NURSING HOME SURVEY AND CERTIFICATION: ASSURING QUALITY CARE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
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THURSDAY, JULY 15, 1982

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:32 a.m., in room 5302, Dirksen Senate Office Building, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Percy, Cohen, Grassley, Chiles, Glenn, Melcher, Bradley, and Burdick.

Also present: John C. Rother, staff director and chief counsel; E. Bentley Lipscomb, minority staff director; Becky Beauregard, deputy staff director; Ann Langley, professional staff member; Kate Clarke, director of communications; Bill Halamandaris, director of oversight; David Holton, chief investigator; Kathleen M. Deignan, minority professional staff member; Robin L. Kropf, chief clerk; and Angela Thimis, staff assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Senator HEINZ. Today, the Senate Special Committee on Aging is meeting to review the serious concerns many of us have and have expressed about the regulations affecting nursing homes that were recently proposed by the U.S. Department of Health and Human Services.

Assuring the delivery of quality care to our Nation's 1.3 million nursing home residents is a responsibility which the Federal Government assumed more than a decade ago, and the other members of this committee and I have been deeply committed to making certain that this responsibility is met.

The Federal involvement with nursing home care has taught us two very important things. First, the delivery of quality care requires the development of basic health, safety, and staffing standards. Second, it is essential to structure monitoring and enforcement mechanisms to guarantee adherence to these standards.

It is clear that Federal standards and enforcement procedures currently on the books have brought about significant improvements in the care of nursing home residents. But we still hear, too frequently, of instances of neglect, abuse, and substandard care.

We know that the present enforcement program is plagued by inadequate funding, bureaucracy, and redtape. We know we must do better.

On May 27, the U.S. Department of Health and Human Services issued proposed regulatory changes to the nursing home inspection program. I have given these proposals very careful consideration; and, regrettably, I have concluded that they will seriously reduce Federal and State oversight capabilities. I believe they will strip the nursing home inspection program of its ability to monitor and enforce the established basis standards of nursing home care.

You might say that, in the name of fiscal responsibility and regulatory relief, the administration seems to be backing away from its stated commitment to quality nursing home care. I say that for two reasons.

First, the HHS proposals would eliminate some very essential enforcement tools. Time limits for correction of deficiencies would be eliminated, as would sanctions which automatically cancel a provider's participation in the medicare/medicaid program if deficiencies are not corrected. Onsite visits to monitor deficiency corrections would no longer be required, and surveyors could simply check on corrections by mail or telephone.

Second, I am concerned about our not fulfilling the commitment to quality care because these proposals would allow the responsibility for survey and accreditation to be shifted from the Federal and State governments to a private organization—the Joint Commission on Accreditation of hospitals.

JCAH is not a regulatory body. It is a private body which keeps its survey results confidential. The regulations suggested to date fail to address how States and the Federal Government can continue to exercise their responsibility to enforce standards of care without this essential survey information.

It was only a few months ago that Secretary Schweiker gave Congress and the American public a commitment to assuring quality nursing home care. Until that time, administration proposals to eliminate basic standards for health, safety, and staffing requirements were under consideration.

In March of this year, the Secretary reaffirmed the need for Federal standards, recognizing that the nursing home is a unique business serving our most vulnerable citizens. He stated, and I quote, "I will not imperil senior citizens in nursing homes by removing Federal protection. I will not turn back the clock."

I think the Secretary's decision not to retreat on the standards and his statement are praiseworthy, but I am nonetheless concerned that the clock may be turned back by the Department's most recent proposals. There can be no reason compelling enough to adopt regulations that would weaken the enforcement of basic nursing home standards for the 18,000 nursing homes at which medicare and medicaid pay for care.

To relax enforcement renders existing standards meaningless. The Federal seal of approval implied by certification would become, I fear, an empty promise without proper followup and enforcement.

The committee has already shared, as recently as its June 15th letter to the Secretary, many of these concerns with the Department. At our hearing this morning, we will discuss the substance of the proposed regulations with the Department, the nursing home industry, and State and consumer representatives in order to gain

the broadest possible perspective on enforcement issues and possible alternative actions.

May I say I am convinced that it is possible to achieve real regulatory relief for the many responsible nursing homes in our Nation without imperiling the basic Federal protections for nursing home residents. I believe that we can work together to do this. I believe we can succeed in that work. I believe that with the rights and needs of nursing home residents uppermost in our minds, as well, we can do so quite responsibly. These are dual goals, and I think perhaps we can lay the groundwork at this hearing today for meeting both.

Senator Chiles.

STATEMENT BY SENATOR LAWTON CHILES

Senator CHILES. I wonder if you realize just how strong a reaction there really is to your proposal, Dr. Davis, for the deemed status certification? The Florida State officials have called it scary, and they think that it is going to endanger our State's whole program for enforcement of nursing home standards.

The chairman of our nursing home ombudsman committee in the Miami area, Dr. Irving Vinger—and he is a physican—said that your proposals would place nursing home care in Florida back in the Dark Ages. And he said, and I am quoting him now:

> Please make it clear to everyone that there are people in nursing homes who are losing their limbs, who are not being fed, who are being beaten with wire hangers, who are not getting the benefit of standard medical care. And we are trying to weed that out. We are making it more difficult for officials to shirk their responsibility, but the effect of these proposals would totally demolish the advances that we have made and would send us back to a nursing home situation that no community could tolerate.

I think he may be right. If the Federal Government turns over its responsibility to a membership organization and if we force the States to do the same through budgetary pressure, it seems that we are abandoning all support for a State who wants to try to protect the lives of nursing home residents.

Some of your proposals may be good. We probably should continue to look at your goal of allowing more flexibility for surveys and to put more emphasis on bad nursing homes, for instance, and maybe some consolidation of the medicare and medicaid surveys. And there are other things that we should consider that are not in your proposals, such as a patient care management system.

But I suspect that the real reason that you are proposing the deemed certification is that you are going to be able to remove a budgetary line item from your medicare budget. Even then, I am convinced that it is only going to look like the Federal budget is being reduced. The actual cost is still going to be there, and the States are going to be forced to spend more. What we spend is going to be hidden in the nursing home's medicare cost report.

And I wonder what we are going to get in return? It seems that if someone sees bad conditions in a nursing home, will they be able to go to the commission and get someone to take action? I am afraid they will not. And if the survey money is going to the commission, will the State be able to take action? I think the answer to that is, probably not.

The State would not have much of a staff left. It would not have any survey information about nursing home conditions to use to take any action. But we would not have to worry about that. We could just say that the Federal Government is not responsible anymore.

I am worried that this is much more than simple regulatory relief. This is just tearing out Federal protection of helpless people. It is saying the Federal Government no longer wants to deal with nursing home problems. It no longer wants to protect nursing home residents, and that is something that I hope this committee will totally oppose, because I certainly do.

