still diffused.

4. ENLARGING THE FEDERAL ENFORCEMENT CAPABILITY

What the President said:

"I am requesting funds to enlarge our Federal enforcement program by creating 150 additional positions. This will enable the Federal Government more effectively to meet its own responsibilities under the law and to support State enforcement efforts."

Action:

A staff expansion was requested and authorized by Congress as part of a \$9.6 million nursing home supplemental appropriation sent to the Congress on October 7, 1971 and signed by the President on December

28, 1971. The new funds enabled deployment of 227 additional enforcement personnel, with most distributed among 10 HEW regional offices to provide technical assistance to State inspection programs.

Comment:

The request for 150 new positions in HEW accounts for the greatest portion of the \$9.6 million appropriation. Some \$3.7 million went to create the new positions. An additional \$300,000 went to put HEW's audit and review procedures on a 2-year cycle. The discrepancy between the new 150 positions requested and the 227 enforcement personnel *deployed* is not otherwise explained by HEW.

Mal Schechter, Washington editor of *Hospital Practice* comments: "This 25-fold increase indicates what Medicaid staffing should have been in recent years, it may also indicate why reforms legislated by Congress have failed to emerge at the bedsides of Medicaid patients."¹⁹

Despite the increase in the numbers of personnel, enforcement will continue to remain a State function. State inspectors who inspect for purposes of State licensure will also continue the inspections for Medicare-Medicaid. Decisions to discipline or close a nursing home will be State decisions. The Federal Government is still in an advisory position. There are a great many more advisors with no real powers to compel proper performance. Pressure from Federal personnel on State officials will continue to result in pressures on the State elected representatives to stop the "harassment" by the Federal Government. The intervention of such elected officials in the past has been enough to nullify even the feeble efforts HEW offered. There is no reason to believe this pattern will not continue.

5. SHORT-TERM TRAINING OF PERSONNEL

What the President said:

"I have directed the Department of Health, Education, and Welfare to institute a new program of short-term courses for physicians, nurses, dieticians, social workers, and others who are regularly involved in furnishing services to nursing home patients. Appropriate professional organizations will be involved in developing plans and course materials for this program and the latest research findings in this complex field will also be utilized. In too many cases, those who provide nursing home care—though they be generally well prepared for their profession—have not been adequately trained to meet the special needs of the elderly. Our new program will help correct this deficiency."

Action:

Federally sponsored programs operated in conjunction with national professional associations and nursing home groups are programed to reach 40,000 of the Nation's 500,000 long-term care personnel. The primary focus will be on physicians, nurses, nursing home administrators, and patient activity directors.

¹⁹ *Washington Star*, August 13, 1972.

Comment:

Short-term training for nursing home personnel is the most potentially beneficial part of the entire Nixon Plan. As of July 1973, the promised 40,000 (of the Nation's over 500,000) nursing home employees had received such training.

First, it should be stated that the program is nowhere near the scope it should be to solve the problem. In terms of duration these training programs were 2 and 3 day seminars. In terms of numbers, 40,000 out of 500,000 employees is hardly significant. Finally, the overwhelming need in nursing homes is for the training of aides and orderlies who account for the great majority of nursing home personnel. Moreover, they provide about 90 percent of the patient care. Some cities charge that these individuals have benefited little from the training grants.

The following is a partial list of HEW training grants out of the total allotment of \$2.4 million: ²⁰

The American Nursing Home Association received \$139,000 to provide 2-day training programs for 10,000 individuals in ways to expand, develop, and enrich the lives of the Nation's nursing home patients. In short, one-fourth of those 40,000 personnel are not trained to take care of patients but how to "enrich their lives." The latter suggests recreation, activities, and crafts which are important. But spending for elementary training in patient care and the administration of drugs and their effects would certainly appear to be a more appropriate use of the money.

The American Medical Association received \$172,000 to hold 10 seminars; one in each HEW region, with the specific purposes of identifying a medical director's specific duties in a nursing home, preparing physicians to serve as medical directors, and upgrading the abilities of those who already hold such positions. These seminars anticipated that the new skilled nursing facility regulations would require all participating facilities to have a medical director. The requirement, while present in early drafts, was deleted in final regulations, but reincorporated in October 1974.

The Association of University Programs in Hospital Administration received \$71,124 for the development of curriculum modules in long-term care administration. Apparently it was assumed that there were no existing educational programs to serve as prototypes for wider duplication.

The American Nurses Association received \$355,760 to train 3,000 registered nurses now employed in nursing homes in geriatrics. This is perhaps the most beneficial of all the contracts evaluated in this sequence.

²⁰ Press release, HEW NEWS, Department of Health, Education and Welfare, Health Services and Mental Health Administration, Community Health Service. HEW Comments: As early as FY 73 the thrust of provider (patient care) training has been away from contracts with professional groups to identification of "centers of excellence" facilities in each region where team training of personnel can be conducted on site. Of the approximately 44,000 workers trained, 16,612 have been RNs and almost 9,000 LPNs and aides. This activity is conducted by the Division of Long-Term Care in the Bureau of Health Services Research, HRA.

In addition to awards made to training sites, funds are allocated to each Regional Office, where the Long-Term Care Training Coordinator assigned by DLTC designs or plans for training to meet special needs of States in that region. Four contracts for training nurses aides in rural areas are in force.

In addition, several State and local organizations also received funds.²¹

HEW admits that only 40,000 have been "trained," and this training consisted of 2 or at most 3-day seminars. Clearly, it was HEW's hope that the training would have a "spread effect." This is obvious from the use of the word "prototype" seminars. It is very difficult to provide much training of nursing home personnel with only \$2.4 million. By any measure this training effort, with a few exceptions, has not been geared toward the aides and orderlies who make up most of the Nation's nursing home personnel. Training needs to be continuous, not an isolated episode staged in hopes that it will spread. In an industry where aides have a turnover rate of approximately 75 percent, continuous training is not too much to expect. Finally, there are some who would oppose the distribution of so much of this limited amount of money to the major professional organizations. While the organizations might provide specialized expertise, it might be asked what such organizations have done on their own to train personnel before this HEW initiative.

6. COMMITTING HEW TO SET UP "OMBUDSMAN" OR INVESTIGATIVE UNITS

What the President said:

"I have also directed the Department of Health, Education, and Welfare to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients. The individual who is confined to an institution and dependent upon it is often powerless to make his voice heard. This new program will help him deal with concerns such as accounting for his funds and other personal property, protecting himself against involuntary transfers from one nursing home to another or to a mental hospital, and gaining a fair hearing for reports of physical and psychological abuse."

²¹ Colorado Associated Nursing Homes, \$115,530 to provide 10 specialized courses of instruction for the 10,000 nursing home personnel in Colorado; Iowa Nursing Home Association, \$120,000 funneled through 15 area community colleges to provide courses from 6 to 30 hours for nursing home personnel; Minnesota Nursing Home Association, \$43,290 to train 400 coordinators who will help nursing home administrators to evaluate nursing home training programs; the Metropolitan Chicago Nursing Home Association, \$45,570 to teach 700 trainers of nurses aides who would then pass on what they learn to as many as 7,000 personnel; the Burke Rehabilitation Center in New York, \$294,000 to study day hospital and day care as an alternative to placing the elderly in long-term care homes; the Massachusetts Mental Health Research Corporation, \$59,800 to train 200 aides and orderlies in 35 nursing homes; the State of South Carolina Division of Administration in the office of the Governor, \$11,750 to undertake short-term training for some 3,000 nursing personnel using the States Educational Television Network (the South Carolina Nursing Home Association is a subcontractor); the Ohio State Department of Health \$192,987 to provide training for 300 Ohio nursing homes ranging from 6 to 30 hours duration; the University of Pittsburgh, \$153,574 to conduct 14 short-term training courses (2 sessions of 12 hours each) in four locations in Pennsylvania; Adelphi University in New York, \$69,000 to provide training to individuals who will themselves become trainers with the hope of reaching 3,500 trainees; North Texas University, \$58,000 to train personnel in 75 north Texas nursing homes; University of Southern California, \$49,600 to prepare trainers from 21 nursing homes in the Los Angeles area with a hoped spread effect of 1,000 personnel.

In addition, there have been several hundreds of thousands of dollars awarded by the National Center for Health Research and Development to focus on the quality of care issue. Some of the Contractors were the Iowa Hospital Association (Data Systems); Department of Public Health, Illinois Data Systems; Paul Denson, Harvard (Quality of Care); Medicus Corporation; and Rush Presbyterian St. Luke, Chicago (Quality care); Executive Office of Elder Affairs, Commonwealth Massachusetts (alternatives to institutionalization). There are also smaller contracts, such as to the Robert Brady Company, to produce material for use in the training of nursing home personnel. The mental health problems of nursing home patients is the subject of inquiry by the National Institute of Mental Health and the American Gerontological Society.

Action:

Five so called "ombudsman" units were funded in June 1972. Four contracts are with State governments to establish State level offices linked to a local unit. Pending the announcement of these five contracts, the 855 Social Security District Offices were directed to receive complaints from patients or relatives for forwarding to Federal agencies. The White House reported that more than 2,000 complaints had been acted upon by July 1972.

Details of the Ombudsman contracts totalling \$500,000 are as follows:²²

Idaho: In Idaho the \$49,500 contract calls for an assistant attorney general, located in the State Department of Special Services, to serve as the nursing home ombudsman. His unit, based in Boise, initially concentrates on the seven-county Treasure Valley area of southwestern Idaho.

The Idaho unit has been linked to an advisory committee composed of nursing home consumers, providers, and representatives of State agencies. Volunteers, recruited from local organizations, will participate.

Pennsylvania: Pennsylvania, under a \$108,000 contract, has its ombudsman in the Governor's office under the Council of Human Services, with an advisory council of 12 (half to be over 60) representing consumers, professional groups, and the nursing home industry.

A local Philadelphia ombudsman unit, operated by the Nursing Home Campaign Committee, Inc., works through volunteers. A Pittsburgh local unit is staffed and directed by the State ombudsman.

South Carolina: The State unit in South Carolina, under a \$82,400 contract, is in the State Commission on Aging, an agency directly responsible to the Governor. A regional unit in Columbia serves the Central Midlands Regional Planning District. Volunteers will be trained to work at both State and regional levels. The medical foundations, a subsidiary of the South Carolina Medical Association, screen medical care complaints and advise on action.

Wisconsin: In the State of Wisconsin, the office of the Lieutenant Governor, which received a \$146,000 contract, has been investigating nursing home care for the past 2 years handled about 1,000 complaints; it operates the State nursing ombudsman program, with a local unit in Milwaukee. Senior citizen volunteers surveyed Wisconsin in nursing homes.

The National Ombudsman Program: The one exception to this pattern of State units, and the most promising, is the program sponsored by the National Council of Senior Citizens which received \$175,900. Its independent program is headquartered in Washington, D.C., with a State unit in Lansing, Mich., and two local units in Detroit and the upper Michigan peninsula.²³

Comment:

HEW's announced intention with respect to these "ombudsman" units is (1) to resolve complaints of residents; (2) to document significant problems in the nursing home field; and (3) to test the effective-

²² "HEW Awards \$500,000 to Test Ombudsman Nursing Home Programs", *Aging*, August 1972, p. 5.

²³ *Senior Citizen News*, September 1972, p. 3. On June 30, 1973, HEW let 11-year contracts to Oregon and Massachusetts expanding the number of ombudsman projects to seven.

ness of the use of volunteers in resolving the problems of nursing home patients. HEW is testing several approaches to determine what are the most appropriate methods to the ombudsman solution.

The ombudsman program could have far reaching effects in that the general community might become intimately involved in the day-to-day operation of nursing homes. Some experts believe that improper care exists in nursing homes simply because the institutions are isolated from the mainstream of society, including the general public, physicians, and other medical personnel.

Assuming that the ombudsman program is viable, there is no legislation requiring the States to establish such programs. (Two States have established them voluntarily, Illinois and Hawaii). In providing utilization reviews, medical reviews and professional reviews—all of which are required by the present law—States might be reluctant to set up further units. Cost would obviously be a factor. It is doubtful that ombudsman units could function unless they were required by law and the Federal Government bore some of the expenses.

Of the three purposes HEW ascribed to the ombudsman program, two seem superfluous and unnecessary: testing the use of volunteers in nursing homes and the documentation of significant problems in the field of long-term care.

The National Center for Voluntary Action and numerous existing experiments in nursing homes have proved the value of volunteers.

The ombudsman program—its critics maintain—is not an effective method of documenting problems in the field of long-term care. By definition the program starts with a cadre of a few trained personnel who hope to utilize and train volunteers. The documentation of problems should be left to more experienced hands.

There are many who argue that the primary existence of an ombudsman organization is to resolve complaints. To do this the agency must have independence and power, for example, access to State inspection records and files. Perhaps the power of subpoena should also be provided, but it is essential that the agency have some ability to influence the destiny of the State's nursing home industry. Such tools might include a rating system of various homes in the State or some input in the States power to suspend a nursing home from participating in State or Federal program.

Ombudsman units should not be involved in the quarrels or power struggle between the State health and welfare departments, or between these departments and the Governor's office. The ombudsman program needs reasonable assurance that its funding will continue year after year. Without a sense of permanence, its recommendations might not be taken seriously.

It is too early to evaluate the ombudsman program in full. There are encouraging reports which relate to the involvement of older Americans in visiting their infirm peers. This can only have beneficial results, but the proper label for this kind of an organization is a visiting society, not an ombudsman program. While the NCSC project appears to have the best chance, there is not one "ombudsman" model which has the three factors necessary to significant success: (1) power to influence the status of nursing homes financially; (2) independence from the exigencies of State government; and (3) some degree of continuity.

7. A COMPREHENSIVE REVIEW OF LONG-TERM CARE FACILITIES

What the President said:

"I am also directing the Secretary of Health, Education, and Welfare to undertake a comprehensive review of the use of long-term care facilities as well as the standards and practices of nursing homes and to recommend any further remedial measures that may be appropriate. Such a review is badly needed. Study after study tells us—compellingly—that many things are wrong with certain nursing home facilities, but there is not yet a clear enough understanding of all the steps that must be taken to correct this picture."

Action:

The Office of Nursing Home Affairs . . . in conjunction with other groups (including those within HEW) has identified the primary issues of long-term care needing additional study, with emphasis on the quality of care, alternatives to institutional care, data collection and analysis, and the costs of long-term care, day care, and homemaker services.

Comment:

HEW is reportedly studying indices of quality of care in nursing homes, alternatives to institutionalization, nursing home costs, and data collection.

With respect to data collection, there is and has been a crying need for reliable statistics in the nursing home field.

With respect to quality of care, there have been many studies but none on any large scale. The results should be useful.

The discussion of alternatives to institutionalization is very popular at the present time. It is obvious that such alternatives, if they existed, would prevent premature institutionalization by helping to maintain individuals in their own homes.²⁴ It is hoped that studies will focus on the costs of benefits, and the length of possible postponement of entry into a long-term facility.

The issue of nursing home costs is a fruitful topic for inquiry. Senator Moss asked HEW Under Secretary John Veneman to study nursing home profits as well. A report was presented in January 1974 with further studies continuing. (See Supporting Paper No. 9).

Another subject worthy of HEW inquiry is the question of who owns nursing homes and what are the implications? Evidence collected by the subcommittee indicates that a small number of individuals control a large number of nursing homes in at least three States. A more comprehensive study is needed.

8. CUTTING OFF FEDERAL FUNDS TO SUBSTANDARD HOMES

What the President said:

"One thing you can be sure, I do not believe that Medicaid and Medicare funds should go to substandard nursing homes in this country and subsidize them."

²⁴ See Part 4, pp. 57-64.

Action:

As of July 19, 1972, the Department of Health, Education, and Welfare surveyed the Medicaid nursing home standard enforcement programs of 47 States, Puerto Rico, and the District of Columbia, and found 39 States deficient as of November 30, 1971. States were given until February 1, 1972, to upgrade certification programs, and until July 1, 1972, to act on certification of all 7,000 Medicaid skilled nursing homes. As of this date, 579 facilities have been decertified or have withdrawn from the program in face of the application of Federal standards; 4,766 have been certified with 6-month timetables to correct deficiencies not affecting patient health and safety; 1,469 have been found in full conformity with all Federal standards; and 244 remain in process of certification with final action expected on or before July 31.

Comment:

In short, 88 percent of the nursing homes previously qualifying for Medicaid continue to qualify. Some 606 facilities have been decertified or dropped out of Medicaid. Specifically, 327 were decertified by the States, and another 279 dropped out voluntarily.²⁵ About 28,000 patients were involved. One-half of this number were in eleven facilities for the mentally retarded in New York State, and now qualify as intermediate care patients. About 2,800 patients were moved to other skilled nursing homes and about 9,000 to homes for the aged.