[The prepared statement of Senator Chiles follows:]

PREPARED STATEMENT OF SENATOR LAWTON CHILES

I want to congratulate the chairman for holding this hearing today. It is important that this committee keep a strong oversight role on nursing home issues.

The atmosphere surrounding Federal policy toward nursing homes has always been uneasy. The adequacy and effectiveness of Federal minimum standards for nursing home care has frequently been challenged. Some say we don't demand enough. Others say we ask too much.

When changes in minimum standards have been proposed, Congress has pretty much taken the position that protection of nursing home patient rights, that assurance of a safe and pleasant living environment, and that quality medical and social care are essential. We must constantly strive to improve the quality of life for all nursing home residents.

That is what happened recently when the U.S. Department of Health and Human Services was considering proposals which we felt would weaken nursing home standards of care. All the members of this committee protested, along with other Members of Congress and the public. Weakened standards were not officially proposed. The Secretary said that we would not do anything that "would turn back the clock" on nursing home reform.

But now we have to have a hearing on additional proposals which many believe will severely weaken both the Federal and State governments' ability to enforce any standards of care. There are many questions which have to be asked before we can proceed any futher.

I am particularly concerned about the proposal to grant deemed status certification for Federal funding of nursing homes to the Joint Commission on Accreditation of Hospitals. I fear that what this proposal basically amounts to is the Federal Government saying that nursing homes can and should regulate themselves, and that the Federal Government should continue paying billions of dollars to nursing homes every year for care of the elderly without asking questions or checking on the kind of care they are getting. Under the proposal, the commission would not even be required to give information from their nursing home surveys to either the State or Federal Government. The results would be keep confidential.

What we are learning about the commission's track record with hospital accreditation give me reason for concern. Over 60 percent of commission-accredited hospitals later checked by State and Federal validation surveys did not meet minimum standards.

I also question who will be responsible for actual enforcement of nursing home standards. It seems clear that the Federal and State governments will still have to make sure that standards are met—if anyone does. But under this proposal, they would have to do it without any information from nursing home surveys, and with funding and staff getting smaller and smaller.

I really don't understand why the administration has made this proposal for deemed status accreditation. If it is a quick response to budget problems, I am not at all sure that any money will be saved. It is is simply the first step in a process of complete Federal withdrawal from any responsibility for assuring quality nursing home care, I am in complete opposition.

We all know that the current enforcement system for nursing home standards is not what it should be. I do not want to be put in a position of defending the status quo. Too many bad conditions still exist. And I know that many good nursing homes could do their job better if their paperwork was eased.

We have had some proposals in the past which could help meet some of the complaints about duplication of nursing home regulations and about a process which is too "paper-oriented." But these proposals don't address that problem either. What I fear is that these proposals would lead to bad conditions getting worse—and maybe even a heavier paperwork burden for some nursing homes.

I think we will get a much broader perspective on the effect of these proposals today. And I hope we will also hear some alternative ideas to strengthen and improve enforcement of nursing home standards of care.

Senator HEINZ. Senator Cohen.

Senator COHEN. I would yield to Senator Percy.

Senator HEINZ. Senator Percy.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. I thank you very much indeed, Senator Cohen. Regretfully, I am conducting a hearing at 10 on another pressing problem, the Middle East.

I have had a long interest in the nursing home industry. I have visited more nursing homes in Illinois than anyone else, outside of the State inspectors. I spent 3 years researching a book, "Growing Old in the Country of the Young," and a large part of that book dealt with the nursing home industry. "Warehouses for the Dying" is the subtitle that some people assigned to it.

The conditions of millions of our elderly residents and the responsibility of the Government to insure an acceptable standard of care is evidenced, I think, by the large number of people we have in this hearing room today, all of whom are concerned with the problem.

No committee in the Congress has a more distinguished record than the Special Committee on Aging when it comes to concern about the quality of long-term care. And few issues have been of more personal interest to most of us. I personally have participated in more than 30 hearings on nursing home conditions in this committee.

Eleven years ago, as a member of this committee, I joined Senator Frank Moss, then chairman of the Subcommittee on Long-Term Care, in Chicago, for a series of hearings on nursing home standards. Our hearings followed up on an investigation conducted at our invitation by the Better Government Association that revealed a large number of unfit, substandard nursing homes. We found that repeated and flagrant violations of health and safety standards and mistreatment of patients was not uncommon.

The disreputable point system that we had gave more points for the more bedridden people. They used drugs to keep them in bed so they could get more payments. It was just an unbelievable situation that we faced.

In 1978, I returned to Chicago for another set of hearings. While many improvements were noted at the time, we also found that problems still existed—unsanitary conditions, negligence, and a disturbing lack of trained medical personnel in many nursing homes.

The proposed regulations which are the subject of this hearing do not change the standards we have set for nursing homes to participate in federally funded programs. They simply affect the process through which Federal and State governments determine whether the standards are being met.

I am not opposed to all of the proposals. In fact, I support the concept to give State agencies the flexibility to concentrate more enforcement efforts on those homes that have histories of noncompliance and abuses. At the same time, we must not reverse any of the accomplishments of the past decade or give the signal that the Federal Government would like to end its involvement in insuring that minimum standards of care are maintained.

I am most concerned about the proposal to give so-called deemed status to nursing homes accredited by the Joint Commission on Accreditation of Hospitals that participate in the medicare program. Under the proposal, States would also have the option of accepting JCAH accreditation in lieu of State surveys for facilities participating in either medicaid or both medicare and medicaid.

I have several concerns. First, it would turn over to a private agency the responsibility for monitoring Federal Government standards—a concern expressed by our chairman. Second, it would appear to be a duplication of effort, because many States, including Illinois, conduct surveys for State licensure at the same time they conduct inspections for certification. Separate certification by JCAH would appear to duplicate effort and cost more money.

Last, JCAH's policy of keeping confidential its survey results would present problems for State agencies who would still be held accountable for enforcement of State and Federal standards. I question whether this particular proposal is workable or in the best interests of this country's nursing home residents.

Given the enormous sums of Federal and State dollars that go for nursing home care, and the strong and lasting commitment we have to provide adequate care to those who reside in nursing homes, we must continue a strong survey and certification program.

Mr. Chairman, I would like to submit for the hearing record a position paper prepared by the State of Illinois Department of Public Health,[1] and letters expressing concern about the proposed regulations from the Gray Panthers of Chicago,[2] and the Illinois Citizens for Better Care.[3]

Senator HEINZ. Senator Percy, thank you very much.

Senator Cohen.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator COHEN. Thank you, Mr. Chairman. I have a prepared statement which I would like to submit for the record and just perhaps offer a couple of comments.

Senator HEINZ. Without objection.[4]

Senator COHEN. One of the reasons I did want to yield to Senator Percy, not only because of his pressing schedule with the Foreign Relations Committee, was also to point out that he has been in the lead on issues concerning the nursing home industry for years.

In fact, I read your book, Senator Percy, many years ago about the "warehouses for the dying," and we have come a long way

[1] See appendix 1, item 1, page 107.
[2] See appendix 1, item 2, page 108.
[3] See appendix 1, item 3, page 109.
[4] See page 8.

since that time, largely because of congressional action. Many of the horror stories of the 1960's and the early 1970's have been eliminated. There are still abuses, but most of them have been eliminated, and I think that the nursing home industry is now testing some rather exciting new options for the elderly, and they are increasingly earning the confidence and the trust of the family members.

Senator PERCY. I might say, Senator Cohen, that this committee has also sent a number of people to jail, and that has helped to correct the problem. [Laughter.]

Senator COHEN. But having said that we have come a long way, I think that we also ought to hear the other side of the story this morning. One of the reasons I am looking forward, and commend Senator Heinz for holding this hearing, is that despite the improvements that have been made in the nursing home industry, we still hear complaints about redtape and bureaucracy that is associated with the inspection of nursing homes, and I think many of the criticisms are valid.

The fact is that we are forcing many nursing homes to spend time and money on redtape and bureaucracy instead of patient care. And I assume that that is one of the reasons why the administration has proposed some changes. I know that any change is always met with certain criticism. No one wants to see a status quo change unless they can be assured it is for the better, obviously.

But we have to deal with the issue of whether or not, in the nursing home industry, as well, we are focusing more upon paperwork and the kind of redtape that is so endemic in our Federal system, thereby diminishing the kind of patient care that we ought to be directing our resources toward.

But I should also say that the reaction on the part of my State, the State of Maine, was one of alarm and concern when they read the proposed regulations. There are some 146 nursing homes in Maine, and many of them are located in very rural areas.

The question they have is, will the relaxation of the current standards mean that consumers in rural areas have to choose between substandard care close to home or better care hundreds of miles away from families and friends? And how will the turning of the inspection over to a private agency whose central headquarters is in Chicago, Senator Percy, serve the rural States like Maine?

In almost every instance, Maine has moved toward requiring more inspections and more regulations rather than less, and they see this proposal as moving in the opposite direction. That was why I joined with Senator Heinz and my colleagues on this committee to express concern about those specific areas of public disclosure, survey results, the strict monitoring of facilities with compliance problems, and the retention of this basic framework for resurveying homes that do have problems.

But I think we ought to put it within that context as we proceed with these hearings to discover the underlying rationale of the administration for the proposals and what changes you might entertain to take into account with the kind of concerns that you are hearing by the members of the committee this morning.

But, also, this will be a learning process for us to find out what is the nature of the burden that has been imposed upon nursing

homes and why we divert many of those resources away from care of the patient to the chore filling out forms.

So, I look forward, Mr. Chairman, to participating in these hearings and listening to Dr. Davis.

Senator HEINZ. Senator Cohen, thank you.

[The prepared statement of Senator Cohen follows:]

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN

Mr. Chairman, 20 years ago, when a family found that it could no longer care for an elderly invalid, the decision to turn to a nursing home was often a sad one. Nursing homes were regarded as warehouses for the dying. Nursing home selection was meager, with conditions often appalling. None of us needs to be reminded of the horror stories which were uncovered in the 1960's, when licensing and inspection of nursing homes was haphazard at best.

Over the years, and largely as a result of congressional action in setting standards for enforcement and care, abuse has been greatly reduced. Nursing homes are now testing exciting new options for the elderly and are increasingly earning the confidence and trust of family members. Attempts to "turn back the clock" to earlier days have been unsuccessful every step of the way. As recently as this winter, Secretary Schweiker rejected a plan to relax health and safety standards for nursing homes, citing significant improvements in the long-term care of nursing home residents.

Despite this progress, we still hear many complaints of redtape and bureaucracy associated with the inspection of nursing homes. Many of these criticisms are valid. The fact of the matter is we are forcing many nursing homes to spend time and money on redtape and bureaucracy instead of patient care.

When the regulations for revising the nursing home inspection process were issued by HHS in May, I must confess that my first reaction was not a negative one. I have long felt that there was room for improvement in the process now employed to inspect and regulate nursing homes.

The reaction on the part of officials from my State, however, was one of alarm and concern. There are 146 nursing homes in Maine, many of them located in rural areas. Will the relaxation of the current standards mean consumers in rural areas have to choose between substandard care close to home, or better care hundreds of miles away from families and friends? How will turning inspection over to a private agency whose central headquarters is in Chicago serve rural States like Maine? In almost every instance, the State of Maine has expressed an interest in strengthening its regulations and inspections. This proposal, they say, would head us in the wrong direction.

I joined a number of my colleagues on the Senate Aging Committee in writing to Secretary Schweiker asking that, at the very least, some basic considerations be given to nursing home patients. Of particular concern, I believe, are such issues as public disclosure of survey results, strict monitoring of facilities with compliance problems, and the retention of the basic framework for resurveying homes with problems. In my view, this was not an unreasonable request, and one which I hope the representatives of the Department will comment on here today.

I do not pretend to have any answers to the problems plaguing the system for licensing and inspecting nursing homes today. I would only remind the witnesses of what one public official in my State said to me prior to this hearing: "Put yourself in the place of a nursing home resident. Think from his perspective."

It is only fair to ask if these changes make a nursing home resident's life better or worse. Will they make nursing homes better and safer places in which to live? What will happen to rural States, where nursing home beds are already full and patients have few options in their communities? Most importantly, are these regulations heading us in the right direction?

Mr. Chairman, I commend you for holding this hearing, and I look forward to hearing from the witnesses.

Senator HEINZ. Senator Melcher.

STATEMENT BY SENATOR JOHN MELCHER

Senator MELCHER. Dr. Davis, I have to draw your attention to a letter that all of us who are here this morning signed to Secretary

Schweiker pointing out that these regulations really do not get to the matter and really do not satisfy us at all.

Now, I have a letter, and I am only going to quote a sentence out of it, from the Montana Department of Health. They say:

These regulations are letting up too much too fast, and it is absolutely and positively ridiculous to use the Joint Commission on Accreditation of Hospitals to deem status for nursing homes.

That is the end of the quote.

It seems to me evident, Dr. Davis, that the regulations abdicate responsibility, and it is a responsibility that the administration and the Congress share. The executive branch and Congress share a responsibility for particularly the helpless who are in nursing homes. I think that is basic, and I believe that the comments made by my colleagues here regarding some of these points and the comment made by the Montana Department of Health are absolutely correct.