With respect to Medicare, Secretary Richardson told the 1971 White House Conference on Aging that, since Medicare began, 100 facilities have been terminated for failure to meet standards. In addition, some 2,000 facilities have voluntarily withdrawn. In short there have been about 6,500 facilities participating in Medicare at one time or another. Some 100 were dropped by Government action, and another 43 were put on notice of intent to cut Federal funds if they did not improve. The Reverend John Mason, Director of Social Services, American Lutheran Church, commented: "The quality of your inspection and enforcement program is not something I would be proud of in my own program. If 6,500 homes have participated in Medicare at one time or another and HEW has decertified 100 and perhaps another 43 now hanging in abeyance, that means about 1.5 percent has been disqualified for failure to meet standards."²⁶

For all the publicity, the enforcement activities of HEW continue to be more paper than real. Many experts contend that the only reason for decertification is a gross failure to meet fire safety standards—posing an immediate and continuing hazard to patients. For all the talk about inspections there is little evidence to suggest that any attention is being given to patient care. Unfortunately, the few Federal inspectors have directed their time to determining such things as:

Whether nursing homes have valid transfer agreements.

Whether there are written patient care plans.

Whether there is a contract between the health and welfare departments of the State, and

Whether Federal standards are used to certify nursing homes for Medicaid.

²⁵ "President Given Report on Upgrading of Nursing Homes", *Aging*, August 1972, p. 6.

²⁶ Letter of Dec. 6, 1971, to HEW Secretary Elliot Richardson from Reverend John Mason, Director of Social Services, American Lutheran Church.

II. THE NIXON NURSING HOME "REFORMS": AN EXPERT EVALUATION

Early in 1973, the subcommittee sent a questionnaire to 150 experts in the field of long-term care. They were sent to the director of each State's department of health, and to those on a list of names supplied by the American Association of Homes for the Aging and the American Nursing Home Administrators. In addition, the subcommittee directed the questionnaire to some physicians participating in the AMA seminars on medical directors, and to selected nurses, labor leaders, spokesmen for senior citizens groups and consumer advocates.

Some 120 of the questionnaires were returned.

Experts were asked to identify the major problems in the field of long-term care and to indicate whether the President's program was reaching these issues. The major problems were:

	<i>Mentioned by</i>
Inadequate reimbursement*.....	55
Inadequate training of personnel.....	38
Absence of physicians.....	22
Lax or uneven enforcement of standards.....	27
Society's treatment of the elderly.....	8
The profit motive.....	5

*An HEW grant was awarded by the Division of Long-Term Care, Bureau of Health Services Research, Health Resources Administration to the American Association of Homes for the Aging and the American Nursing Home Association to develop tools and systems to collect cost data. P.L. 92-603 mandates reasonable cost-related reimbursement by 1976.

It is clear that some experts mentioned more than one problem while others mentioned just one. Of the 118 that answered this question, 101 or 86 percent stated the major problems in the field had not been reached by the President's program.

When asked: "Has the quality of patient care been improved because of the Nixon reforms?" 63 percent said to a minor degree; 18 percent said not at all. Only 17 percent said there had been "moderate" improvement and 3 percent said there had been "substantial" improvement.

In short, 80 percent indicated that the quality of care had been improved only to a minor degree or not at all by the Nixon reform.

Some 52 percent of the respondents said that the President's program had been "slightly" successful in eliminating substandard nursing homes, and another 24 percent said "not at all." Only 4 percent said the President's program was "very successful" in eliminating substandard homes, and 21 percent indicated it was "moderately successful." (See table, p. 106.)

Finally the experts were asked for their overall opinion of the President's commitment to nursing home reform. Many felt there was too much emphasis on inspection and enforcement and not enough on patient care. A very small minority of the responses gave the President credit for "good intentions but bad execution." Typical of the assessments received are:

- "Viewed in its totality, six of the eight points are generally punitive, vindictive, punishing, threatening, oppressive, and negative. (About the only thing good that can be said for them is that they are good for the economy and the bureaucracy. They create white collar jobs for inspectors and enforcement officers. The single initiative that could have some positive impact (No. 5) 'to institute short term training of health workers,' has floun-

dered for lack of a clear policy, goal or direction. Yet, this is the only aspect of the whole program that has potential payoff, and which should continue."

- "It is a punitive approach, where the major effort is to hire an elite cadre of investigators rather than assist a vital industry in fulfilling their commitment to the elderly."
- "The President mouths pious words but does little to reach the real problems involved; namely, financing of institutional care."
- "Too much talk about quality and enforcement of standards while at the same time cutting back funds which will enable those standards to be implemented."

RESULTS OF QUESTIONNAIRE ON THE EFFECTIVENESS OF THE NIXON NURSING HOME "REFORMS"

Total questionnaires sent: 150; 120 received—80 percent return.

(1) (a) What are the most significant problems in the nursing home field?

Problem:	<i>Mentioned by</i>
Inadequate reimbursement-----	55
Inadequate training of personnel-----	38
Absence of physicians-----	22
Lax or uneven enforcement of standards-----	27
Society's treatment of the elderly-----	8
The profit motive-----	5

(b) Have these programs been reached by the President's program?

	<i>Percent</i>
Answering "no" (101)-----	86
Answering "yes" (17)-----	14
Total answering this question: (118)	

(2) Has the quality of patient care been improved because of the Nixon "reforms"?

	<i>Percent</i>
Substantially (4)-----	3
Moderately (20)-----	17
To a minor degree (73)-----	62
Not at all (21)-----	18
Total answering this question: (118)	

(3) Has the President's program been successful in eliminating substandard nursing homes?

	<i>Percent</i>
Very successful (5)-----	4
Moderately successful (25)-----	21
Slightly successful (62)-----	52
Not at all (28)-----	24
Total answering this question: (120)	

(4) What is your overall assessment of the President's commitment to solving nursing home problems? (Various answers received.)

THE HEW NURSING HOME REFORMS—PART II

HEW Assistant Secretary Frank Carlucci, in June 1974, again aroused hopes of senior citizens and consumer advocates by announcing a followup to President Nixon's eight-point plan. Earlier, in a personal letter to Senator Moss, Carlucci announced the consolidation of authority for overseeing the enforcement of Federal standards in the hands of HEW regional directors and his intention to improve the quality of long-term care.²⁷

²⁷ *Washington Report on Long-Term Care*, June 28, 1974, *Federal Register*, June 13, 1974.

Carlucci's plan includes the following:

- Unannounced inspection of 304 randomly selected nursing homes around the Nation by HEW validation teams. Each team will have a physician, a registered nurse, a physical therapist, a nutritionist, a pharmacist, a fire and safety engineer, and a health care facility administrator. The team will spend a minimum of 2 days in each facility, assessing the quality of nursing home care.
- Creation of a long-term care management information system which can supply information rapidly about surveys, certification, inspections, and the status of individual homes.
- The establishment of monthly cost of care indices with separate estimates for skilled nursing care and intermediate care.
- The development of uniform inspections and a system of uniform ratings for nursing homes. A "scoreboard" rating of "A" for a facility would carry the same meaning in every State.
- Organization in regional offices of long-term care standards enforcement units and confirmation of responsibilities (*Federal Register*, June 13, 1974).
- Development of instructional guidelines for SNF, ICF, and IMR.
- Preparation of regional director's and State agency standard operating procedure manuals for long-term care standards enforcement.
- Continuation of health facility surveyor improvement program as well as training of nursing home provider personnel.
- Confirmation of Office of Nursing Home Affairs roles and responsibilities (*Federal Register*, September 30, 1974).
- Organization of Interagency Advisory Group under the Chairmanship of the Office of the Under Secretary and the Office of Nursing Home Affairs to coordinate long-term care activities.

The August 30, 1974, *Federal Register* contains details of HEW's latest reorganization giving the Office of Nursing Home Affairs greater authority. Two divisions are created within the agency: (1) The Division of Standards Enforcement, and (2) the Division of Policy Development.²⁸

These initiatives are welcome but still far from the massive reform effort that is required. Whether they will be the basis of a wider and genuine effort to improve the quality of nursing home care of fading actions of the moment remains to be seen.

SUMMARY

Major changes in national policy in the field of long-term care are long overdue. The Nixon reforms, while bringing some improvements, fail to come to grips with the root causes of poor nursing home care.

On the positive side, it is possible that the training program initiated will spread beyond the 40,000 original trainees. In fact, as of January 1974 HEW claimed that 14,485 more personnel had been trained. Nevertheless, this is still far short of the meaningful training program that is needed.

It is also possible that the ombudsman projects will grow in strength and function as advocates for nursing home residents and their rela-

²⁸ *Washington Report on Long-Term Care*, September 6, 1974.

tives. It is also possible that the Office of Nursing Home Affairs will receive more responsibility. However, until it receives direct "line authority" over other HEW agencies, its role will still be a reflection of the interest of the Secretary and Under Secretary in long-term care rather than a responsibility fixed in law.

The efforts of HEW to study several primary issues in long-term care are welcome and greatly needed—especially with respect to nursing home costs, profits, and quality of care.

On the negative side, the Nixon reforms placed heavy emphasis on more and better "policing" efforts, while the Federal role in the enforcement of standards remain negligible. *The States will still have the responsibility to insure that facilities conform to Federal standards as well as their own.* This very fact was cited by HEW spokesmen previously as the primary cause of "widespread non-enforcement of standards."

Taken in their best light, the Nixon reforms have been sadly overshadowed by the administration's efforts to cut back the overall Medicaid budget. Previous parts of this report have illustrated how budget considerations have resulted in a restrictive definition of skilled care and a serious weakening of standards for both skilled and intermediate care.

What remains, unhappily, is a continuing lack of Federal direction in the field of long-term care which is unsatisfactory to all parties concerned.

INITIAL RECOMMENDATIONS

TOWARD A NATIONAL POLICY ON LONG-TERM CARE

A National policy on long-term care—comprehensive, coherent and attentive to the needs of older Americans—does not exist in the United States today. The need for such a policy becomes more evident with each passing day that brings an increasing number of older Americans. The rapid increase in America's over-75 population indicates that (1) a policy is needed immediately, and (2) long-term care should properly be considered within the context of national health insurance plans.

To help stimulate discussion and actions which will help formulate that policy and implement it in an orderly and far-sighted fashion, the Subcommittee offers initial recommendations which will be reviewed once again in the final report of this study. They are not necessarily the only appropriate approach to a national policy on long-term care.

The recommendations are offered in two groupings: (1) to provide a comprehensive benefits with heavy emphasis upon improvement of Medicare coverage, and (2) to improve the inspection and enforcement of nursing home standards.

RECOMMENDATIONS FOR IMPROVING BENEFITS

The Medicare program should be the base for an expanded benefits package for the infirm elderly for two reasons. First, because of its almost universal application nearly 23 million aged and disabled Americans are now eligible for Medicare coverage. Second, there is great dissatisfaction with the Medicaid program and the "welfare" stigma associated with it.

In developing a national policy on long-term care, the Subcommittee recommends that the following immediate steps be taken:

1. The Medicare nursing home program should be greatly expanded. It should include 100 days (per spell of illness) in a skilled nursing facility as now provided, and an additional 365 days in an intermediate care facility. Co-insurance should begin on the 101st day for skilled care, and on the 266th day for intermediate care. After a patient pays \$1000 in co-insurance charges, he would pay no further costs. Such care should be provided without any requirement of prior hospitalization.

2. The Medicaid nursing home program should be retained as a supplement to Medicare, for patients who need care for more than one year and for other purposes. For example, Medicaid can pay the Medicare monthly premium charge (now \$6.70 for the elderly and disabled) and co-insurance charges for indigents for medical services. In addition, there are strong arguments for continuing other Medicaid

services for the elderly poor, particularly hospitalization, physician's services, X-ray and laboratory services and mental health care. In addition, States should be allowed to provide optional services, such as dental care and eye care.

3. It is also urged that these additional benefits be financed by general revenues, instead of saddling today's workers with new payroll taxes.

4. Eligibility for home health services should not be limited to those who qualify for "skilled care". The numbers of reimbursable home health visits under Parts A and B should be increased from 100 to 200. Relatively few Medicare patients require more than 100 home health visits. But those who do should not be denied these vital services and quite possibly forced back into a hospital.¹

Additionally, all in-home services should be available without requiring "skilled" nursing care of physical or speech therapy. Moreover, homemaker services (e.g. housework, chore services, and grocery shopping) should also be included as a covered service under Medicare. Day care should be authorized as an optional substitute for some or all of the authorized home health visits presently offered.²

5. Federal grants should be made available to assist in the formation of home health agencies which are in short supply in some areas of the country.³

6. HEW should establish an experimental program to subsidize families to take care of their elderly in their own homes.⁴

7. The Secretary of Housing and Urban Development should authorize the construction or conversion of facilities for the elderly so that a broad spectrum of institutional and related services can be provided at single sites. A demonstration program for such "campuses for the elderly" could be an effective beginning step for implementing this proposal.⁵ The complex would include a nursing home, rest home with nursing supervision, congregate living facilities, and residential facilities for the elderly. Such facilities could be contiguous to a senior citizens center.

8. Federal funds should be available to establish day centers along the lines developed at "day hospitals" in England.⁶

9. The Social Security Administration and the States should make a greater effort to increase public understanding of Medicare and Medicaid and the long-term care benefits available.⁷ Particular attention should be given to informing minority groups.

10. Existing long-term care programs should be modified; first to provide preventive care; and second, to facilitate rehabilitation and return to the community.

¹ See S. 2690 introduced by Senator Edmund S. Muskie on November 13, 1973, and S. 1825 introduced by Senator Moss on May 16, 1973. For cost estimate of these proposals, see appendix 9, pp. 160-161.

² See bills cited in footnote 1.

³ See S. 2695 introduced by Senator Frank Church on November 13, 1973, which was added to S. 3280 which passed the Senate on September 11, 1974.

⁴ See S. 1826 introduced by Senator Moss on May 16, 1973. A similar provision passed the Senate as an amendment to H.R. 1 (P.L. 92-603) but was lost in Conference.

⁵ See S. 1997 introduced by Senator Moss.

⁶ See S. 1825 introduced by Senator Moss on May 16, 1973. See also testimony of Dr. Lionel Z. Cosin in "Trends in Long-Term Care". Part 14, hearing by the Subcommittee on Long-Term Care, Washington, D.C., June 15, 1971, p. 1375.

⁷ The Subcommittee places such importance on this recommendation that it is writing to educators asking for specific suggestions for educational efforts along this line. *It is not enough to establish programs; government must also act to assure that they are understood by the people they are meant to serve.*

11. A mini-White House Conference on Aging should be called to discuss the important and increasingly timely issues related to long-term care.

12. Policy makers, providers and the public must work together to improve the "image" of nursing homes. This realignment of public attitudes must begin with the recognition that nursing homes have an important and vital function to perform in society. Moreover, it is absolutely essential to remove the present negative connotations to allow nursing homes to perform more effectively as a part of the American health care continuum.

RECOMMENDATIONS FOR THE IMPROVEMENT OF THE INSPECTION AND ENFORCEMENT ACTIVITIES

Improved benefits are essential for the development of an effective and comprehensive national policy on long-term care. Equally important is the need to improve inspection and enforcement activities for long-term care facilities. The Subcommittee urges:

1. State systems of enforcement should be reorganized so that a single agency is responsible for the entire regulation and compliance system rather than spreading responsibility through various agencies and departments.

2. Simplified inspection forms should be prepared by the State and HEW with specific directions and procedures for inspections. Such forms would aid the inspectors and make for easier understanding by the public, since HEW regulations now make such surveys public information.

3. Simplified Code requirements and regulation requirements should be made available to the general public so that they and nursing home administrators would be cognizant of what the law requires.

4. As far as practical, states should unify inspection procedures so that sanitation, environment, patient care, dietary and fire safety are examined in one visit. *Care should be taken to give no advance notice.* Inspectors should utilize spot-checks and follow-up visits, particularly for those facilities which previously had deficiencies and are under a period of grace.

5. State legislatures should consider additional enforcement powers—short of revocation of licenses—for State agencies.

6. The Wisconsin proposal that nursing home operators carry out comprehensive and continuing self-evaluation surveys (in addition to existing licensure proceedings) is worthy of duplication on a wider basis. Falsified self-evaluation surveys should carry criminal penalties.

7. States should establish a system under which patients and nursing home personnel can submit complaints or reports concerning the operations of long-term care facilities without fear of reprisal. The ombudsman program may be effective if it can be given some degree of permanence, independence and enforcement authority.

8. Computer files should be established as an alternative to the uncoordinated procedures in most states. Such files would allow instant information retrieval. In developing computer files, the consumers right to see and understand and survey reports would, in no way, be compromised.