While I am interested in hearing your justification for the regulations, I think indeed they are ridiculous.

Thank you, Mr. Chairman.

Senator HEINZ. Before we hear from our first witness, I am going to insert into the record a statement by Senator David Pryor, who cannot be with us today due to a previous engagement.

[The statement of Senator Pryor follows:]

STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I am pleased that the Special Committee on Aging has chosen to explore administration proposals to alter the budget allotments and regulations currently in place for survey and certification of health care facilities participating in the medicare and medicaid programs. It is only appropriate that this committee, which was established chiefly for the purpose of investigating issues related to the aging of our Nation, closely examine each aspect of these new proposals. I am proud to be a part of this process.

While these proposed changes would affect the residents of all health facilities participating in these programs, my chief concerns lie with the more than 1.3 million Americans currently residing in nursing homes throughout this country. As you know, Mr. Chairman, my concern for this most vulnerable population goes back over a decade, to a time when many of our nursing homes were little more than warehouses in which many of our elderly were forced to live their final days in neglect and loneliness. Through the efforts of a small group of concerned and dedicated individuals, and through many years of uphill battles against almost insurmountable odds, we have been marginally successful in establishing some minimum standards for long-term care facilities. Yet we are all well aware that conditions in these homes could be further improved. We are not out of the woods yet.

I make this statement, Mr. Chairman, not only because we are still uncovering abuses in these homes (and many more of these incidents, as we all know, go unreported), but also because of the aging nature of our population. As we approach the year 2000, the population aged 65 and over will reach 32 million or more—a 30-percent increase over that group's number today. And the fastest growing segment of the population will be 85 and over—the group which will be most in need of the types of services long-term care facilities provide.

While it is true that there are countless other areas which we must consider for reform and innovation as we look at our current and future long-term care needs, this in no way absolves us of our current obligation to these institutionalized citizens, nor should it draw our attention away from the almost guaranteed irreparable harm that would result should these regulations be implemented.

Mr. Chairman, we were all "encouraged" by Secretary Schweiker's announcement earlier this year that he would not act to implement draft regulations which would have relaxed the standards by which these facilities are found to be eligible for medicare and medicaid reimbursement. These proposed changes come in the wake of heavy budget reductions in fiscal year 1982. In fact, on March 5, 1982, the New York Times reported that Federal money for survey and certification in many States was reduced between 15 and 65 percent. I would like at this point to place

portions of this article in the hearing record.[1] In addition, I will summarize some of the findings: "New York, New Jersey, and Connecticut all reported that Federal financing had been reduced by 50 to 60 percent * * * In New Mexico, the medicare inspection budget has been cut to $90,000 from $250,000." My own home State was "lucky" enough to have only been reduced by 15.7 percent. We were fortunate enough to have a small cushion to fall back on, but even this relatively small reduction required some major changes. Staff in outlying areas were recentralized, with Little Rock as their official work station. Travel funds were cut back. And many of the staff members who were lost through attrition were never replaced.

But even more alarming is the fact that this administration has proposed, through the budget process, a reduction from 75 to 50 percent in the Federal matching rate for survey and certification. The National Citizens' Coalition for Nursing Home Reform has estimated that this change could result in up to 50 percent less dollars for survey and certification for these facilities.

I am deeply concerned over these requested changes, and am anxious to hear what our witnesses will have to say today.

I would also like to alert my colleagues that on June 15, 1982, I introduced S. Res. 411, which expresses the sense of the Senate that the Secretary of Health and Human Services not issue the proposed survey and certification regulations in final form. At this time I would like to urge my colleagues to join in cosponsorship of this resolution.

Senator HEINZ. Our first witness is Carolyne Davis, Administrator, Health Care Financing Administration.

Dr. Davis.

STATEMENT OF DR. CAROLYNE K. DAVIS, WASHINGTON, D.C., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY DANIEL BOURQUE, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; AND THOMAS MORFORD, DIRECTOR, OFFICE OF STANDARDS AND CERTIFICATION, HEALTH CARE FINANCING ADMINISTRATION

Dr. DAVIS. Thank you. I am pleased to be here today to clarify the Department's recently proposed regulations which we believe will improve the survey and certification process for health facilities under both medicare and medicaid.

With me today are Dan Bourque, the Deputy Administrator of the Health Care Financing Administration, on my left, and on my right Tom Morford, the Director of the Office of Standards and Certification.

Your committee indeed has a strong tradition of interest in protecting the health and safety of our Nation's elderly, but I believe that the Department also has interests that are compatible with yours, and I welcome the opportunity to clarify what I consider are some misperceptions about our regulatory proposals.

Last year in the Omnibus Budget Reconciliation Act of 1981, Congress recognized that the statutory basis for annual surveys for skilled nursing facilities was no longer necessary by allowing the repeal of the provision that would require the 12-month resurvey.

The Congress, in repealing the provisions in the law, stated that program experience indicated that many facilities have been consistently in compliance with medicare's conditions of participation. We did support that legislation, and I believe that our regulations are consistent with this philosophy.

[1] Retained in committee files.

We, too, are committed to assuring that patients under the medicare and medicaid programs receive high quality health care. Our proposed rules will strengthen our enforcement process in four ways.

First, they will allow for an increased focus of our enforcement efforts on problem facilities. Second, through our deeming proposal, we can increase the involvement of other health professions in the certification process. Third, enforcement time can be better spent through the elimination of certain current requirements that have been generally ineffective. Fourth, providers will be able to increase their attention to patient care because there will be a reduction of unnecessary paperwork.

All providers and suppliers under medicare and medicaid must be surveyed to determine whether they can be certified to meet strict conditions of participation. Under current procedures for medicare, the Federal Government contracts with State survey agencies which make recommendations to HCFA. HCFA makes the final determination on whether the provider qualifies for participation. In addition, hospitals that are accredited by the Joint Commission on Accreditation of Hospitals are deemed to meet medicare's conditions of participation. Under medicaid, the State determines whether a provider meets the health and safety requirements and makes the final certification decision. Most providers which qualify under medicare automatically meet Federal eligibility requirements for medicaid.

Since 1973, the survey and certification procedures have not changed substantively. In 1980, the Health Care Financing Administration conducted public hearings in each one of our 10 regional offices and in Washington, D.C. After reviewing the testimony and analyzing the comments from many witnesses, we determined that some of our survey and certification regulations did need revision because there was little evidence that they contribute to good patient care.

For example, we recognize that provider performance varies widely, and yet the current process does not recognize that variability. It provides us with no ability to survey those individual facilities who do have a good compliance record less frequently than those who have major problems.

I would also like to remind the committee that these proposed regulations on survey and certification extend beyond just nursing homes, and encompass home health agencies, hospitals, and others. Why should hospitals automatically be surveyed with the same frequency as home health agencies?