9. Supplementary or direct Federal enforcement rather than exclusive reliance on State inspectors should be a goal for an effective enforcement. In far too many cases, the State inspectors become too close to the nursing homes which they regulate. They oftentimes become subject to local political pressure. Additionally, they may not have adequate knowledge of the Federal regulations, which they are now asked to enforce. A cadre of Federal inspectors making spot checks on the compliance of selected homes and the operation of State enforcement systems would be a minimum first step.

10. Inspectors and nursing home employees must be able to complain to Federal personnel without fear of losing their employment. It is also recommended that a new employer unfair labor practice be established under the National Labor Relations Act to make it unlawful to discharge an individual because he testifies about employer violations in a governmental proceeding.

11. The Nursing Home industry should establish State and possibly national "self-regulation boards" to enforce their Code of Ethics, as well as State and Federal statutes.

12. There should be meaningful accreditation of nursing homes by an independent organization with publishing of ratings of nursing homes (perhaps by State ombudsman units).

(Additional—and possibly revised—recommendations will be made in SUPPORTING PAPERS and in the final report in this series.)

APPENDIXES

APPENDIX 1

EXAMPLES OF RETROACTIVE DENIALS

MEDICARE—ADMINISTERED BY IOWA MEDICAL SERVICE AS CARRIER FOR
PART B OF MEDICARE*

MARCH 9, 1971.

L. L. LONG, M.D.
Perry, Iowa.

DEAR DR. LONG: On January 15, 1971 you received from the District 12 Peer Review Committee their recommendation as to what services were allowable on your billings to Medicare for _____. From March of 1969, the month that you started billing for services to _____, to the current date we allowed one weekly office visit and one weekly injection unless the diagnosis warranted additional injections. All diathermy treatments were disallowed.

We applied guidelines to all of the claims that you had already received payment on, and found that a refund for \$940.80 is necessary. The check should be made payable to Iowa Medical Service and sent to my attention.

If you have any questions feel free to contact me.

Sincerely,

DONALD R. BLASS, *Manager,*
Quality Assurance Department

L. L. LONG, M.D.,
Perry, Iowa, April 15, 1971.

L. J. O'Brien, M.D.,
President, Iowa Medical Society,
Fort Dodge, Iowa.

DEAR DR. O'BRIEN: Please see enclosed letter. It is incredible! Are there any precedents for this? Have other doctors refunded Medicare payments? Does Medicare have any legal or any other authority to demand refunds?

The patient has offered to pay this. However, the principle involved is far more important than the money.

When I received my first notice of a Peer Review Hearing, I predicted to Mr. Bob Lippold, field representative, what the result would be. I knew allowances in this case would be changed. The questions are: Why have a hearing at all, when Medicare can simply disallow a claim? Why wait 2 years to have a hearing? How can the decision be made retroactive? When no one is likely to sue a government bureau when it doesn't pay, why does it pay and then ask for a refund?

*Letters presented to Senator Moss by Dr. L. L. Long, Perry, Iowa.

My experience with the Peer Board of Review is that it is a device where Medicare gets what it wants. It sets up the rules for the hearing and supplies the cases. In my case, four doctors drove a total of some hundreds of miles and spent several hours reviewing my care of the patient, without seeing the patient to know what I dealt with, and arrived at a foregone conclusion. This was a careless waste of their time and effort, not including mine with letters like this.

The patient's satisfaction with his treatment, his willingness to pay, or the success the doctor might have with the treatment has nothing to do with this problem. Treat the patient as an individual, which is continually preached in medical school, and he immediately becomes ineligible for Medicare.

If payments had been discontinued entirely in 1969, I would have considered it a part of the picture, and after a letter or two, dropped it. But this retroactive pattern is impossible, and this I cannot disregard. To demand a refund after 2 years means that innocent people pay for medicrat bungling.

With apologies to Donald Kaul, Des Moines Register humorist, imagine a world in which an increase in prices was retroactive 2 years; or a wage cut; or a tax increase; or a change in golf tournament rules, so that champions for the last few years become losers!

It is like telling my children that I have decided to spank them for the times they have come into the house with muddy shoes, and therefore I shall spank them 100 times for what they have done the past 2 years.

This case demonstrates that Medicare changes the rules to its own advantage as it goes along, like my children in playing games. Originally it was going to pay on the basis of usual and customary fees; now it has changed this to pay for the usual and customary care. Next it will decide to pay for only the usual and customary cases.

For these, is each doctor supposed to be checking up on other doctors to find out what those are? Imagine a doctor's reaction if others started checking up on him?

* * * * *

The experiences of Dr. Long were by no means unique. Dr. Frederick Offenkrantz, Medical Director of the Cranford Health and Extended Care Center provided the subcommittee with these examples:

CASE No. 7058

Transferred from Rahway Hospital on January 31, 1970; after a 23 day hospital stay.

Diagnosis: Fracture of left hip and cystitis.

She is under a complete regimen of care both nursing and physiotherapy without weight bearing permitted being subject to review by the orthopedic surgeon as late as March 7, 1970. This patient was cut off on March 11, 1970, retroactive to the date of admission without explanation or discussion. The attending physician and orthopedic surgeon and the Utilization Review Committee feel that this is an absolute malpractice decision.

CASE No. 69736

Transferred from St. Elizabeth Hospital on December 17, 1969, after 11 day hospital stay.

Diagnosis: Advanced carcinoma of left breast as well as Parkinsons disease, arthritis, and generalized ASCVD.

She was put on extensive medical and medicinal care for her malignancy, her degenerative cardiac disease and general systemic maintenance. Although the admitting physician, the attending physician and the Utilization Review Committee felt that this patient required total E.C.F. care, on March 10, 1970, she was cut off retroactive to January 25, 1970, without explanation.

CASE No. 7019

Transferred from Rahway Hospital on January 12, 1970, after 37 day hospital stay.

Diagnoses: Fracture of pelvis and left fibula, ASCFD.

The patient was treated with usual combined medical, medicinal, skilled nursing and physiotherapy programs appearing to achieve improvement that might eventually return her to self care with rehabilitation. On February 23, 1970, this patient suffered a pulmonary embolus which caused her death, as determined through autopsy by the County Medical Examiner. Without reference to any part of this patient's chart, on March 11, this patient's benefits were terminated retroactive to February 1. This is one of the most outstandingly stupid errors made through the intermediary.

CASE No. 7023

Transferred from Memorial General Hospital, January 13, 1970, after 48 day hospital stay.

Diagnosis: Cerebral vascular accident; congestive heart failure and diabetes.

While here, a severe ASHD was discovered in addition to her paralysis. A program of treatment aimed at combating the heart disease and the stroke was instituted, which included skilled nursing care, physiotherapy and medical attention. On March 11, 1970, this patient was cut off retroactive to February 1, 1970, which allowed a stay of only 17 days which may be considered malpractice for these diagnoses. No patient records were requested by the intermediary before making this decision. This poor Negro patient, who is hardly able to afford medication for her bona fide illness, is medically a potential casualty in this situation. She is now being returned to an acute hospital since "returning her home would be lethal" is the opinion of the attending doctor.

CASE No. 69718

Transferred from St. Elizabeth Hospital on December 7, 1969.

Diagnoses: Bilateral wrist fractures.

This is another incomprehensible situation. This woman with both arms completely immobilized because of bilateral wrist fractures, was

admitted here for rehabilitation and certain return to previous status in life. This was being accomplished with usual E.C.F. programs under the guidance of Dr. Lepree, Union County's foremost orthopedic surgeon. On December 29, this patient was cut off by the intermediary as of the date of admission. Photographs of this patient were sent at that time to her Congressman as interesting examples of how Medicare was functioning under these conditions.

CASE No. 7025

Transferred from Rahway Hospital on January 13, 1970, after 13 day hospital stay.

Diagnoses: Fracture of pubis, ischemia and greater trochanter plus old coronary occlusion.

This patient on examination here was found to have severe ASHD including coronary disease in addition to her multiple fractures of the pelvis. She was treated actively with a program of medicinal, medical, physical therapy and skilled nursing care with continued improvement. The Utilization Review Committee felt that her improvement in both cardiac and fracture pathology required E.C.F. care, electing to keep this patient for an additional 30 days. However, on March 11, 1970, without reference to any portion of this patient's chart, the intermediary cut off benefits retroactively to February 1, 1970. On that day, March 11, this patient had a massive stroke with complete paralysis at this facility necessitating her being returned to this referring hospital in extremis. We regard the fact that this occurred here and not several hours later when she would have been discharged in accordance with the intermediary's request, as an Act of God in our behalf.

APPENDIX 2

At the request of the Senate Finance Committee, HEW developed the following table estimating cost savings to the Medicaid program as the result of amendments included in H.R. 1 (Public Law 92-603).*

Table 10.—Changes in estimated Medicaid costs (+) and saving (–) under P.L. 92-603

	<i>Calendar year 1974 in millions of dollars</i>
Coverage of the disabled under Medicare.....	–70
Increase in Medicare Part B deductible from \$50 to \$60.....	+8
Reduction in Medicaid matching if States fail to perform required utilization review.....	–162
Imposition of premium, copayment and deductible requirements on Medicaid recipients.....	–89
Families with earnings under Medicaid:	
Eligibility extended 4 months.....	+33
Limitation on nursing home and intermediate care facility reimbursement to 105 percent of last year's payment.....	–22
Elimination of requirement that States move toward comprehensive Medicaid program by 1977.....	(1)
Elimination of requirement that States maintain their year to year fiscal efforts in Medicaid.....	–640
Payments to States under Medicaid for installation and operation of claims processing and information retrieval systems.....	+10
Increased Medicaid matching for Puerto Rico and the Virgin Islands.....	+10
More specific requirements as to eligibility for skilled nursing level of care.....	–14
100 percent reimbursement for the cost of certifying skilled nursing homes under Medicaid.....	+10
Expansion of Medicaid coverage to include inpatient care for mentally ill children.....	+120
90 percent Federal funding of family planning services.....	+36
Coverage of persons needing renal dialysis or transplantation under Medicaid.....	–20
Preserving Medicaid eligibility for social security beneficiaries.....	
Total estimated reduction in Medicaid costs under P.L. 92-603.....	–790

¹ The prior law estimates take no account of the effect of the requirement that States move toward comprehensive Medicaid programs by 1977; therefore, no savings are attributed to the repeal of this requirement.

Source: Department of Health, Education, and Welfare.

Reprinted in "Summary of Social Security Amendments of 1972", Joint publication of the Senate Committee on Finance and the House Committee on Ways and Means, November 17, 1972, p. 42.

*See pp. 35-38 of this report for further discussion.

APPENDIX 3

HEW RESPONSE TO SENATOR KENNEDY'S INQUIRY ABOUT LICENSURE OF NURSING HOME ADMINISTRATORS

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., April 23, 1973.

HON. EDWARD M. KENNEDY,
*Chairman, Subcommittee on Federal, State, and Community Services,
Special Committee on Aging, U.S. Senate, Washington, D.C.*

DEAR SENATOR KENNEDY: This is in response to your letter of March 29, requesting information about the Department's response to the lawsuit in Florida challenging HEW regulations which implement provisions of title XIX of the Social Security Act relating to the licensure of nursing home administrators. The action, *State of Florida, et al. v. Richardson*, U.S.D.C. N.D. Fla., Civil No. TCA-1826, was filed in June 1972 by the State of Florida, the Florida Board of Examiners of Nursing Home Administrators and its individual members, and various associations involved in the field of nursing home care, including the Florida Nursing Home Association, the American College of Nursing Home Administrators, the American Nursing Home Association and the National Association of Boards of Examiners of Nursing Home Administrators. The Secretary of Health, Education and Welfare was the sole defendant.

On March 13, 1973, the federal district court granted the Secretary's motion for summary judgment. On March 26, plaintiffs filed a notice of appeal in the United States Court of Appeals for the Fifth Circuit. Enclosed are copies of the district court's opinion, the complaint and the Government's main brief (Memorandum of Points and Authorities in Support of Defendant's Motion for Judgment on the Pleadings or, in the Alternative, for Summary Judgment), which sets forth the substantive arguments made by the Secretary on the merits of the case. Other pleadings filed on behalf of the Secretary, primarily involving procedural and technical aspects of the case, are not included; however, the Department will be happy to provide you with copies of these pleadings, if you should wish to have them.

While they raised several issues, plaintiffs concentrated their attack on the HEW regulations in 45 C.F.R. 252.10(b)(3), relating to the composition of the nursing home administrator licensure boards, which serve to prohibit any single professional or institutional category from constituting a majority of the board, and which provide that an individual who has a direct financial interest in a nursing home is deemed, for purposes of this rule, to be considered a representative of the nursing home category. The net effect of these rules is to preclude nursing home owners and administrators from constituting a majority of the nursing home administrator licensure boards. Plaintiffs argued that this interpretation of section 1908(b) of the Act goes far beyond the congressional intent. HEW responded, in sum, that the Congress plainly intended that the board be representative of a variety of profes-

sional and institutional interests and that the regulation merely effectuates this purpose. Our argument on this point, which is extensive, is set forth in the brief primarily at pages 15-30.

Incidentally, while we have relied to a considerable extent on your testimony before the Senate Finance Committee regarding broad representation on the licensing board (pp. 17-22 of the brief), we have not provided for consumer representation, as such, on the board, which your letter suggests should be included. The statutory language provides that the board be "representative of the professions and institutions concerned with care of chronically ill and infirm aged patients . . ." And, despite our initial success, the litigation to defend our regulation as it now exists is far from resolved.

Sincerely,

FRANK C. CARLUCCI,
Secretary.

APPENDIX 4

LEGISLATION AUTHORIZING NEW AND INNOVATIVE NURSING HOME ENFORCEMENT AUTHORITY IN CALIFORNIA AND WISCONSIN

California

COMMENTARY ON ASSEMBLY BILL 1600, THE LONG-TERM CARE HEALTH, SAFETY, AND SECURITY ACT

BACKGROUND AND JUSTIFICATION

Attached is California Assembly Bill 1600 (1973), the Long Term Care Health, Safety, and Security Act. The bill establishes the following: (1) a citation system for the imposition of prompt and effective civil sanctions against long term health care facilities (nursing homes) in violation of laws and regulations relating to patient care; (2) an inspection and reporting system to insure that long term health care facilities are in compliance with state statutes and regulations pertaining to patient care; and (3) a provisional licensing mechanism to insure that full time licenses are issued only to those long term health care facilities that meet state standards relating to patient care. In California, the bill was introduced by the entire Joint Committee on Aging (a bipartisan joint legislative committee) and 25 co-authors. It is also supported by the Attorney General.

The bill was proposed by the Joint Committee on Aging after that Committee had held a series of hearings on nursing homes and alternative care throughout the state of California in the winter and spring of 1973. Those hearings indicated that there was a dual crisis of confidence among the general public regarding the care being given in the state's nursing homes. The public widely believed—and the hearings uncovered much evidence to support this belief—that some nursing homes were providing inferior patient care. The public also felt that the state agency charged with policing nursing homes, the State Department of Health, was not doing an adequate job in assuring that nursing homes met applicable legal standards. In this regard, there was evidence to the effect that the sanctions available to the Department of Health were inadequate because the only remedies against violators were "all or nothing"; in other words, the existing criminal penalties and delicensing provisions were too harsh to be enforced. In addition, delicensing procedures often were tied up in administrative and judicial processes for long periods of time.