We believe that the Government ought to concentrate more of our resources on providers whose past history demonstrates problems. Our medicare and medicaid automated certification system, which we refer to as MMACS, contains general descriptive information on all of our participating nursing homes so we have the ability to identify good facilities and to track bad ones.

Our beneficiaries are not necessarily protected by annual surveys of good facilities; and beneficiaries in problem facilities, we believe, could be better served by subjecting those providers to more frequent attention than on an annual basis. Our proposed regulations

therefore, focus on those providers that warrant closer and more frequent inspection.

In May, Secretary Schweiker announced the proposed survey and certification rules. When the Secretary decided earlier this year not to change the conditions of participation, he stated that we would strengthen the enforcement method of surveying providers.

Before I discuss the specific provisions of the regulations, I would like to make clear several things that the proposals will not do.

They will not allow unsafe or deficient facilities to participate in the medicare and medicaid program, and they will not allow any facility to go without inspection. They will not result in less protection of our medicare and medicaid beneficiaries' health and safety.

Now, I would like to discuss in detail some of the issues in our proposed regulations beginning with deemed status for the JCAH-accredited facilities. The Joint Commission on Accreditation of Hospitals is a nationally respected accrediting organization. In fact, its prestige was such that when medicare was enacted in 1965, the law provided that hospitals which were accredited by the JCAH were deemed to meet the conditions of participation for medicare.

The statute also allowed deemed status to be extended to other providers, and it is in that context that we are proposing to accept JCAH accreditation as sufficient evidence that skilled nursing facilities, intermediate care facilities, and hospital-based home health agencies do meet the medicare conditions of participation.

Under our proposal, I would stress that States, at their option—and I underline "at their option"—may accept JCAH accreditation for medicaid or for those facilities that participate in both medicare and medicaid. We believe that this permits States to determine the survey method that they believe will work most efficiently for providers who are receiving benefit payments under medicaid.

After a long and laborious analysis, we determined that the JCAH process and standards are indeed equivalent to, and, in some cases, even superior to our own standards. For example, some of the JCAH requirements for disaster preparedness are stricter than medicare's. We believe the JCAH record in the hospital sector is excellent, and we have no reason to believe that JCAH would perform any less effectively in assuring that health and safety standards are met by other providers.

Additionally, some 1,300 skilled nursing facilities and intermediate care facilities currently approved for medicare or medicaid are accredited by the JCAH. The JCAH has experience since 1965 in acceditation of long-term care facilities.

The deeming provisions eliminate existing duplication of survey effort which now can involve several agencies. In your letter to us Mr. Chairman, you asked about the effects of this proposal on the cost of the survey and certification program.

We expect that there will be no additional Federal costs. While the Federal Government pays a share of accreditation costs as allowable costs under medicare, we also pay the cost for the surveys conducted by the State survey agency. These costs should offset one another. In fact, our costs may decrease, since some facilities are now surveyed both for accreditation and certification.

To further protect the medicare and medicaid beneficiaries, however, we did include some additional requirements. We determined

that as a condition of deemed status, the facility must post its current JCAH report of the survey findings in a prominent place so that the public could examine it. This differs from the current procedures whereby the JCAH reports are confidential.

Also, we stated clearly that HCFA can revoke the deeeed status of a JCAH-accredited facility if it determines that accreditation no longer provides reasonable assurance that facilities do meet Federal requirements. We will have regular validation surveys conducted on the accredited long-term care facilities on a sample basis and in response to allegations of significant deficiencies. Any provider accredited by the JCAH would have to meet any higher health and safety standards that may be prescribed by HCFA.

In regard to the fdexible survey cycle, at present the State agencies are required to survey all medicare and medicaid providers at least annually, regardless of compliance history. Cofgress indicated that the annual surveys were an unnecessary burden on the facilities if their compliance record was excellent, and for that reason we are modifying the requirement for annual surveys for most providers.

Under our proposed regulations, hospitals would be surveyed at least once every 3 years, and all other facilities would be surveyed every 2 years, with the exception of intermediate care facilities for the mentally retarded which would be surveyed at least annually.

Now, there is an important point here. Those are the maximum lengths of time between inspections of a nursing home. If a facility has a poor record of compliance, our regulations allow for more frequent inspections.

ICF's/MR preseft a special case—most of these patients lack the necessary experience or capability to bring problems of quality of care to the attention of outside authorities. Thus, we propose that ICF's/MR's be surveyed each year to make certain that serious problems are detected and solved.

Our office of research and demonstrations is funding experiments in three States designed to make the nursing home survey and certification process more effective. Preliminary resudts from an experiment in Wisconsin, suggest that the experimental methods did result inn5 a reallocation of surveyor time toward problem homes.

In regard to the time-limited agreements, I would like to point out that Congress did repeal the provisions that has been in effect since 1973 requiring that skilled nursing facility provider agreements under medicare be renewed annually, and it is on that basis that we believe that we have the ability to propose flexible survey cycles.

In regard to the quarterly staffing reports, currently the State survey agency is required to obtain from each facility, every 3 months, the number of full-time employees it has. This process takes considerable time and effort with no identifiable benefit, and indeed is somewhat duplicative of other reports.

We are, therefore, proposing a modification of the current policy to require those reports only when a facility has been shown to have deficiencies in staffing during its most recent certification survey or if it is marginal in terms of meeting staffing requirements.

However, all facilities will be required to have the information available when they are surveyed. We think that this change allows the surveyors to monitor compliance with the staffing requirements in a less burdensome and more targeted fashion. But I would like to emphasize that the State may obtain such staffing reports at any time if it wishes to do so.

In regard to the 90-day resurvey cycle, there are a great deal of misperception about this. At present, if any deficiency is found on the annual survey, the State is required to conduct a followup visit to the facility within 90 days to verify that corrective action is completed or progressing at a reasonable pace. Frankly, the 90-day requirement does not allow for realistic and practical timeframes for followup.

Sometimes there are structural deficiencies that may take more than 90 days to correct, in which case the 90-day followup is a virtual waste of time. We think that the 90-day requirement is arbitrary. Our proposed rules specify that the survey agency would be required—and I stress, would be required—to follow up on a deficiency, but at a time when it determines that the progress or correction can be assessed most realistically.

Yes; we would permit telephone or mail contacts, when appropriate, to follow up or to verify the correction of certain deficiencies where onsite visits are simply not needed. There are times when the compliance simply is a matter of checking of minutes or a checking of written policy procedures. We believe that those can adequately be done by telephone or by a combination telephone and mail survey.

In regard to the automatic cancellation clause, currently a skilled nursing facility or an ICF which is not in full compliance with all the standards may be certified and approved, subject to an automatic cancellation clause, if the corrections of deficiencies are not made within a 60-day period of time from when the correction was determined.