THE CITATION SYSTEM

The citation system proposed in Assembly Bill 1600 is an attempt to provide a less harsh, and hopefully, more effective remedy—swiftly imposed civil penalties for nursing homes which are in violation of applicable requirements of law. Class "A" violations are viola-

tions which "present an imminent danger to the patients or guests of the long term health care facility and the substantial probability that death or serious physical harm would result therefrom." A Class "A" violation is subject to a civil penalty of not less than \$1,000 and not more than \$5,000 for each violation. [Section 1408(a)] Class "B" violations are violations which have a "direct or immediate relationship to the health, safety or security of long term health care facility patients, other than class 'A' violations." A class "B" violation is subject to a civil penalty in an amount not less than \$50 and not more than \$250 for each violation. If a class "B" violation is corrected within the time specified in the citation, no civil penalty is imposed. [Section 1408(d)] The bill establishes a streamlined administrative review procedure, which should take approximately 20 days from start to finish, within which the licensee can contest the existence of the factual basis upon which a citation or violation is founded. [Section 1413(a)] A penalty of \$50 per day is assessed when a deficiency continues beyond the date specified for correction in the citation. [Section 1413(b)]

PUBLIC INPUT

Inasmuch as this legislation was prompted primarily by patient and general public skepticism about current procedures, the bill provides for substantial public input into the entire citation process, including the following:

(1) Regulations implementing the statute, in particular definitions of class "A" and "B" violations, are to be enacted only after consultation with industry, professional and consumer groups. [Section 1409]

(2) The citation system inspection process may be instituted by any member of the general public, and the name of the complainant may, at his option, be kept anonymous. [Section 1403]

(3) If the complainant requests the opportunity to do so, he or his representative or both, may be allowed to accompany the inspector to the site of the alleged violations during the inspector's tour of the facility. [Section 1404]

(4) Each citation which has become final must be posted in a place or places in plain view of the patients, persons visiting those patients, and persons who inquire about placement in the facility. [Section 107]

(5) Retaliation against any patient or employee who participates in the citation process is specifically prohibited. [Section 1415(a)] Any type of discriminatory treatment of a patient by whom or upon whose behalf a complaint has been submitted, within 120 days of the filing of the complaint, raises a rebuttable presumption that such action was taken in retaliation. [Section 1415(b)]

(6) Any written material pertaining to the citation process is specifically required to be open to public inspection. [Section 1417]

(7) The Department of Health is required to publish annually a report, available to the public, listing all nursing homes and the status of any citations issued against them. [Section 1420]

CONCLUSION

Comments and suggestions regarding this novel legislation would be most appreciated. Please write to: Peter D. Coppelman, Directing Attorney, California Rural Legal Assistance, National Senior Citizens Law Center, San Francisco, Calif. 94102.

Assembly Bill No. 1600

CHAPTER 1057

An act to add Chapter 2.4 (commencing with Section 1417) to Division 2 of the Health and Safety Code, relating to health care.

[Approved by Governor October 1, 1973. Filed with
Secretary of State October 1, 1973.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1600, McCarthy. Health care facilities.

Provides for a system of regular periodic inspections and inspection upon complaint of long-term health care facilities, as defined, to be conducted by the State Department of Health. Permits duly authorized officers, employees, and agents of the department to enter and inspect such facilities, including interviewing residents and reviewing records, and provides that no advance notice shall be given unless previously and specifically authorized by the director or required by federal law. Requires public employees giving advance notice in violation of specified provisions to be suspended without pay as prescribed.

Classifies types of violations and requires the Director of Health to propose and adopt regulations, subject to specified limitations, setting forth criteria or, if feasible, acts constituting such violations. Authorizes the assessment of civil penalties therefor. Requires the Director of Health to prescribe procedures for the issuance of notices of violation, where the violation has only a minimal relationship to safety or health. Requires posting of specified citations until the violation is corrected up to a maximum period of 120 days and requires licensee to promptly make available for inspection by any member of the public who so requests a copy of all final uncorrected violations. Sets forth procedures for contesting citations and civil penalties.

Authorizes the Attorney General on his own complaint or upon the complaint of others, as specified, to bring actions for injunction or civil damages with respect to delineated violations. Requires the State Department of Health to assess a civil penalty of \$50 per day against licensees not correcting violations within the time permitted. Trebles the amount of civil penalties for second or subsequent violations occurring within any 12-month period, if a citation was issued and a civil penalty assessed for the previous violation occurring within such period.

Requires actions brought pursuant to the act to be given priority on the court calendar.

Makes it a misdemeanor to do specified acts relating to interference with enforcement of the act and the conduct of investigations pursuant to the act. Prohibits retaliation or discrimination against

any patient or employee by a licensee on account of initiation of, or participation by, any person in any proceeding under the act and provides a civil penalty for violation. Provides that remedies provided by the act are cumulative and nonexclusive.

Provides that licensee shall not be cited for any violation caused by any person licensed pursuant to the State Medical Practice Act if such person is independent of the licensee and the licensee shows that he has exercised reasonable care and diligence in notifying such persons of their duties to patients in the licensee's long-term health care facility.

Authorizes public inspection of specified writings received, owned, used, or retained by the department, but requires the deletion of names in copies of such writings provided for public inspection.

Requires the department to prepare a list of all licensees, their citations, and the status of such citations. Commencing in 1974, requires the department, on or before February 1 of each year, to notify specified public agencies of long-term health care facilities in the area found, upon inspection within the previous 12-month period, to be without violations. Prohibits referral of patients by any public agency to long-term health care facilities which have over a certain number of uncorrected violations, with an exception for facilities exempted by the Director of Health due to a lack of the same type of facilities in the area sufficient to satisfy the demand for services provided by such type of facilities. Requires such public agencies to give priority in referring patients to certain long-term health care facilities based upon their record of violations. Requires the department to provide for additional and ongoing training of inspectors charged with implementation of the act.

Requires initial license to operate a long-term health care facility to be provisional, expiring in 6 months. Provides for inspection by the department and for one renewal of the provisional license or issuance of a regular license. Prohibits renewal of the initial provisional license if the facility has not made substantial progress towards meeting the requirements for licensure, and prohibits issuance of a regular license unless there is full compliance with the requirements for licensure.

Requires the department, on or before January 1, 1977, to submit a specified report to the Legislature.

Declares that no state-mandated local costs are contained in the enactment requiring state reimbursement under provisions of law.

The people of the State of California do enact as follows:

SECTION 1. Chapter 2.4 (commencing with Section 1417) is added to Division 2 of the Health and Safety Code, to read:

CHAPTER 2.4. QUALITY OF LONG-TERM HEALTH FACILITIES

1417. This chapter shall be known and may be cited as the Long-Term Care, Health, Safety, and Security Act of 1973.

1417.1. It is the intent of the Legislature in enacting this chapter to establish (1) a citation system for the imposition of prompt and effective civil sanctions against long-term health care facilities in violation of the laws and regulations of this state relating to patient care; (2) an inspection and reporting system to insure that long-term health care facilities are in compliance with state statutes and regulations pertaining to patient care; and (3) a provisional licensing mechanism to insure that full-term licenses are issued only to those long-term health care facilities that meet state standards relating to patient care.

1418. As used in this chapter:

(a) "Long-term health care facility" means any facility licensed pursuant to Chapter 2 (commencing with Section 1250) which (1) maintains and operates 24-hour skilled nursing services for the care and treatment of chronically ill or convalescent patients, including mental, emotional, or behavioral problems, mental retardation, or alcoholism; or (2) provides supportive, restorative, and preventive health services in conjunction with a socially oriented program to its residents, and which maintains and operates 24-hour services including board, room, personal care, and intermittent nursing care. "Long-term health care facility" includes nursing homes, skilled nursing facilities, extended care facilities, intermediate care facilities, and shall not include acute care hospital or other licensed facilities except for that distinct part of such hospital or facility which provides nursing home, skilled nursing facility, extended care facility, or intermediate care facility services.

(b) "Licensee" means the holder of a license issued under Chapter 2 (commencing with Section 1250) for a long-term health care facility.

1419. Any person may request an inspection of any long-term health care facility in accordance with the provisions of this chapter by giving notice to the state department of an alleged violation of applicable requirements of state law. Any such notice shall be in writing signed by the complainant and shall set forth with reasonable particularity the matters complained of. The substance of the complaint shall be provided to the licensee no earlier than at the commencement of the inspection. Neither the substance of the complaint provided the licensee nor any copy of the complaint or record published, released, or otherwise made available to the licensee shall disclose the name of any individual complainant or other person mentioned in the complaint, except the name or names of any duly authorized officer, employee, or agent of the state department conducting the investigation or inspection pursuant to this chapter, unless such complainant specifically requests the

release of such name or names or the matter results in a judicial proceeding.

1420. Upon receipt of a complaint, the state department shall assign an inspector to make a preliminary review of the complaint and shall notify the complainant of the name of such inspector. Unless the department determines that the complaint is willfully intended to harass a licensee or is without any reasonable basis, it shall make an onsite inspection within 10 working days of the receipt of the complaint. In either event, the complainant shall be promptly informed of the department's proposed course of action. Upon the request of either the complainant or the department, the complainant or his representative, or both, may be allowed to accompany the inspector to the site of the alleged violations during his tour of the facility, unless the inspector determines that the privacy of any patient would be violated thereby.

1421. (a) Any duly authorized officer, employee, or agent of the state department may enter and inspect any long-term health care facility, including, but not limited to, interviewing residents and reviewing records, at any time to enforce any provision of this chapter. Inspections conducted pursuant to complaints filed with the state department shall be conducted in such a manner as to ensure maximum effectiveness. No advance notice shall be given of any inspection conducted pursuant to this chapter unless previously and specifically authorized by the director or required by federal law.

(b) Any public employee giving such advance notice in violation of this section shall be deemed to be in violation of subdivision (t) of Section 19572 of the Government Code and shall be suspended from all duties without pay for a period determined by the director.

1422. The state department shall, in addition to any inspections conducted pursuant to complaints filed pursuant to Section 1419, conduct at least two general inspections, and as many additional inspections as may be necessary, in every calendar year of all long-term health care facilities in the state without providing notice of such inspections.

1423. If upon inspection or investigation the director determines that a long-term health care facility is in violation of any statutory provision or rule or regulation relating to the operation or maintenance of such facility, except with respect to violations determined to have only a minimal relationship to safety or health pursuant to Section 1427, he shall promptly, but not later than one day after the date of inspection, issue a citation to the licensee. The citation shall be served upon the licensee personally or by registered mail in accordance with subdivision (c) of Section 11505 of the Government Code. A copy of the citation shall also be sent to each complainant. Each citation shall be in writing and shall describe with particularity the nature of the violation, including a reference to the statutory provision, standard, rule or regulation alleged to have been violated. The citation shall fix the earliest feasible time for the

elimination of the condition constituting the violation, where appropriate.

1424. Citations issued pursuant to this chapter shall be classified according to the nature of the violation and shall indicate the classification on the face thereof, as follows:

(a) Class "A" violations are violations which the state department determines present an imminent danger to the patients or guests of the long-term health care facility or a substantial probability that death or serious physical harm would result therefrom. A physical condition or one or more practices, means, methods, or operations in use in a long-term health care facility may constitute such a violation. The condition or practice constituting a class "A" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the state department, is required for correction. A class "A" violation is subject to a civil penalty in an amount not less than one thousand dollars (\$1,000) and not exceeding five thousand dollars (\$5,000) for each and every violation.

(b) Class "B" violations are violations which the state department determines have a direct or immediate relationship to the health, safety, or security of long-term health care facility patients, other than class "A" violations. A class "B" violation is subject to a civil penalty in an amount not less than fifty dollars (\$50) and not exceeding two hundred fifty dollars (\$250) for each and every violation. A citation for a class "B" violation shall specify the time within which the violation is required to be corrected. If a class "B" violation is corrected within the time specified, no civil penalty shall be imposed.

1425. Where a licensee has failed to correct a violation within the time specified in the citation, the state department shall assess the licensee a civil penalty in the amount of fifty dollars (\$50) for each day that such deficiency continues beyond the date specified for correction.

1426. After consultation with industry, professional, and consumer groups affected thereby, but not later than three months after the effective date of this chapter, the director shall publish proposed regulations setting forth the criteria and, where feasible, the specific acts that constitute class "A" and "B" violations under this chapter. Not later than six months after the effective date of this chapter, the director shall adopt regulations setting forth criteria and, where feasible, specific acts constituting class "A" and "B" violations. The regulations shall be adopted as prescribed in Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code, except that such regulations shall not be adopted as emergency regulations pursuant to subdivision (b) of Section 11421 of the Government Code and shall not mandate a quality of care or new procedures which were not required on January 1, 1974, without providing additional reimbursement if the change in quality of care or the new procedures entail substantial

new costs.

For purposes of this section, "new costs" shall not include costs which are the direct or indirect consequence of meeting the requirements of the citation system established under this chapter.

1427. The director shall prescribe procedures for the issuance of a notice of violation with respect to violations having only a minimal relationship to safety or health.

1428. (a) If a licensee desires to contest a citation or the proposed assessment of a civil penalty therefor, he shall within four business days after service of the citation notify the director in writing of his request for an informal conference with the designee of the director for the county in which the cited long-term health care facility is located. The director's designee shall hold, within four business days from the receipt of the request, an informal conference, at the conclusion of which he may affirm, modify, or dismiss the citation or proposed assessment of a civil penalty. If the director's designee modifies or dismisses the citation or proposed assessment of a civil penalty, he shall state with particularity in writing his reasons for such action, and shall immediately transmit a copy thereof to each party to the original complaint. If the licensee desires to contest a decision made after the informal conference, he shall inform the director in writing within four business days after he receives the decision by the director's designee. If the licensee fails to notify the director in writing that he intends to contest the citation or the proposed assessment of a civil penalty therefor or the decision made by a director's designee after an informal conference within the time specified in this subdivision, the citation or the proposed assessment of a civil penalty or the decision by a director's designee after an informal conference shall be deemed a final order of the state department and shall not be subject to further administrative review.

(b) A licensee may, in lieu of contesting a citation pursuant to this section, transmit to the department the minimum amount specified by law for each violation within four business days after the issuance of the citation.

(c) If a licensee notifies the director that he intends to contest a citation, the director shall immediately notify the Attorney General. Upon such notification, the Attorney General shall promptly take all appropriate action to enforce the citation and recover the civil penalty prescribed thereon, and shall take such other action as he shall deem appropriate, in the superior court of the county in which the long-term health care facility is located.

(d) In assessing the civil penalty for each count of violation, a court shall consider the nature of the violation and the seriousness of the effect of such violation upon the effectuation of the purposes and provisions of this chapter.

(e) The civil penalties authorized by this chapter shall be trebled for a second or subsequent violation occurring within any 12-month

period, if a citation was issued for the previous violation occurring within such period and a civil penalty was assessed therefor.

(f) Actions brought under the provisions of this chapter shall be set for trial at the earliest possible date and shall take precedence on the court calendar over all other cases except matters to which equal or superior precedence is specifically granted by law. The times for responsive pleadings and for hearings in any such proceedings shall be set by the judge of the court with the object of securing a decision as to such matters at the earliest possible time.

1429. (a) Each citation for a class "A" violation specified in subdivision (a) of Section 1424 which is issued pursuant to this section and which has become final, or a copy or copies thereof, shall be prominently posted, as prescribed in regulations issued by the director, until the violation is corrected to the satisfaction of the state department up to a maximum of 120 days. The citation or copy shall be posted in a place or places in plain view of the patients in the long-term health care facility, persons visiting those patients, and persons who inquire about placement in the facility.

(b) Each citation for class "A" and class "B" violations specified in subdivisions (a) and (b) of Section 1424 which is issued pursuant to this section and which has become final, or a copy or copies thereof, shall be retained by the licensee at the facility cited until the violation is corrected to the satisfaction of the department. Each such citation shall be made promptly available by the licensee for inspection or examination by any member of the public who so requests. In addition, every licensee shall post in a place or places in plain view of the patient in the long-term health care facility, persons visiting those patients, and persons who inquire about placement in the facility, a prominent notice informing such persons that copies of all final uncorrected violations issued by the department to the facility will be made promptly available by the licensee for inspection by any person who so requests.

1430. Except where the state department has taken action and the violations have been corrected to its satisfaction, any licensee who commits a class "A" or "B" violation may be enjoined from permitting the violation to continue or may be sued for civil damages within a court of competent jurisdiction. Such actions for injunction or civil damages, or both, may be prosecuted by the Attorney General in the name of the people of the State of California upon his own complaint or upon the complaint of any board, officer, person, corporation or association, or by any person acting for the interests of itself, its members or the general public. The amount of civil damages which may be recovered in an action brought pursuant to this section shall not exceed the maximum amount of civil penalties which could be assessed on account of the violation or violations.

The remedies specified in this section shall be in addition to any other remedy provided by law.

1431. It is a misdemeanor for any person to do any of the

following:

(a) Willfully prevent, interfere with, or attempt to impede in any way the work of any duly authorized representative of the state department in the lawful enforcement of any provision of this chapter.

(b) Willfully prevent or attempt to prevent any such representative from examining any relevant books or records in the conduct of his official duties under this chapter.

(c) Willfully prevent or interfere with any such representative in the preserving of evidence of any violation of any of the provisions of this chapter or of the rules and regulations promulgated under this chapter.

1432. (a) No licensee shall discriminate or retaliate in any manner against a patient or employee in its long-term health care facility on the basis or for the reason that such patient or employee or any other person has initiated or participated in any proceeding specified in this chapter. A licensee who violates this section is subject to a civil penalty of no more than five hundred dollars (\$500), to be assessed by the director and collected in the manner provided in Section 1430.

(b) Any attempt to expel a patient from a long-term health care facility, or any type of discriminatory treatment of a patient by whom, or upon whose behalf, a complaint has been submitted to the state department or any proceeding instituted under or related to this chapter within 120 days of the filing of the complaint or the institution of such action, shall raise a rebuttable presumption that such action was taken by the licensee in retaliation for the filing of the complaint.

(c) No licensee shall be cited for any violation caused by any person licensed pursuant to the State Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code) if such person is independent of and not connected with the licensee and the licensee shows that he has exercised reasonable care and diligence in notifying such persons of their duty to the patients in the licensee's long-term health care facility.

1433. The remedies provided by this chapter are cumulative, and shall not be construed as restricting any remedy, provisional or otherwise, provided by law for the benefit of any party, and no judgment under this chapter shall preclude any party from obtaining additional relief based upon the same facts.

1434. Commencing in 1974, the state department shall, on or before February 1 of each year, notify all public agencies which refer patients to long-term health care facilities of all of the long-term health care facilities in the area found upon inspection within the previous 12-month period to be without class "A" or "B" violations. Public agencies shall give priority to such long-term health care facilities in referring publicly assisted patients. No public agency

shall refer patients to long-term health care facilities with any uncorrected class "A" violations or five or more uncorrected class "B" violations, except those long-term health care facilities which the director may exempt because of a lack of facilities of the same type in the area sufficient to satisfy the demand for services provided by such type of facilities.

1435. The state department shall annually prepare and make available in all offices of the facilities licensing section a report listing all licensees by name and address, indicating (1) the number of citations and the nature of each citation issued to each licensee during the previous 12-month period and the status of any action taken pursuant to each citation, including penalties assessed, and (2) the nature and status of action taken with respect to each uncorrected violation for which a citation is outstanding.

1436. On or before July 1, 1974, the state department shall provide for additional and ongoing training for inspectors charged with implementation of this chapter in investigative techniques and standards relating to the quality of care provided by long-term health care facilities. The investigative-technique element of such training shall be adopted after consultation with the Department of Justice and such investigative training may, but need not, be provided through a contract with the Department of Justice.

1437. If a long-term health care facility has not been previously licensed pursuant to Chapter 2 (commencing with Section 1250), the state department may only provisionally license such facility as provided in this section. A provisional license to operate a long-term health care facility shall terminate six months from the date of issuance. Within 30 days of the termination of a provisional license, the state department shall give such facility a full and complete inspection, and, if the facility meets all applicable requirements for licensure, a regular license shall be issued. If the long-term health care facility does not meet the requirements for licensure but has made substantial progress towards meeting such requirements, as determined by the state department, the initial provisional license shall be renewed for six months. If the state department determines that there has not been substantial progress towards meeting licensure requirements at the time of the first full inspection provided by this section, or, if the state department determines upon its inspection made within 30 days of the termination of a renewed provisional license that there is lack of full compliance with such requirements, no further license shall be issued.

If an applicant for a provisional license to operate a long-term health care facility has been denied provisional licensing by the state department, he may contest such denial by filing a statement of issues, as provided in Section 11504 of the Government Code, and the proceedings to review such denial shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2 of the Government Code.

1438. On or before January 1, 1977, the state department shall review the effectiveness of the enforcement of the provisions of this chapter in maintaining the quality of care provided by long-term health care facilities and shall submit a report thereon to the Legislature together with any recommendations of the state department for additional legislation which it deems necessary to improve the enforcement of the provisions of this chapter or to enhance the quality of care provided by such facilities.

1439. Any writing received, owned, used, or retained by the state department in connection with the provisions of this chapter is a public record within the meaning of subdivision (d) of Section 6252 of the Government Code, and, as such, is open to public inspection pursuant to the provision of Sections 6253, 6256, 6257, and 6258 of the Government Code. However, the names of any persons contained in such records, except the names of duly authorized officers, employees, or agents of the state department conducting an investigation or inspection in response to a complaint filed pursuant to this chapter, shall not be open to public inspection and copies of such records provided for public inspection shall have such names deleted.

SEC. 2. There are no state-mandated local costs in this act that require reimbursement under Section 2164.3 of the Revenue and Taxation Code.

Wisconsin

MANUAL OF INSTRUCTIONS AND ADMINISTRATIVE PROCEDURES

SECTION OF HOSPITALS AND RELATED FACILITIES AND SERVICES, DIVISION OF HEALTH

SUBJECT: NURSING HOME ENFORCEMENT PROCEDURE

General Policies

1. All nursing home surveys and inspections shall be unannounced.
2. Surveyors shall use the forms provided by the central office and the accompanying instructions for employment of a magnetic tape selectric typewriter (MT/ST). This procedure will promote accuracy, speed and efficiency.
3. The rules in Chapter H 32 for nursing homes have been divided into (3) categories based upon their relative importance. Violations of rules in the categories have been designated as Type I Deficiencies, Type II Deficiencies and Type III Deficiencies with Type I Deficiencies the most serious.
4. (a) Type I Deficiencies will be followed by an immediate recommendation for injunction against any licensee, owner, operator or administrator of a nursing home to restrain and enjoin the repeated violation of any of the provisions of the nursing home law or administrative rules adopted by the Department of Health and Social Services where the violation affects the health, safety or welfare of the patients, or for other appropriate legal action and denial of payments without a grace period.
- (b) Type II Deficiencies will be followed by an immediate recommendation for denial of payments without a grace period. If, within 30 days following the date that denial of payments takes effect, corrective action has not been initiated or correction of all deficiencies has not been accomplished, a recommendation will be made for injunction proceedings or other appropriate legal action.
- (c) Type III Deficiencies will be followed by an order for correction; a plan of correction shall be submitted within 30 days. All deficiencies are to be corrected or in the process of correction within 60 days. If, on scheduled reinspection, all deficiencies have not been corrected or are not in the process of correction, an immediate recommendation will be made for denial of payments, injunction proceedings or other appropriate legal action.
5. Following a survey, each surveyor will complete and submit a form indicating the code number of Type I Deficiencies which he believes do and/or do not jeopardize the health, safety or welfare of the patients. This form will be signed by the surveyor. (See attached form R-1.*)
6. The classification of H 32 rules follows.*

*Retained in committee files.

APPENDIX 5

EXAMPLES OF COST SAVINGS ATTRIBUTABLE TO THE USE OF IN-HOME (AS OPPOSED TO) INSTITUTIONAL SERVICES*

MINNEAPOLIS AGE & OPPORTUNITY CENTER, INC.,
Minneapolis, Minn., April 17, 1974.

CASE NO. 1

Clients: Frank and Elizabeth P.
Ages: Frank (83); Elizabeth (72).
Income: \$320/month from pension alone.

Problem

Partial paralysis, urine incontinence, speech impairment. Nursing home placement versus home care.

Health

Client (Frank) suffered a stroke in early May 1973 leaving him partially paralyzed on his right side. Client is incontinent of urine, but not feces. His speech is impaired. Prognosis is fair to poor in regards to rehabilitation. Some therapy, minimal is required. Chances of client regaining much use of his right side are very slim. Client weighs approximately 120 lbs.

Client's wife (Elizabeth) health appears good. She has diabetes and this is under control through use of insulin. She seems to be strong and fit. Her emotional state is static due to fears that her husband will be taken from her and placed in a nursing home.

History

Frank and Elizabeth have been married for over 50 years. They had four sons. The youngest died from an accident suffered during an epileptic seizure while he was still a young man. Her oldest son lives in California. Another son died several years back in a car accident. The remaining son is partially disabled. He lives in the Twin Cities, but is physically unable to assist his parents.

Frank and Liz live in an older two-story wood structure in the near south side of Minneapolis. Their home is heated by two oil heaters—one in the dining room and one in the living room. Liz mentioned the need to use the oven and a small old wood burner in the kitchen during cold days of winter. They have two prize possessions—a parakeet named Chipper, and a 1954 DeSoto automobile that neither of them can drive any more. The bird has a large vocabulary and at times offers embarrassment to Frank and Liz because of some of the "dirty" words he uses.

*See "Barriers to Health Care for Older Americans," hearing, June 25, 1974 Special Committee on Aging, Subcommittee on Health of the Elderly.

Frank worked for the City of Minneapolis most of his life. Both have lived in the home since they were first married. Friends and neighbors that were close to them have long time since passed away or moved with two exceptions. The only relative they can rely on for some assistance is their disabled son's wife. She works to support her family and is available to them sometimes in the evenings.

Narrative

When Frank was ready to leave the hospital to be transferred to a nursing home on recommendation of his doctor, Mrs. P. requested Social Service to help her find some way to take Frank home so that she could care for him. The only agency in the Twin Cities able to handle this matter is coordinating services and delivery for adequate home care according to Liz Blood, MSW. was M.A.O. She told Mrs. P. that she would make a referral to M.A.O and they would help her.

A M.A.O. counselor was immediately assigned to this case to make an evaluation of the situation and to set up and coordinate a home care plan that would provide an alternative to nursing home placement for Frank P. While the rights and desires of the seniors involved was the main factor, cost analysis was also to be considered. Elizabeth and Frank P. were so close to eligibility for Medical Assistance, that this would take effect within one month of nursing home placement. Either way, some public funds would be used for care of Frank P.

A M.A.O. counselor met with Mrs. P to determine a "patient plan." It was decided that until the plan could be implemented, the counselor would come three times a week to assist Mrs. P. with her husband's personal care, and that a homemaker would also help her. Then the plan was implemented as follows:

1. M.A.O. handyman built a ramp and fixed the steps on their home to accommodate a wheelchair for Mr. P.
2. M.A.O. counselor assisted clients in obtaining medical assistance.
3. The M.A.O. counselor arranged for a patient lift from Courage Center to assist the client in and out of bed. This made it possible for Mrs. P. to handle and care for her husband without assistance and the M.A.O. counselor was no longer needed for this purpose.
4. Mrs. P. would handle the feeding, bathing, and cleaning of client.
5. A M.A.O. homemaker gave three services to the clients during the time of implementing the patient plan to help Mrs. P. "catch up" with the work left undone due to this emergency. When caught up, Mrs. P. managed.
6. After the above plan was implemented, Mrs. P. was independent of M.A.O. and able to take care of her husband for three months until he returned to the hospital where he died.

Cost effectiveness of this M.A.O. home care plan versus institutionalization

M.A.O. services provided for 3-month period :	<i>Cost</i>
Counseling (23) -----	\$230. 00
Homemaking (3) -----	11. 10
Handyman (1) -----	27. 75
Transportation of client to see husband in hospital (3) -----	10. 50
 Total cost of services (30) -----	 <u>1 279. 35</u>

¹ The lift was on loan without charge. If Mr. P. had lived longer, then some charge would have had to be arranged.

Nursing home costs for 3-month period :

Basic cost for 3 mo. care in a nursing home.....	1, 350. 00
Less Mr. P's pension of \$118 a month which would go toward the cost of his care.....	354. 00
Remaining cost to be paid by Medicaid.....	996. 00
Less cost of M.A.O. services.....	279. 35
Total	716. 65

Therefore, the care M.A.O. provided during this 3-month period saved the taxpayer \$716.65.

 CASE No. 2

Clients: Charles and Eva O.
 Ages: Charles (80), Eva (72).
 Income: \$214/month.

Problem

Mr. and Mrs. O. first came to M.A.O.'s attention in May, 1971. They were referred to M.A.O. by the Southside Community Center, with the information that the Medical Assistance worker at Hennepin County felt a nursing home was needed for both the O.'s because Mrs. O.'s brother was no longer willing to assist them.

An agency meeting was called. Representatives from M.A.O., Southside Center, Hennepin County Welfare, and Mrs. O.'s brother and niece met to determine how to best handle the O.'s case. All the above felt that the clients should be placed in a Nursing Home unless M.A.O. was willing to take on the responsibility for their care. The following problems were identified at that time:

1. Clients would need to move because Mrs. O.'s brother was selling the home where they were living.
2. Home delivered meals were necessary and homemaking services also might be needed, although Mr. O. was able to do a little around the house.
3. Volunteer services would be needed with an emphasis on friendly visitation.

Prior to implementing this plan, the O.'s doctor, Dr. Widen of the Bloomington-Lake clinic, was contacted to obtain his evaluation of client's ability to remain in independence. Despite the fact that Mrs. O. had been crippled most of her life and Mr. O. had dropsy and a heart condition, *Dr. Widen saw no reason why they could not remain independent with the aid of M.A.O. services.* Therefore, M.A.O. proceeded with the original plan and the following results:

1. With the assistance of a M.A.O. volunteer working with the M.A.O. counselor, inexpensive housing was found for them at 616 East 22nd Street where they could keep their dog. (Public Housing was refused by the clients because of their desire to keep the dog.) M.A.O. moved the clients.

2. M.A.O. counselor assisted in getting clients on Old Age Assistance
 3. M.A.O. home delivered meals were started and maintained on a permanent basis. (This also provided a daily check of the clients' situation.)

4. Home specialist services were refused by the clients, but the counselor made regular checks on their situation—approximately once a month, and at that time the counselor helped with anything the clients couldn't handle.

The O.'s were maintained with this plan from May, 1971, until Mrs. O.'s death on January 6, 1973, and Mr. O.'s hospitalization on March 6, 1973, and subsequent death.

Cost effectiveness of this M.A.O. home care plan versus institutionalization

M.A.O. Service from May 1971 to Mar. 6, 1973:

Meals—2 meals a day each, 7 days a week (including delivery charges) for Mr. O., May 1971 to March 1973 and Mrs. O., May 1971 to Jan. 6, 1973	\$3,295
Counseling services (time varying)—20	310
Volunteer services, percent of cost producing them—1972	86

Total cost of MAO services from May 1971 to March 1973	<u>3,691</u>
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Nursing home costs:

Mr. O.—22 months at \$450 a month	9,900
Mrs. O.—20 months at \$450 a month	9,000

Total	<u>18,000</u>
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Less pension of \$186 a month which would be applied toward Nursing Home costs (the O.'s would have been allowed \$14 each a month for personal needs)	4,092
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Remaining cost to be paid by Medicaid	<u>14,808</u>
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Less cost of M.A.O. services	<u>3,691</u>
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Total	<u>11,117</u>
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Therefore, the care M.A.O. provided during this time saved the taxpayer \$11,117.

CASE NO. 3

Clients: Martha and Matilda H.
 Ages: Martha (90); Matilda (92).
 Income: \$252.91/month (combined).

Problem

The clients first came to M.A.O.'s attention on February 28, 1974, when Martha was brought to the Abbott-Northwestern/M.A.O. Clinic on an emergency basis with congestion in her lungs. Martha also has some difficulties with her memory and is somewhat confused.

At the time of Martha's visit to the Abbott-Northwestern/M.A.O. Clinic, she was already in serious problems, because her sister, Matilda, had been hospitalized the previous week. Matilda took care of her sister, so that when Martha was treated and released ahead of her, she had no one to care for her at home.

Matilda's on-going medical problems consist of chronic bronchitis, numbness in the fingers, excessive tiredness, poor sight, difficulty hearing.

Their closest relative is a niece living in St. Paul.

Because of the on-going medical problems of both sisters, the doctors determined the prognosis for independence was poor without M.A.O. services.

Action taken

1. M.A.O. transportation as needed to the Abbott-Northwestern/M.A.O. Clinic.
2. On-going M.A.O. home delivered meals. The M.A.O. driver will check each day as to the condition of the sisters and report other needs as necessary.
3. Help in the home provided on an occasional basis by the niece and a friend.

Cost effectiveness of this M.A.O. home care plan versus institutionalization

M.A.O. services needed per month :

Meals—120 meals per month (including delivery charges), 2 meals a day, 7 days a week for both sisters-----	Cost \$180.00
Clinic visits—Average 2 Abbott-Northwestern/M.A.O. Clinic visits per month (no charge for clinic above Medicare, see Abbott-Northwestern/M.A.O. flyer)-----	
Transportation—Average 2 to Abbott-Northwestern/M.A.O. Clinic per month-----	6.80
Total cost of services-----	<u>186.80</u>

Basic cost of nursing home care per month :

\$450/month each-----	900.00
Less clients' income of \$202.91 (both sisters would be allowed to keep \$25 each per month for personal needs)-----	202.91
Remaining cost to be paid by Medicaid-----	697.09
Less cost of M.A.O. services-----	186.80
Total -----	<u>510.29</u>

Therefore, the ongoing care M.A.O. is providing is saving the taxpayer \$510.29 per month.

CASE No. 4

Client: Clara T.

Age: 78.

Income: \$170/month (Social Security).

Problem

Client is legally blind; has glaucoma and cataracts. Due to the fact that her apartment house was razed and the neighbor who cooked and cleaned for her moved away, the client was faced with need for assistance to remain in independence or Board and Care Home placement.