This policy was established, we recognize, because some facilities were cited for deficiencies year after year. But we must call your attention to the fact that in the last 3 years, no facilities have been automatically cancelled by use of this clause. And we believe that it is better to eliminate the automatic cancellation requirement and concentrate on those facilities that have major deficiencies.

There are other sanctions that we can apply to facilities, such as the denial of reimbursement for newly admitted medicare or medicaid patients. And I would also call to your attention that we always have the ability to terminate the facility's participation in a program.

In closing, I would like to strongly reemphasize that our proposed regulations will not permit any facility with life-threatening deficiencies to continue to participate in the program. The termination of the facilities with life-threatenting deficiencies will be in no way affected by these proposals, and we will not permit beneficiaries to have their health and safety jeopardized, as Secretary Schweiker has said repeatedly.

Our proposed regulations, we believe, are designed to eliminate cumbersome and unnecessary requirements. We want to commend you for having this open hearing and allowing us to have the op-

portunity to clarify our points. I would call your attention to the fact that the regulations are still open for comment until July 26, and we will welcome your suggestions, as well as those of the beneficiaries, various consumer organizations, States, and providers.

I will be happy to answer any questions that you have at this time.

Senator HEINZ. Dr. Davis, thank you very much. Before we start questions, I would like to recognize Senator Grassley, if he has an opening statement he would like to make.

Senator GRASSLEY. I am going to wait at the time of the next panel to make my opening statement because there is an individual here from my State.

Senator HEINZ. Very well.

Dr. Davis, probably the issue that has received more attention than anything else is that of deemed status, and Senator Percy, Senator Cohen, and others have commented on their fears, as well as mine, of turning over to the JCAH, a private organization, the work of checking up on nursing homes.

Now, one of the arguments you made in your statement was that you say that the JCAH record in the hospital sector is excellent. Yet, on March 2, 1982, the report submitted to Congress by HHS indicated that 61 percent of the JCAH-accredited hospitals checked had failed to meet basic medicare-medicaid standards; 51 percent of the hospitals checked were found to be in violation of important fire safety standards; in other words, they had Life Safety Code violations.

Is that really an excellent record?

Dr. DAVIS. Let me clarify that particular point. The material that you are referring to is our annual report on our validation or look-behind surveys. It is always true that when we go in for a validation survey, we are using our criteria, and those criteria are not exactly matched against the JCAH standards, although they are similar. But in some cases, they are slightly different.

We do use a different team, so there is obviously going to be some variation between the standards that the JCAH has used as its acceditation and our standards. Also, the fact that we have a different survey team makes for some differences.

Many of those deficiencies were minor in terms of the differences. However, as a result of our identification, particularly in the life safety area, we did discuss this with the JCAH and it agreed to have its surveyors undergo more life safety training.

I would point out, too, that it is possible to have a great deal of variation in the life safety area, depending upon which set of Life Safety Codes one is surveying from. There are a number of variations of this particular code, so it depends upon what year's code one utilizes.

I would also point out that in May 1979, there was a report issued to Congress by the GAO relative to the medicare hospital certification system which states that the JCAH identifies more deficiencies, identifies more important deficiencies, and stimulates faster corrections.

Indeed, one of the recommendations from the GAO report was that Congress ought to consider requiring the Department to con-

tract with the JCAH for the conduct of all certification surveys of hospitals. I think we will have a difference of opinion on this.

Senator HEINZ. I think so because a hospital is a rather different place from a skilled nursing facility or an intermediate care facility. In a hospital, we all know there are a large number of medical professionals, including M.D.'s. There is a very high proportion of R.N.'s, and a lot of very well-trained health care professionals, who, if we did not have Federal standards, you might not find in many nursing homes.

But I am puzzled by your statement that many of these deficiencies were minor. If they were so minor, why were the hospitals placed under State surveillance for correction?

Dr. DAVIS. They were not all placed under State surveillance. I would like to state a couple of things. First, we did not decertify a number of those hospitals. Second, if the States felt that the JCAH was not of sufficient quality, I wonder why some 30 States accept JCAH accreditation for their licensure of hospitals.

So, it is clear that at least concerning hospitals, we have fairly good evidence that almost everyone—Congress, the States, ourselves—believes that JCAH has a good history and a good record. I have no reason to believe, having very carefully examined all of its standards and compared them to our own standards and our own conditions of participation, that it would do less for nursing homes.

Senator HEINZ. I would urge you to reconsider that position because when you have 51 percent of the hospitals checked, violating to some degree something as important as Life Safety Code standards, I would suggest there is a problem.

Let me turn to the second other major problem that I think JCAH poses for us. They are a private organization. Now, you do indicate that although they are a private organization which normally keeps their survey results private, you would require that the findings be posted in a centrally located spot in the facility.

Now, that is fine, I suppose, if someone is going to visit the facility. But that kind of information has been absolutely essential for Government agencies which monitor nursing homes. How do you propose to make this very important information available to the public generally, not just to people who go to a nursing home?

You say that you do not want Federal or State agencies to have to visit many of these nursing homes more than once every 2 years. It sounds to me like the consumer is going to have to visit every single nursing home in his or her State to find out what the JCAH says about each of those nursing homes.

How, also, can records be used to decertify a facility, build a prosecution, or, as a I mentioned a minute ago, inform the customer if they are only posted in a specific nursing home? What can you do about that?

Dr. DAVIS. I think there are two different points that you are asking there, Mr. Chairman. One relates to the use of the survey information to decertify a facility. Let me address that one.

It is the intent that if a facility is deemed, when JCAH goes in for its accreditation visit, if it finds instances that are life threatening, JCAH would immediately take steps to advise the State agency and the central office of the Health Care Financing Administration.

We would immediately place that facility on termination procedures and would follow up on it. In the case of deficiencies which were not serious enough to be necessary for termination, then the JCAH does have the same type of process as the State agency. That is, it would identify those areas and ask for corrective action, and would monitor that corrective action.

If, at any point in time, either ourselves or the State agency wished to step in as a result of complaints or as a result of referrals we can perform our own validation and do our own complaint surveys. We can also, at any point in time, revoke the JCAH deemed status and return that institution to a State survey.

Senator HEINZ. Well, you understand why I have some serious doubts about that, because what we are saying is we are going to leave it up to JCAH to let a State agency know when they, JCAH, thinks that there is some kind of life-threatening problem. And that is the same organization, JCAH, which, according to your own report issued this March, indicated that 60 percent of the JCAH-accredited hospitals, not nursing homes, failed to meet the basic standards, and 51 percent of those hospitals were found to be in violation of the Life Safety Code.