History

Client is legally blind. She remained in independence for nearly nine years through the help of a neighbor. When the apartment house was taken down in September 1973, the client contacted M.A.O. for assistance. She had raised two children working as a housekeeper in a local hospital. The children now live out of town. She did not want to lose her independence now. She was unable to do her own cooking and could not clean due to blindness and no mobility training. Her legs were patchy and inflamed at the time of initial contact.

Plan

A new apartment was immediately secured through M.A.O., and needed medical attention delivered through Abbott-Northwestern/M.A.O. clinic by which the client's Medicare was accepted as full payment (See Abbott-Northwestern/M.A.O. Newsletter). Client had been putting off medical attention for the inflammation of her legs because of high costs and fear of inability to meet the charges above Medicare.

The diagnosis for inflammation was phlebitis and shingles. The client was hospitalized for ten days, being discharged Oct. 11, 1973.

Because the client was unable to cook and clean, she was placed on meals and housekeeping services. Regular clinic follow-ups continued on monthly basis, checking on shingles and glaucoma and cataracts.

A volunteer was found by M.A.O. in her apartment building to assist the client with eye drops. Counseling was continued with the client to encourage further independence in the form of mobility training through State Services for the Blind, arranged for by the M.A.O. Counselor.

Some adjustment and emotional problems prolonged the period in which supportive services were necessary. This counseling was provided by M.A.O.

The Client is now independent of M.A.O. and has avoided being placed in a Home. The Client also knows, should she need M.A.O. in the future, that we would help as needed.

Cost effectiveness of this M.A.O. home care plan versus institutionalization

M.A.O. services provided over a 6-month period :	Cost
Meals (including delivery charges) 2 meals a day, 7 days a week...	\$90. 00
Housekeeping (6)	44. 40
Volunteer services, including friendly visiting for emotional support (5) cost of producing services	2. 50
Counseling (10)	90. 80
Total cost of services	<u>227. 70</u>
Basic cost of board and care home for 6-month period :	
6 months at \$250 a month	1, 500. 00
Less clients' income of \$145/month for 6 months (client would be allowed to keep \$25 a month for personal needs)	870. 00
Remaining cost to be paid by Medicaid	630. 00
Less cost of M.A.O. services	227. 70
Total	<u>402. 30</u>

Therefore, the care M.A.O. provided during this 6-month period saved the taxpayer \$402.30.

On-going monthly saving

The above costs do not reflect the fact that because M.A.O. services enabled this client to become independent of M.A.O., and kept out of a Board and Care Home, the current on-going savings to the taxpayer per month is \$105.

CASE NO. 5

Clients : Benjamin and Lucy R.
 Ages : Benjamin (69) ; Lucy (64).
 Income : \$240/month from SS-AD (no savings).

Problem

Ben has a severe diabetic condition and uses a cane for walking assistance. His sight is fair. Lucy is obese and also needs a cane for walking assistance.

History

Their medical condition necessitates assistance in cleaning, as well as transportation for grocery shopping and medical appointments. Minneapolis Housing and Redevelopment Authority Evaluation of clients' living situation indicated that without M.A.O. housekeeping help, as well as M.A.O. transportation, Nursing Home placement would have been necessary.

Plan

Housekeeping was arranged for clients on a weekly basis to safeguard independence and fulfill cleaning needs. Transportation for grocery shopping was arranged on bi-weekly basis and for medical appointments as needed.

Prognosis

With M.A.O. services, clients' ability to remain in independence has been secured and has kept these clients out of a Nursing Home. Minneapolis Housing and Redevelopment Authority follow-up evaluation has confirmed this fact, that on-going M.A.O. services are needed to maintain them in independence.

Cost effectiveness of this M.A.O. home care plan versus institutionalization

	<i>Cost</i>
M.A.O. services needed per month :	
Housekeeping (2) -----	¹ \$29. 60
Transportation, for grocery shopping and doctor appointments (4) -	14. 00
Counseling (1) -----	9. 00
 Total cost of services -----	 <u>52. 60</u>
 Basic cost of nursing home care per month :	
\$450 a month for each -----	900. 00
Less clients' income of \$190/month (both clients would be allowed to keep \$25 each for personal needs) -----	190. 00
 Remaining cost to be paid by medicaid -----	 710. 00
Less cost of M.A.O. services -----	52. 60
 Total -----	 <u>657. 40</u>

¹ It should be noted that in the first month's services given to these clients, M.A.O. chore services were needed to clean the heavy filth that had accumulated at an additional cost the first month of \$14.88. Since then, his services have not been needed and the home-makers have maintained the cleanliness of the apartment and any personal care they have needed. Therefore, we did not include this cost as on-going.

Therefore, the on-going care M.A.O. is providing is saving the taxpayer \$657.40 per month.

CASE No. 6

Client: Emma B.
 Age: 69.
 Income: \$124/month.

Problem

Client had severe Parkinson's disease.

1. Her doctor determined that in order for her to live in independence, M.A.O. would have to commit services.

2. If M.A.O. would commit services immediately, the doctor would permit her to leave the hospital. Otherwise he intended to keep her in the hospital another four days.

Action taken

Services were immediately provided, consisting of: (1) M.A.O. meals in the home; (2) regular counseling because of client's nervous condition because of the drug she was taking, her fear of death and nursing home placement; and, (3) M.A.O. volunteer provided transportation to her doctor, as his office was outside Minneapolis.

Cost effectiveness of client's discharge from hospital 4 days early

	<i>Cost</i>
Cost of maintaining client in hospital for 4 days at \$119/day.....	\$476
Less cost of M.A.O. meals (2 meals a day for 4 days) \$12; cost of M.A.O. counseling services (3) \$15.....	27
Savings to taxpayers.....	449

Cost effectiveness of this M.A.O. home care plan versus institutionalization

M.A.O. services needed per month:

Meals (including delivery charges) 60 meals, 2 meals a day, 7 days a week	\$90
Counseling, average 4/month.....	32
Volunteer transportation services to doctor, average 2/month, cost of producing this service.....	1
Total cost of services.....	123

Basic cost of nursing home care per month:

\$450 a month.....	450
Less client's income of \$99/month (client allowed to keep \$25 a month for personal needs).....	99
Remaining cost to be paid by Medicaid.....	351
Less cost of M.A.O. services.....	123
Total	228

Therefore, on-going care provided by M.A.O. is saving taxpayers \$228 per month.

CASE No. 7

Client: William F.

Age: 75.

Income: Currently \$129.20/monthly (after M.A.O.'s intervention, see history).

Problem

The Client was a patient in a Nursing Home who signed himself out in July, 1973 against his doctor's orders.

At the time of his release, the client's income was \$78.20 per month from Social Security.

The Client's caretaker referred this case to M.A.O. because he felt the client would not be able to remain in independence without M.A.O. services, but would have to return to the Nursing Home.

The Client is a shut-in due to a back injury that he received by falling off a ladder when he worked as a house painter. He has little control of his legs, but can walk in his apartment with a cane.

Action taken

After the M.A.O. Counselor's visit: (1) M.A.O. home delivered meals began July 25, 1973; (2) Old Age Assistance application was made with M.A.O. Counselor's assistance and became effective August 13, 1973, adding \$51 to his income; and (3) Food Stamps applied for with M.A.O. Counselor's assistance and became effective September 1, 1973. Client pays \$1 a day towards his M.A.O. meals in food stamps. (M.A.O. is certified to handle food stamps.)

Prognosis

Client will be a permanent meals client, with occasional checks on his situation.

Home care services and transportation are handled by a volunteer.

Client refuses to see a doctor at this time, but the M.A.O. counselor has made him aware of the Abbott-Northwestern/M.A.O. Clinic should he need it.

Cost effectiveness of this M.A.O. home care plan versus institutionalization

M.A.O. services needed per month:

Meals (including delivery charges) 60 (2 meals a day, 7 days a week) -----	Cost \$90.00
Less food stamps paid by client -----	30.00
Subtotal -----	60.00
Counseling (1) -----	7.50
Volunteer services providing transportation and home care, percent of cost producing them (15) -----	7.50
Total cost of services -----	<u>75.00</u>

Basic cost of nursing home care per month:

\$450 a month -----	450.00
Less Mr. F.'s income of \$104.20 a month (Mr. F. would be allowed to keep \$25/month for personal needs) -----	104.20
Remaining cost to be paid by Medicaid -----	345.80
Less cost of M.A.O. services -----	75.00
Total -----	<u>270.80</u>

Therefore, the care M.A.O. is providing is saving the taxpayer \$270.80 a month.

CASE NO. 8

Client: Mildred R.

Age: 64.

Income: \$140/month SS-SSI.

Problem

Client spends most of her time in a wheelchair. She has multiple sclerosis and gall bladder problems. She is unable to walk, prepare food and clean house.

Action taken

On reviewal of this case, the counselor recommended: (1) Home delivered meals; (2) Housekeeping; and (3) Voluntary action for social functions at Courage Center handicapped socials to relieve isolation problems.

The above services have been provided for three years.

Prognosis

With M.A.O. services, client is able to remain in independence, receiving meals and occasional housekeeping. Obviously without M.A.O. services, this client would have to be in a Nursing Home.

Cost effectiveness of this M.A.O. home care plan versus institutionalization

M.A.O. services provided for 3-year period :

Meals (including delivery charges) 3 years (2 meals a day, 7 days a week)-----	Cost
Housekeeping, 3 years (3 services a month)-----	\$5, 525. 00
Counseling, 3 years (average 1 a month)-----	399. 60
	324. 00
Total cost of services-----	4, 008. 60

Nursing home costs for 3-year period :

\$450 a month for 3 years-----	16, 200. 00
Less client's income of \$115/month for 3 years (client would be allowed to keep \$25 a month for personal needs)-----	4, 140. 00
Remaining cost to be paid by Medicaid-----	12, 060. 00
Less cost of M.A.O. services-----	4, 008. 60
Total-----	8, 051. 40

Therefore, the care M.A.O. provided this client for 3 years saved the taxpayer \$8,051.40.

On-going monthly services

In addition to the above savings to the taxpayer provided over the last three years, because M.A.O. is continuing to serve this client, there will be an on-going monthly saving to the taxpayer of \$233.65.

APRIL 22, 1974.

Subject: Legal Services for Senior Citizens.

From: Joe Wolkowicz, Attorney, M.A.O.

To: Daphne H. Krause.

I have been employed at the Minneapolis Age and Opportunity Center, Inc. (M.A.O.) for 14 months, providing legal services to our Senior Citizens clients. During that time I have formulated the conclusion that any agency, such as M.A.O., attempting to provide comprehensive services to the Elderly cannot effectively do so without employing an attorney on its staff.

My conclusion is premised on the fact that Seniors have particular legal needs, they require highly specialized attention and communication. There is no doubt there is insufficient, and inadequate legal representation for this segment of our population. In short, the legal profession, state and federal governments, social service agencies, must recognize the Elderly's needs for legal representation and provide for the funds and mechanism that will allow the attorneys to specialize in this area.

As a result of our program and work at M.A.O. this specialization has been acknowledged in our community. The attorney receives many inquiries and referrals from religious groups, churches and social service agencies such as Hennepin County Welfare and Adult Services on a daily basis. Moreover the Minneapolis Legal Aid Society refer numerous Seniors to our legal department.

Finally, the attorney receives numerous inquiries from other local attorneys inquiring about what techniques, procedures, legal strategy they should utilize in handling particular Senior problems.

The legal component of M.A.O. is engaged in broad and diverse legal areas. The attorney deals in probate, consumer problems, landlord-tenant problems, housing, and family law. He is also called upon to represent Seniors before administrative hearings involving Medicare, Medicaid, and Social Security issues. These latter areas are especially important to Seniors because they affect their lives most directly and many local attorneys refuse to take these cases for a number of reasons.

The Seniors also need an attorney readily available to them in order to explain and clarify the governmental forms that deluge them daily, to advocate and communicate their intent and desires to businessmen, salespeople and others with whom they deal and as a resource person to assist them to find immediate practical solutions to their daily problems.

Perhaps, the most important and heartbreaking area that our legal component is involved in is protecting Senior Citizens from unwarranted guardianship proceedings. These proceedings originate from such various sources as the welfare department, family members and doctors. These parties may feel the Senior is being difficult, recalcitrant, and obstinate in refusing to recognize what they may deem as "beneficial" for the Senior. Seniors are especially sensitive to these proceedings because of the tremendous emotional and social stigma that is attached, and because it results in the loss of their social-political civil rights and liberties. Most of all because it signals the clear demise of their independence and dignity. It is vital and imperative that Seniors possess confidence and self-assurance in an agency and its attorney, when seeking his advice and representation in these matters, with full knowledge that the attorney will deal with these matters from their perspective.

One of the unique and important aspects of M.A.O. is that it was established to provide comprehensive services to Senior Citizens; i.e. it has an attorney, social workers, transportation, homemakers, health, drug and alcohol dependency and emotional counselors, and others all on the same staff all under one roof and easily accessible to each other.

The benefits of this arrangement cannot be over-emphasized. It allows staff members to discuss the full social and legal implications and ramifications of a course of conduct on the client and others before implementing it.

Secondly, the arrangement permits staff members to refer their client's legal problems directly to the attorney.

Finally, the arrangement permits the attorney to immediately refer non-legal related problems to appropriate staff members within the agency. The benefit of the M.A.O. program is that it commands virtually all resources to handle the Seniors efficiently, expediently and competently. The concomitant benefit to the Senior is that he has all the services in one agency and thus avoids the problems of contact-

ing or engaging other agencies scattered throughout the city, with its consequent problems of obtaining transportation, and overcoming unnecessary "bureaucratic red-tape".

In this brief memo I have attempted to demonstrate the importance and necessity of providing an attorney in any program attempting to bring comprehensive services to Seniors. In my opinion, there are persuasive arguments concerning the need of programs similar in organization and purpose as M.A.O. In my opinion and experience there are persuasive arguments for the training and funding of attorneys who are willing to specialize in providing legal services for the Elderly in this type of a social service agency.

Finally, our experiences at M.A.O. clearly demonstrate that the inter-relationship of these services and disciplines have a positive and beneficial effect on the Senior Citizens and the staff in order to assure the Seniors, their dignity, independence and protection.

JOE WOLKOWICZ,
Attorney, M.A.O.

ANECDOTES

Case of Agnes Krezowski.—This is an 83-year old woman who contacted me for legal assistance. She informed me that her five children had petitioned the court for guardianship over her and her husband. Apparently, the husband had severely deteriorated both physically and mentally and was in need of a guardian. The children wanted to institutionalize both parties.

An M.A.O. counsellor and myself went to interview the client. We found her to be alert, lucid and in complete control of her faculties. Her home was immaculate, her personal hygiene was good, and she was preparing her own meals. In short, she was perfectly capable, she had the ability and the willingness to live in independence. The children had taken her savings and checking books away from her. They were giving her small amounts of money to live on. The children were complaining about the life style of their mother. They felt she would be better off in a nursing home.

Through the involvement of our agency, we had the guardianship against the mother dismissed. We also got a division of her property and the children returned \$10,000 to her. Finally, the mother continues to live in independence and in the manner she prefers. In short, without M.A.O.'s involvement, she would be in a nursing home and under guardianship.

Case of Jean Townsend.—Miss Townsend has a severe medical problem and was unable to work. She attempted to be certified disabled for Social Security purposes in 1969. She attempted to get several attorneys to represent her and all of them turned her down.

She then took her case to the Legal Aid Society. They represented her at the hearing and lost. They refused to appeal her case on the grounds they deemed it hopeless.

She came to M.A.O. for assistance. After losing the appeal, we took the case to Federal District Court. The court remanded the case back to Social Security. I represented her at the new hearing and won. The Senior was awarded retroactive benefits which amounted to \$4,000.00.

She admitted to me that the M.A.O. attorney was her last resort and if we didn't take the case, she would have been forced to drop her case.

Case of Ann Blais.—This Senior came to seek assistance against another attorney. The attorney had represented her husband in a Workmen's Compensation claim in 1967. Her husband died in 1971. The attorney settled the case in 1969, but he never contacted them about the settlement.

I went to the Workmen's compensation commission and reviewed the records. I discovered that the husband had been awarded compensation in the amount of \$900.00. Further investigation revealed that the check was sent to the attorney in 1969 and it was never negotiated.

I wrote to the attorney several times and he ignored my letters. I was then forced to bring a complaint before the Ethics Committee. The attorney finally sent us the check and we then asked the insurance company to reissue a new draft in her name. The senior was now enjoying the \$900.00. She lives in a high-rise and her only income is Social Security. Needless to say, she certainly could use the money.

APPENDIX 6

[From the Sunday Star, Washington, D.C., Dec. 26, 1971]

HOW A NURSING HOME POLICY SPRANG FORTH*

(By J. F. terHorst)

Like a mighty oak that springs from a stray acorn, Presidential policy may result from a paragraph dubbed into a speech at the last moment.