Now, that seems to me to suggest that we are putting not only a great responsibility on JCAH, but we are asking them to do something that, to date, the record would suggest they have not been able to do well, even in a hospital.

Could you reply to that?

Dr. DAVIS. Yes, Mr. Chairman. First, I think I did try to clarify that there are different Life Safety Codes and it does depend upon which one the survey team was utilizing when it went in that will cause some differences.

Second, I would also like to point out that in 1981, 20 hospitals were not accredited by the JCAH as a result of its findings. Those hospitals had significant variations from the JCAH standards. Yet, when we checked, 17 of those hospitals remained certified by the State agencies.

So, I think here again there is adequate demonstration that one can have differences of opinion on both sides of this. I believe that the JCAH has shown that it does an adequate job.

Senator HEINZ. Before I yield to Senator Chiles, I would say you are right. We do have a difference of opinion, because I really have great problems with how we can leave all this information basically in the hands of JCAH. There is no way, except at JCAH's instigation, that it can get into the hands of State survey and licensing agencies. That really seems to me to make it extremely difficult for the States, who you obviously want to do more here, to do the job that you suggest they ought to do.

Unless you have a comment, I would like to yield to Senator Chiles.

Mr. BOURQUE. Mr. Chairman, I would just like to add to what Dr. Davis said with respect to this issue. First of all, the JCAH does provide us additional information. For example, we are aware of the accrediting decisions that it makes on a monthly basis. The JCAH submits those reports to us so that we know what actions it is taking vis-a-vis specific facilities, and we are in constant communication with the JCAH.

We expect, if we were to allow deemed status, to have an agreement with the JCAH that stipulated what types of information we felt was necessary for it to report. We would not, of course, ask the JCAH to violate its own standards and rules for confidentiality, but we would ask that it agree with us to support certain information, particularly when it relates to serious deficiencies in a facility.

With respect to the public posting of this information, this is really more than is required now under our current standands. Currently, that information goes to a State agency, but it can get locked up in the bowels of the bureaucracy, and it might take a freedom of information request or a specific request to get it.

This will be a very visible sign to people who come into the nursing home. We believe that nursing homes would be embarrassed and want to improve that quality if they had a report that cited serious deficiencies hanging up for public view. So, we think this is a step in the right direction.

Senator HEINZ. Senator Chiles.

Senator CHILES. Mr. Chairman, neither Senator Burdick nor Senator Bradley have had a chance to make an opening statement. I do not know if they have one. I would just yield if they had one.

Senator HEINZ. Excuse me. Do either of you gentlemen wish to make an opening statement?

Senator BURDICK. I do not.

Senator BRADLEY. No.

Senator CHILES. Dr. Davis, you seem to have some real problems with your budget for nursing home surveys. You already told the States to survey some nursing homes less than once a year even before you proposed a change in regulations. Most States have already lost a lot of their survey staff. Florida has already lost almost $1 million in funding for surveys over the last 2 years, and has lost some 32 staff already. Florida, however, is still doing surveys for federally funded nursing homes because the State has appropriated additional funds.

I know that you asked for additional funds this year. My understanding is that you asked the Appropriations Committee to reprogram $9 million from medicare contractor audits to survey and certification, and I understand that the Appropriations Committee refused that request, saying that they felt that taking it from contractor audits was not acceptable because we are now just paying medicare claims without even reviewing them.

It is also my understanding that they said that you could send a supplemental request for survey and certification, and the committee would act on it. Being on the Appropriations Committee, I want to assure you that I will certainly help in that regard.

Are you going to request a supplemental, and how much will you need to fully fund survey and certification? If you make that request, I would like to have you submit to me in writing how much you need to continue your annual surveys of nursing homes.

Dr. DAVIS. We would be happy to.

Senator CHILES. Can you tell me today what kind of funds you would need?

Dr. DAVIS. Yes; our estimate is that we would need about $4 million for the rest of 1982.

Senator CHILES. For the rest of 1982. It was my understanding at one time that you thought you had a $24 million shortfall. Was that earlier in the year, or is it that we are later in the year now?

Senator HEINZ. Senator Chiles, could I interrupt for a second?

Senator CHILES. Yes.

Senator HEINZ. If there is someone in the audience named Velma Lacey, it would be appreciated if you would call home. It is important if you are here.

[No response.]

Senator HEINZ. If you know Velma Lacey, tell her to call home; it is important. Thank you.

I am sorry, Senator Chiles.

Mr. BOURQUE. Senator Chiles, a few months ago when these regulations were proposed, the Secretary was concerned that the policy he was trying to implement with these regulations—that being stronger enforcement and monitoring of homes with poor compliance records—be based on a sufficient budget. He asked us to go back and look at that issue.

We did, and that was when we determined that we were $9 million short. This was a couple of months ago. We sent that request, as you noted, to the Appropriations Committee and it was denied. Since that time, we have been discussing the need for a supplemental request and we are working now in the administration to put that together.

But at this time, we feel we need less money because time has passed and there is only so much the States can do between now and September 30, when the fiscal year ends. I would note that we do have additional funds in the 1982 budget.

Senator CHILES. All right.

Dr. DAVIS. Senator Chiles, I think that part of the confusion may have arisen when the initial budget materials were submitted because there was a typographical error which did give rise to some of the States assuming that there was a larger amount requested than there had been in the budget. We never asked for an additional $20 million.

I will say that between that and three continuing resolutions, we have had continued discussions with the States relative to their level of budgeting for this year. So, I can appreciate their concern relative to knowing what the final dollar figures were. The confusion has been a result of the three different time segments under which we had to issue budget figures based upon the continuing resolution, as well as the typographical error.

Senator CHILES. I see. I was just looking at a memo of yours, dated February 24, 1982, that discusses whether the States, not the individual facility, should be given the right to exercise a JCAH deemed status option. You say:

> If States have the authority to concur, they would be in a position to assure that the option is not exercised. In that eventuality, HCFA could not meet the anticipated $24 million shortfall in the fiscal year 1982 survey and certification budget.

So, that is where I got the $24 million from. Give me your estimate in writing on that, if you will.

Dr. Davis, under the terms of the deemed status proposal as it affects medicare-only nursing homes, the commission would survey

according to their own standards, not the Federal standards. Is that correct?

Dr. DAVIS. That is correct, Senator Chiles. I would like to point out that we have very carefully examined its standards. I have personally read this particular volume. It is a side-by-side comparison of standards against our conditions of participation. These are only the standards and not the analysis and discussion that backed it up.

I would like to point out that, as I said earlier, we believe they are equivalent. In some cases, the JCAH requirements are even more prescriptive than the Federal requirements. For example, in the area of pharmaceutical services, the JCAH requires that the facility's pharmacists provide training to other professional staff in the area of drugs and biologicals. There is not a similar requirement in the SNF conditions.