That, at least in the opinion of a White House staffer who should know, was the genesis of the Nixon administration's nursing homes for the elderly.

The story began early in June when President Nixon's staff was alerted to his intention to go into the Midwest and make a few speeches and shake a lot of hands.

As preparations commenced backstage, the speech-writing team was instructed to come up with several thousand well-chosen words which Nixon could use to enthuse a combined convention of the National Retired Teachers Association and the American Association of Retired Persons in Chicago on June 25.

THREE MILLION MEMBERS

The two groups have a membership of 3 million, a respectable slice of the nearly 20 million Americans over 65.

Several drafts were prepared, touching all the key points of elderly concerns—Social security, pensions, recreation, housing, medical care and the like. But every draft contained one glaring omission. The Office of Management and Budget, it seems, hadn't ever come up with an authorized Nixon policy on nursing home care. The speechwriters, naturally, didn't quite know how to deal with the subject, so each draft of the Nixon speech traveled around the upper staff levels of the White House with a note on nursing homes: "To be inserted later."

In time, time itself ran out. The OMB hadn't come through with a policy and Nixon had a zillion other things on his mind. (That was the period of the Pentagon Papers episode.)

Finally, the President's day of departure for the Midwest was at hand. He and key staffers, followed by the press, took off.

But a funny thing happened on the way to Chicago.

Several top Nixon aides, knowing how keenly the President felt about the well-being of older people, delegated a traveling speechwriter to come up quickly with appropriate remarks which Nixon might use in his speech.

POLICY IS MADE

And so Nixon came to say, before the big Chicago convention, that nursing homes too often were "warehouses for the unwanted—dumping grounds for the dying."

*For additional discussion of origins of this presidential policy, see pp. 92-105.

The President visibly winced at his own rhetoric, according to one White House aide. Not that it wasn't true, but only that having said it, he couldn't merely let it go at that. So Nixon ad-libbed a few lines to explain what he was going to do about the horrible things he had just said about some nursing homes. And it was in that context that the President made policy.

OMB CATCHES IT

He said the nursing home problem would get "particular attention" from the White House Conference on Aging, this fall, and he added: "One thing you can be sure, I do not believe that Medicaid and Medicare funds should get to substandard nursing homes in this country and subsidize them."

By the time the President got back to Washington, the OMB, by some miraculous means, had come up with a policy on nursing homes identical with Nixon's rhetoric in Chicago.

There's no clue that the Conference on Aging ever gave the problem the high priority Nixon had promised, though there's a possibility that it is included in the vague "minimum quality standards" the conference report talks about on page 58 of its 176-page document regarding Federal services for the elderly.

But no need to worry. A conference official says the final report won't be ready until next spring and he's sure it'll be amply covered then.

NURSING HOMES AND POLITICS

(Introduction from New York: Today Washington Editor Bill Monroe has obtained a copy of a memorandum that was not supposed to leak outside of government. It involves nursing homes and politics. Bill is in our Washington studio with a Byline report.)

Elliot Richardson, the Secretary of Health, Education, and Welfare, sent a private memorandum to President Nixon in July listing five different proposals for government action to improve nursing homes. On August 6th the President visited a New Hampshire nursing home and came out for plan number five, which Richardson had recommended, including more federal training and funding of state nursing home inspectors and consolidation of all federal nursing home activities under HEW.

But there was one thing in the *private* memorandum from Richardson to the President that did *not* come out in the *public* announcement—the political factor. Three times in his private message the Secretary of Health, Education and Welfare specifically mentioned politics.

Under his Option Two, involving a *study* of nursing homes but no immediate *action*, Richardson listed one of the advantages like this, "The delay in action may yield a political success at a possibly more appropriate time." The Secretary may have been thinking here about 1972 as a better political moment for real action.

Under *disadvantages* of the same plan, he said, "There is a definite risk that such a statement will be received as 'another study,' another delay in action. We would be faced with the political cost of failing to assume the initiative in an area which has such significant political potential."

Under Option Five, the plan actually accepted by Mr. Nixon, Richardson told the President that this plan could achieve measurable improvements in nursing home care . . . and he went on to list five advantages, concluding, "This program would be sufficient to give the Administration the initiative in this politically sensitive field and enable us to be on the offensive rather than reacting defensively to continuing criticism."

By Washington standards, all of this may amount to more of a footnote than a revelation. It's assumed here that officials at least consider the political implications of anything they do. And Secretary Richardson did argue for the health merits of his recommended nursing home plan ahead of its political advantages. But officials don't usually admit they think of policy and politics at the same time. In this case, documented: the politics of nursing homes.

BILL MONROE,
NBC News, Washington.

APPENDIX 7

CONFIDENTIAL MEMORANDUM TO PRESIDENT NIXON FROM HEW SECRETARY ELLIOT RICHARDSON: RE: NURSING HOME "REFORMS"

MEMORANDUM FOR THE PRESIDENT

JULY 16, 1971.

Attached is a decision paper dealing with issues involving nursing home care reforms.

The options presented are designed to be responsive to your statement of June 25 that you "do not believe that Medicare and Medicaid funds should go to substandard nursing homes in this country and subsidize them."

We have had the valuable assistance of Leonard Garment and Arthur Flemming in preparing this paper; but the responsibility for the product is this Department's.

I agree with the attached recommendations that you propose an expansion of programs designed to enforce strictly cost and quality standards for nursing homes.

I believe that these proposals effectively provide a mix of proper incentives to the States. The resulting State actions should achieve higher quality care through enforcement of standards.

In my opinion proposals along these lines would dramatically demonstrate this Administration's responsiveness to the needs of older Americans. Such actions would be enthusiastically received by the majority of older citizens and by the major organizations representing older people.

ELLIOT L. RICHARDSON.

JULY 16, 1971.

MEMORANDUM

Subject: Enforcement of Nursing Home Standards.

In your speech Friday, June 25, 1971, in Chicago, before the Joint Conference of National Retired Teachers Association and American Association of Retired Persons, you emphasized your concern with the conditions of the more than 900,000 persons over 65 who live in nursing homes. You deplored the degrading and depressing conditions in substandard nursing homes and assured the Nation of our determination that Medicare and Medicaid funds would not go to sub-standard homes and would not subsidize them. Reaction to these remarks has been highly favorable.

I plan to issue a press release describing the many small but positive steps which HEW has recently undertaken to implement our resolve in this area. I will also be describing some further actions which we

are contemplating. It is apparent that such activities are not considered as the bold, new measures which are required to meet the challenge presented by the problems of the aging in long-term facilities. At this time we appear to be falling short of the pledge that "Federal, State and local governments, working together with the private sector, can do much to transform the nursing home . . . into an inspiring symbol of comfort and hope."

The problem

About 20 million citizens in this country are aged 65 years or older. It is estimated that about five percent of this elderly population cannot live in their own homes or must receive personal support in daily living. In fiscal year 1970, 922,500 people were served by over 7,000 skilled nursing homes or extended care facilities through the Medicaid and Medicare programs.

In 1970 the Federal Government contributed over one billion dollars for long term care in those institutions through Medicare, Medicaid, and other public programs. State and local governments spent another \$700 million and private expenditures exceeded \$900 million. The total size of the "nursing home industry" is thus close to \$2.6 billion. These expenditures generally were undertaken because the institutional care was part of a medical care and treatment program.

Many of these long-term care institutions are deficient in terms of safety and health—they pose fire hazards, unsanitary conditions or neglectful concern with their residents.

In May, 1971, GAO issued a report on the enforcement of Medicaid and Medicare standards in 90 nursing homes in Oklahoma, New York, and Michigan. Serious deficiencies were found in more than 50 percent of these homes. For example, 48 of the 90 homes lacked adequate nursing staff; 47 did not have adequate physician attendance; and 44 did not meet fire safety standards. All of these homes had Medicaid patients and many were approved for Medicare.

The options

It should be noted that the following options are not mutually exclusive.

OPTION 1

The clearest and simplest option available to us is a continuation of the current situation. The decision to introduce no change in Federal posture in this situation is, of course, not one which can be supported for a long time. The conditions which exist will contribute to mounting political pressure for change generated by the aged, their relatives and concerned citizens in general.

Considerations for

1. No additional allocation of Federal personnel and no additional administrative costs to Federal programs would be involved.

Considerations against

1. The decision to support the status quo is fraught with the danger that scandals and exposes of inadequate care and facilities in these homes will continue and increase with ensuing distrust of Administration programs and intentions. Since about 40 percent of the funds going

into these homes are Federal dollars, and the statutes clearly establish the Federal responsibility to assure that these funds go to services meeting standards, then disgraces in these homes may well lead to accusations of Federal non-feasance. We have already seen instances of such charges in studies by the Senate Committee on Aging, the Senate Finance Committee and by Ralph Nader.

2. The implications of this choice are that we recognize that the violations of standards will probably continue in Medicare and Medicaid homes, but that we are unable or unwilling to do anything about it. Enforcement deficiencies, as those described above, will undoubtedly continue and if "crime in the nursing homes" appears to be acceptable, will inevitably enlarge.

3. The pressures that mount for change may be difficult to channel. They could well take the form of pressures for enlarged Federalization of the costs and supervision of these homes.

OPTION 2

Publicly direct the Secretary to undertake a comprehensive review of nursing homes and extended care facilities.

Considerations for

1. The successfully completed study would provide us with much needed information on the extent of the violations in the nursing homes and more precise estimates of any possible cost implications of making the required improvements in facilities and services. We would have a firmer base for proceeding with subsequent remedial measures.

2. The delay in action may yield a political success at a possibly more appropriate time.

Considerations against

1. There is a definite risk that such a statement will be received as "another study;" another delay in action. We would be faced with the political cost of failing to assume the initiative in an area which has such significant political potential.

2. Certainly, until the study is completed and further action taken, we would be faced with all of the negative implications of Option 1: continued violations of standards, inadequacies of care and continued neglect of many thousands of helpless aged citizens.

OPTION 3

Expand Federal training of State inspectors to provide 2,000 trained State personnel for surveillance and enforcement purposes. The Federal cost of this project would be about three million dollars over an eighteen month period. . .

Considerations for

1. The announcement of this program would represent a Federal response to standards enforcement problems which, at the same time, recognizes and underscores the role of State agencies.

2. The number and qualifications of State and local personnel engaged in inspecting nursing homes are generally acknowledged to be insufficient, and this program responds directly to that practical problem.

Considerations against

1. It is highly probable, however, that under current conditions the training projects alone would encounter State resistance. The employment of the trained personnel and the increased level of enforcement activity would involve additional incremental costs to States which many would be unwilling or unable to undertake.

2. Unless coupled with measures to relieve the added burden on State budgets of supporting the survey teams, it may be impossible to realize the benefits of the training program.

OPTION 4

Undertake a large scale Federal program to train State nursing home inspection personnel as described in Option 3 and at the same time request Congress to amend title XIX of the Social Security Act to authorize reimbursement to States of 100 percent of the costs of inspection and enforcement activities on behalf of the Medicaid program. (States are required to provide from 25 to 50 percent matching funds for Medicaid surveys. States are reimbursed 100 percent for Medicare surveys.)

Consideration for

1. In combination, the Federal financial support of the development of the surveyors and the costs of operating the surveys will contribute to the required improvement in the States' abilities to determine the adequacy of the care provided in these long-term care institutions and to apply Federal quality standards.

2. The approach retains an appropriate degree of emphasis on the role of State agencies in the regulation of nursing homes within the States while providing that the costs incurred by States in surveying the homes in the light of Federal standards, will be borne by Federal funds.

3. While making possible improvement in the integrity of administration of Federal program requirements in the short run, it will also significantly upgrade the capacity of State authorities to regulate in this field.

Considerations against

1. A risk does exist that the systemic factors which have contributed to the lack of enforcement will continue to operate. It is conceivable that the recognition of the deplorable state of many homes will engender fears among State legislators and other officials that improvements in standards will require sizeable increases in costs to the State. In any event, the States certainly would be subject to increased pressures for higher payments to nursing homes as a result of stepped up enforcement of standards.

2. In the absence of solid backing from the Federal level these anxieties could result in Option 4 becoming an expensive way to achieve little more than the "do nothing" policy of Option 1.

OPTION 5

This option consists of a balanced program of increased Federal activity as well as increased assistance to States in carrying out their responsibilities with respect to Federal nursing home standards.

It combines Options 2 and 4 and adds a major Federal administrative effort. In summary, Option 5 consists of the following elements:

A. Establish a nursing home standards enforcement program in HEW which would coordinate the various elements in the Department concerned with the problem into a concerted effort to enforce over State operations for which the Federal Government is clearly responsible and to give necessary backing to State efforts.

B. Expand Federal training of State inspectors to provide over an eighteen month period 2,000 trained State personnel for surveillance and enforcement purposes.

C. Request statutory authority for the Federal Government to assume the entire cost of the operations of State inspection teams, rather than the 50 to 75 percent as the Medicaid law now provides.

D. Publicly direct the Secretary of HEW to undertake a comprehensive review of nursing and extended care facilities, standards and practices, and to recommend appropriate additional remedial measures to assure proper high quality care.

Considerations for

1. The announcement of this full program would be an appropriately dramatic and credible follow-up to the policy which you enunciated in Chicago.

2. This balanced effort, which would simultaneously increase both Federal and State capability, can be effective in achieving measurable improvements in the nursing home care of beneficiaries of Federal programs and is consistent with your reference to "Federal, State, and local governments working together . . ." toward this objective.

3. The integrity of present Federal laws and regulations is involved in this matter, and an effort of this magnitude is minimally required if Federal administration is to assure that these laws are faithfully executed.

4. The addition of both Federal and State capability would enable us immediately to improve the enforcement of present laws and regulations and at the same time build a base for following through on the findings of the Secretary's full-scale review of nursing homes.

5. This program would be sufficient to give the Administration the initiative in this politically sensitive field and enable us to be on the offensive rather than reacting defensively to continuing criticism.

Considerations against

1. A truly effective program of standards enforcement in nursing homes could have the effect of increasing operating costs in nursing homes which would carry over into increased costs in the Medicare and Medicaid programs. Unfortunately, the deficiencies in our knowledge about nursing homes, the degree of their violation of standards, the costs of overcoming these inadequacies, and the cost. However, an effort to examine this question is made in the paper attached at TAB A.

RECOMMENDATION

The Secretary of HEW recommends that Option 5 be adopted. This Option proposes a program which I believe will move us considerably closer to fulfilling your pledge.

If the recommended Option is adopted, the immediate, direct Federal costs in fiscal year 1972 would be approximately 6 million dollars,

including the costs of 130 new Federal positions. The pay-off to the Federal and State governments in improved compliance with health and safety standards and to the nursing home patients (and families) in improved conditions is not measurable on the same scale—nor is the cost of our failure to implement our pledge to improve the lot of some five percent of our elderly population who must live in institutions.

DECISION

Approve recommendation ----- Disapprove ----- Other -----
 ELR,
 Secretary.

[Enclosure]

LONG-RUN COST IMPLICATIONS OF ENFORCEMENT OF FEDERAL
 NURSING HOME STANDARDS

ISSUE

If a vigorous program of enforcement is undertaken and skilled nursing homes generally are brought into conformity with minimum Federal standards, will this result in increased operating costs and, in turn, an increase in the total outlay of tax dollars for skilled nursing home care?

This question cannot be answered with certainty. Some analysts who have studied the contemporary nursing home scene closely are of the opinion that the widespread assumption that public payments to nursing homes are inadequate to sustain minimum standards is a myth which persists today with little or no validity. The preponderance of informed opinion outside the industry itself contends that present payment rates in a majority of States, especially the larger and more affluent States, are quiet sufficient to support a level of services exceeding Federal minimum requirements. However, these are opinions—educated judgments—and the studies necessary to document them have not been made.

One recent study which is unfortunate is an analysis of income, costs and profits in Connecticut commissioned by the Connecticut State Health Department. The study found that — percent of the patients in Connecticut nursing homes in 1970 were Medicaid patients and that in these homes profits as a percent of invested capital averaged 42.3 percent.¹ Average profit margins by classification of home were found to be as follows:

Nursing home classification :	<i>Profit as percent of invested capital</i>
A-1 -----	44.9
A-2 -----	35.3
A-3 -----	35.7
B -----	45.3
C -----	61.5
D -----	34.6

We suggest that the situation reflected in Connecticut is not atypical. The Connecticut licensure and inspection program is reputed to be above average. We do not know the intent to which these profits may

¹ From hearings of the Public Health and Safety Committee of the General Legislature of Connecticut, March 30, 1971.

have been increased by failures to meet standards, but the highest classifications (Class A homes) must be presumed to meet at least the Federal minimums.

The average Medicaid payment to nursing homes in Connecticut is \$339 per month. This is close to the median for all Medicaid States, ranking 23rd in the 49 jurisdictions. (Please see Table 1). Thus, in Connecticut, not notably a low cost State, nursing homes of a classification which may be presumed to meet or exceed all Federal minimums can realize profits averaging from 35 to 45 percent on the basis of a Medicaid payment which is equalled or exceeded by almost half the States.

The dramatic influx of new capital into the nursing home industry with the advent of Medicare and Medicaid as third party payers also suggests that the economics of the industry in Connecticut is not atypical. An industry which loses money on more than half its customers does not expand. An industry which shows above normal profit possibilities attracts capital.

A vigorous program of enforcement of minimum standards certainly will result in a great deal of agitation for increased payments. This agitation will be based largely on the mythology relating to rates and standards and State and Federal program administrators must be prepared to counter it with facts. This is one of the important reasons for the additional staff positions proposed in Option 5. A portion of these positions should be devoted to obtaining facts on nursing home operations, costs, and profits and assisting States in establishing rational bases for rate setting.

Average Medicaid payments in some States are obviously too low. Requirement of adherence to minimum standards will result in a legitimate, and probably demonstrable, need to increase payments in those States. For purposes of this analysis we have assumed that valid needs for increased rates may be revealed in States in which the average payment is less than \$300. Table II shows that the estimated increase in program cost, if the average payment were increased to that level in all States, would be \$51.6 million annually in total of which the Federal share would be \$32.1 million.

It should be emphasized that we are not predicting that increases in program costs in these amounts will occur. We offer these figures as an estimate of the upper limit of cost increases which could legitimately be attributed to a program of standards enforcement at a point in time at which the program has been successful in achieving universal compliance with minimum standards.

A more realistic expectation is that the actual and necessary increases will be less and assumed gradually over several years. However, it should be noted that the full cost impact amounts to only 3.4 percent of the amount Medicaid is now paying for nursing home care. This is a modest premium indeed for the sake of getting proper value from the one and a half billion tax dollars which are otherwise being spent and for the sake of faithfully executing the laws.

APPENDIX 8

MEMORANDUM FROM FAYE G. ABDELLAH, DIRECTOR, OFFICE OF NURSING HOME AFFAIRS, PHS, TO SPECIAL ASSISTANT UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, OCTOBER 22, 1974

Subject: Ratio of Patients to Personnel—A Limited Guide for Patient Staffing.*

The ratio of patients to personnel as a guide and an index to the amount of care available to patients is a crude index at best. But over and above, the ratio is not an indicator of quality of care.

Let me explain. The assumption is often made that the total time expressed in the ratio is time available for patient care. This is not necessarily true because ratios may or may not exclude from the total time activities spent on activities which are not patient care activities e.g. charting and doctors' rounds.

In addition, some ratios were merely accepted without critical study prior to adoption. For example, the ratio utilized in a number of hospitals in New York which were identified as providing good medical care were adopted by other institutions on this basis alone.

Another method that has been utilized to develop a patient/personnel ratio is that of identifying the "number of tasks" to be performed by nursing e.g. bed baths, enemas, injections, etc., and staff accordingly. Ratios based on the number of tasks to be performed leaves much to be desired because many patient needs are not met and patient care is often fragmented. This is due to two factors. First, patient teaching, communication and referrals are not included among the tasks and second, continuity of care is also lacking since the tasks are performed by different persons and the patient is not able to identify or relate to one person as "his nurse."

Ratios cannot answer all the questions pertaining to staffing since staffing is complex. There are many factors to be considered when staffing units in either acute or long term care units. These factors include: patient numbers and characteristics; staff competency and staff supervision; unit design; and logistic support to nursing service. For example, there is a difference between staffing based on 100.0 percent occupancy versus the needs of patients. In order to staff to meet patient needs, some institutions build on a basic staff or the minimum number of staff needed to operate a unit. Complementary personnel are added to the basic staff when indicated to provide the additional patient care required.

Further, the interrelationships among and between factors affecting staffing are not clearly understood. For example, hospitals with larger and more active medical staffs usually have higher occupancy rates. Indications are that with a greater proportion of specialists among the

*For additional discussion of this issue, see pp. 22-24.

active medical staff, the greater the proportion of non-nursing personnel among the hospital employees. This would be expected since specialists utilize a greater number and variety of ancillary medical workers than do nonspecialists. This may indicate a greater complexity with a greater number of coordinating, scheduling and preparatory procedures being delegated to nursing.

As has been mentioned, there are many factors pertaining to staffing that need to be considered. Many of these factors have and are being studied. No one single method e.g. patient/personnel ratios will provide the answer. The many questions that still remain need research to provide the answers.

FAYE G. ABDELLAH,
Assistant Surgeon General.

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APPENDIX 9

LETTER FROM SENATOR FRANK E. MOSS, CHAIRMAN, SUBCOMMITTEE ON LONG-TERM CARE; TO REPRESENTATIVE WILBUR D. MILLS, CHAIRMAN, HOUSE WAYS AND MEANS COMMITTEE, AUGUST 15, 1974

DEAR WILBUR: As we begin to see the broad outlines of a compromise National Health Insurance bill emerging, I wanted to write and urge your special consideration for the health and especially the long-term care needs of older Americans.

As chairman of the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging since 1963, I can tell you that these needs are critical. My Subcommittee has just completed a massive study of this problem based on 22 hearings since July 1969, and more than 3,000 pages of testimony. Our forthcoming Subcommittee Report will detail the chronicle of government insensitivity to the unmet needs of one out of five older Americans.

I. THE NEED

In the context specifically of long-term care, a June 21, 1974, working paper by Burton D. Dunlap of the Urban Institute projects (I think correctly) that some 3 million older Americans require some degree of long-term care from personal care to 24-hour a day skilled nursing. Subtracting 1.1 million, those whose needs are not purely medical, i.e., those who need help with meal services and the minimum supervision found in congregate living facilities, leaves *1.4 million who require home health services, and 600,000 as the unmet need for nursing home care.*

Few older Americans can afford the care they need

There is no question but that the great majority of our senior citizens cannot afford the care they need. Few can afford the services of a home health nurse at \$3.50 or more an hour. Still fewer can afford nursing home care which averages \$625.00 per month as compared to the \$310.00 in income received monthly by the average retired couple.

II. CURRENT PROGRAMS ARE OF LITTLE HELP

As the 1970 Task Force Report on Medicaid and Related problems noted: "Long-term care is a neglected and underdeveloped area. Medicare and Medicaid are not efficient and effective mechanism for dealing with the problem."

A. Medicare

Medicare authorizes coverage for home health care under both Part A and B of Medicare and skilled nursing home care under Part A but these services are of little help to older Americans.

Home health.—According to the July 9, 1974, audit by the U.S. General Accounting Office, home health expenditures declined from \$115 million in fiscal year 1970 to about \$75 million in fiscal year 1973. Clearly, home health expenditures constitute far less than one percent of Medicare's \$12 billion total outlays.

Nursing home care.—The latest statistics from the Social Security Administration indicate that Medicare pays only 6.5 percent of the nation's total nursing home bill or about \$200 million. Some time ago Mr. Art Hess, Deputy Commissioner of Social Security Administration, told my Subcommittee that only 70,000 individuals on any given day out of the one million patients in U.S. nursing homes have their care paid for by Medicare.

Why Medicare is of so little help

In both the home health and the nursing home context reimbursement under the Medicare program is limited to individuals who require and qualify for the intense nursing attention known as "skilled nursing care." According to Mr. Thomas Tierney, Director of the Bureau of Health Insurance, the removal of the word "skilled" from the existing statute or the specification of lesser levels of care would do much to open up the program in both the home health and institutional areas.

B. Medicaid

Unlike Medicare which is totally Federal, Medicaid is, of course, a grant-in-aid program which sees the Federal government paying from 50 to 83 percent of the cost of services provided to needy indigents. Medicaid authorizes payment for two levels of nursing home care, skilled nursing home care and intermediate nursing home care, as well as the broad spectrum of home health services.

Home health.—My 1967 amendment to the Social Security Act required the states to provide home health care as a precondition of participating in Medicaid. It is now one of the six essential services which must be provided, but HEW has not insisted on anything more than token compliance. Unlike Medicare's home health coverage, Medicaid's home health benefit is not limited to "skilled nursing care". Non-skilled nursing and even preventative nursing can be provided but is seldom offered. In fact, a May 24, 1974, report from the Social and Rehabilitation Service, DHEW, points out that in 1972, the U.S. spent only \$24 million out of \$5 billion for home health care under the Medicaid program.

Oregon provided coverage for only 10 recipients at a cost of \$2,160; Wyoming paid 12 people a total of \$3,392. Missouri provided for 36 recipients at a cost of \$1,637. More than half of the total \$24 million was spent by the state of New York (\$15.5 million) to cover about 33,000 recipients.

Since Medicaid is a state-federal matching program, the only obstacle to Medicaid's providing home health care to more seniors is that the states must be willing to provide the services. Many states apparently have not been willing to do so or could not afford to do so. This is tragic in view of the universally accepted premise that viable home health services rendered in time can maintain individuals in their own homes, postpone and prevent institutionalization, with the added benefit of savings to the taxpayers as compared with the cost of nursing home placement.

Nursing home care.—Medicaid now pays for about 60 percent of the nation's total nursing home bill or about \$2.1 billion. Medicaid is the only way most older Americans can receive the nursing home care they need. But Medicaid is only available to indigents. This means that most seniors must pay for nursing home care on their own as long as they have any assets of consequence and an income over \$2,000 (to make matters worse such "means tests" for eligibility differ from state to state). This practice compounds the welfare stigma associated with Medicaid and perpetuates the negative images of nursing homes as "repositories of the unwanted."

III. SUGGESTIONS FOR REFORM

The American Association of Retired Persons, National Retired Teachers Association, and other senior citizen groups are unanimous that long-term care should be provided to all older Americans and not just to the poor. They are unanimous that *Medicare* should be the vehicle for extended long-term care coverage. Recognition of this fact was the most favorable aspect of Title II of the Kennedy-Mills bill, S. 3286. The goal can be accomplished as follows:

1. Liberalize the definition of Medicare's nursing home coverage beyond "skilled nursing".

2. Include intermediate care as a covered service.

3. Liberalize the home health benefit beyond "skilled nursing" by removing the word "skilled" or authorizing coverage for other levels of nursing, i.e., "non-skilled" or "preventative".

4. Day care should be authorized as an optional substitute for some or all of the authorized home health visits presently offered.

5. Preferably, coinsurance amounts should be eliminated, but if they are retained, then they should be tied to whatever catastrophic coverage is provided. For example, when a long-term care patient reached \$1,000 in coinsurance or deductible amounts, the circuit would break and catastrophic protections should apply.

6. Funding should be from general revenues rather than further increases in regressive Social Security payroll taxes.

7. A residual Medicaid program would absorb premiums for the poor as well as providing the remaining 4 mandatory services; physician's care, X-ray and lab services, hospital care and mental health care, as well as other voluntary services.

8. There should be some tie-in with the Area-wide Agencies on Aging authorized under the Older Americans Act, which have been given the various areas of our states. Perhaps senior citizens centers could be established as screening centers in which the medical and social needs of the elderly could be assessed and then matched with medical services under agencies participating in Medicare or with services under Title III of the Older Americans Act.

IV. COST

A. Home health care

The Urban Institute projected that 1.4 million elderly needed home health services. The cost of providing these services in the first year through an expanded Medicare program is \$300 million, an estimate provided by the Social Security Administration and reinforced through the following projections:

In 1972, the U.S. spent \$24 million for home health under the Medicaid program, whose definition is more liberal than the Medicare definition. These services were provided to about 113,000 people, or precisely \$213 per recipient. Multiplying \$213 by 1.4 billion yields an estimate of about \$298 million.

B. Nursing home care

About \$3.7 billion is presently being spent for nursing home care which breaks down as follows:

	<i>Billions</i>
From Medicaid.....	\$2.1
From private paying patients.....	1.4
From Medicare.....	.2
Total	3.7

Assuming that the Federal government would pay what is presently paid by private paying patients (which would not be so if coinsurance were imposed), the cost to the taxpayer would be \$1.4 billion. Added to that would be the cost of meeting the *unmet need*, or 600,000 elderly now in the community who need care. While most actuaries are cautious with cost projections for nursing home care, the above analysis provides a reasonable estimate. In 1972, the U.S. spent \$1,470,939,166 for nursing home care under the Medicaid program for 562,330 beneficiaries or an average of \$2,615 per individual. The estimated cost then of meeting the needs of 600,000 *new* beneficiaries would be \$1,569,000,000, rounded off to \$1.6 billion.

C. Total cost

Assuming a cost of \$1.6 billion to provide nursing home care for 600,000 needy aged who are going without the care they require, and \$1.4 billion cost in relieving private paying patients, the total cost to the taxpayer would be \$3 billion. The cost of an expanded Medicare home health program would be roughly \$300 million.

In short, for \$3.3 billion Congress could make long-term care a right for all Americans, not just the poor; it would provide nursing home coverage for 600,000 new patients and the broad spectrum of home health services to 1.4 million more. This compares favorably with the \$5.3 billion estimate in S. 2513, which proposes the "Federalization" of Medicaid (but locks the states in at their current level of expenditure) and covers few if any new beneficiaries.

It is my hope that these thoughts will be useful to you in your deliberations and that any bill reported out of your Committee will provide some relief to the urgent needs of Americans who suffer the compound burdens of illness and advanced age.

With best wishes.

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

APPENDIX 10

TABLE 2.—NATIONAL HEALTH EXPENDITURES, BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FISCAL YEARS 1972-73 THROUGH 1973-74

(In millions)

Type of expenditure	Total	Source of funds					
		Private			Public		
		Total	Consumers	Other	Total	Federal	State and local
1973-74 1/							
Total.....	\$104,239	\$62,929	\$58,043	\$4,886	\$41,311	\$28,343	\$12,968
Health services and supplies.....	97,183	59,815	58,043	1,772	37,369	25,335	12,034
Hospital care.....	40,900	19,272	18,759	513	21,628	14,845	6,783
Physicians' services.....	19,000	14,476	14,462	14	4,524	3,277	1,248
Dentists' services.....	6,200	5,858	5,858	---	342	210	132
Other professional services.....	1,990	1,629	1,591	38	361	226	136
Drugs and drug sundries 2/.....	9,695	8,900	8,900	---	795	404	391
Eyeglasses and appliances.....	2,153	2,065	2,065	---	88	50	38
Nursing-home care.....	7,450	3,504	3,474	30	3,946	2,208	1,738
Expenses for prepayment and administration.....	4,224	2,934	2,934	---	1,290	1,042	247
Government public health activities.....	2,126	---	---	---	2,126	1,234	892
Other health services.....	3,445	1,177	---	1,177	2,268	1,840	428
Research and medical-facilities construction.....	7,056	3,114	---	3,114	3,942	3,008	934
Research 2/.....	2,684	205	---	205	2,479	2,395	84
Construction.....	4,372	2,909	---	2,909	1,463	613	850
Publicly owned facilities.....	1,112	---	---	---	1,112	277	835
Privately owned facilities.....	3,260	2,909	---	2,909	351	336	15
1972-73							
Total.....	\$94,235	\$58,415	\$53,638	\$4,777	\$35,819	\$24,280	\$11,539
Health services and supplies.....	87,805	55,271	53,638	1,633	32,533	21,793	10,740
Hospital care.....	36,174	17,274	16,803	471	18,900	12,751	6,149
Physicians' services.....	17,518	13,535	13,523	12	3,983	2,933	1,049
Dentists' services.....	5,767	5,456	5,456	---	311	212	99
Other professional services.....	1,803	1,478	1,444	34	325	216	109
Drugs and drug sundries 2/.....	8,942	8,272	8,272	---	670	365	305
Eyeglasses and appliances.....	1,985	1,905	1,905	---	80	45	35
Nursing-home care.....	6,650	3,386	3,358	28	3,264	1,896	1,367
Expenses for prepayment and administration.....	3,753	2,877	2,877	---	876	700	177
Government public health activities.....	1,685	---	---	---	1,685	911	774
Other health services.....	3,528	1,088	---	1,088	2,440	1,763	677
Research and medical-facilities construction.....	6,430	3,144	---	3,144	3,286	2,487	799
Research 2/.....	2,285	203	---	203	2,082	2,002	80
Construction.....	4,145	2,941	---	2,941	1,204	485	719
Publicly owned facilities.....	967	---	---	---	967	263	704
Privately owned facilities.....	3,178	2,941	---	2,941	237	222	15

1/ Preliminary estimates.

2/ Research expenditures of drug companies included in drugs and drug sundries and excluded from research expenditures.