Senator CHILES. Are there areas where the commission standards are less detailed? Specifically, what about patients' rights?

Dr. DAVIS. I think you would find that in examining the patients' rights sections of the JCAH requirements, as I did, that they are very strong.

Senator CHILES. Are they that strong?

Dr. DAVIS. Yes; I think that we have provided copies of this document to the staff, and I think the staff would find it useful to read that.

Let me point out that there are several other areas where I think it is useful to indicate where the JCAH requirements are more prescriptive than ours. For example, its requirement that a drug review be conducted by a pharmacist, nurse, and physician together is more specific than our own requirements.

In the area of dental services, the JCAH requires that a complete record of all dental care be maintained for each resident. The JCAH is specific on more support by the facilities in providing dental care.

In the area of physical plant and safety, we have no requirement that skilled nursing facilities have a safety committee. The JCAH requires one. We do not have a requirement in the area of building security. The JCAH has very specific guidelines on building security measures.

Senator CHILES. Well, would you say that the JCAH standards are an indictment of the existing Federal standards?

Dr. DAVIS. No, sir. I am simply pointing out that the JCAH in some areas has a more prescriptive set of standards than we do. We feel that ours are basically good, minimal standards, but the JCAH obviously has some areas where they are more prescriptive than we are.

The final example that I would use is in the area of nursing services. The JCAH requires that a registered nurse be on duty for each shift, which is a more specific standard than ours.

Senator CHILES. What happens if the JCAH changes its standards—we go into the deemed status and they decide to change their standards?

Dr. DAVIS. We have an agreement with JCAH that before standards would be changed, it would discuss them with us.

Senator CHILES. Do they have the right to change standards?

Dr. DAVIS. It is a private organization. The JCAH obviously has the right to change its own standards, but I am certain, it would not do so without discussion with us, since if that were to happen, we would not be able to say that it was the same set of standards when we took it under advisement. We could at that point withdraw our deemed status.

Senator CHILES. My time has expired.

Senator HEINZ. Senator Chiles, thank you very much.

Senator Cohen.

Senator COHEN. Thank you very much, Mr. Chairman.

Dr. Davis, on page 6 of your testimony you indicate that there will be no additional cost to the Federal Government from the JCAH deemed status proposal. I am told that in a recent congressional briefing, one administration official said that you would not reduce the Federal funds to the strapped State agencies who conduct the surveys now.

Since we are going to be paying, I assume, the JCAH surveys out of medicare and medicaid funds and we are not going to reduce the funding to the State agencies, how are you going to achieve this no-cost proposal?

Dr. DAVIS. The statement that we would not reduce funding to the States is correct. We do not intend to do that. Already, the JCAH does accredit some.

Senator COHEN. Well, they are not going to work for nothing.

Dr. DAVIS. No, they do not work for nothing, sir. They have a fee that is somewhat similar to the State agency's accrediting cost for a survey. The facilities at that point would be charged a fee by the JCAH that would come out of their overall operating costs and which would appear as part of their overhead expenditures.

Mr. BOURQUE. There are really two elements of the budget, Senator. We have a direct appropriation for the survey and certification activity which the States conduct. When the JCAH performs an accreditation process for the facility, it goes into the allowable costs of the facility and we reimburse the facility through the entitlement budget as opposed to this specific account. So, there is no direct expenditure from the appropriated funds.

On balance, looking at the two accounts, we would expect that it would be a no-cost proposal, because if the State does not have to undertake the survey which the JCAH performs, we are going to pay either one or the other.

Senator COHEN. Well, if the State does not undertake the survey, that means you are not going to be sending that money to the State.

Mr. BOURQUE. We would anticipate continuing to provide sufficient funds so that the State could monitor other facilities—again, this targeting principle—that are poor performers, and I think the Secretary has stated pretty strongly that this is not a budget-related proposal in the eyes of the administration.

Senator COHEN. Let me come back to that targeting proposal because I think it makes some sense, at lease in my mind.

But on page 3 of your testimony you indicate that through this medicare-medicaid automated certification system, you have been able to identify good facilities and to track bad ones. How many

good facilities have been identified and how many bad, and how have they been targeted under your certification proposal?

Dr. DAVIS. We estimate that approximately 20 percent of all of the facilities have a superior record of not having any significant problems and not having ever been out of compliance. Another two-thirds do not have serious deficiencies but have some problems.

Senator COHEN. Well, we are up to, what, 86 percent?

Dr. DAVIS. About 80 percent.

Senator COHEN. So, you have got 20 percent that are bad?

Dr. DAVIS. I would say approximately that level, yes.

Senator COHEN. Then how do you go about targeting them?

Dr. DAVIS. Well, we provide in our computer an absolute tracking mechanism which has a compliance history component to it; not just the current year's citations, but also the previous history.

Senator COHEN. What kind of a base period do you use, 1 year, 5 years?

Dr. DAVIS. Our data base goes back for 3 to 5 years.

Senator COHEN. So, if you find an institution or home that has a good record for—well, let me get a little more complex—not below the minimum, but it is not much above the minimum standards. How does that figure into your computer calculation?

Do you allow 3 to 5 points just above minimal requirements, but kind of marginal in places? What do you do there?

Dr. DAVIS. We would have to look at it at that time. Perhaps Mr. Morford, who handles the MMACS system, could clarify this in greater detail.

Senator COHEN. In other words, that 20 percent of superior people present less of a problem. Then you have got that other two-thirds that are sort of adequate, and maybe some of those two-thirds come closer to the not-so-adequate line, and there are those below the line. Now, how do you compute that?

Mr. MORFORD. Senator, we track all the deficiencies in all these facilities. You are exactly right that some are better than others among that remaining 80 percent.

We have talked to the Secretary about that, and that is why he decided that only 20 percent of the nursing homes would be on the 2-year survey cycle and the other 80 percent would be looked at annually.

In addition to the MMACS system, we work fairly closely with the State agencies because it is not a matter of simply pulling it out of the computer and handing it to them. They work with us and with our regional offices. By virtue of not only the data that we have in the system, but by their program experience and general knowledge, we will work together to decide which facilities should be targeted. States will have a wide range of options along those lines.

Senator COHEN. In the letter that the committee wrote to the Secretary, one of the major areas of complaint, or at least interest was the so-called 90-day limitation, which we agreed was arbitrary.

We were also concerned about the enforcement and the monitoring being weakened by this verification by telephone or mail. During your direct testimony, you indicated that those were just sort of minor deficiencies that can be verified either by telephone or by mail.

I would like to know what sorts of deficiencies you have in mind that would fall into that category of being minor. I do not mean to be trivial in what I am suggesting, but we are going through some talks, and so forth, and one of the major issues is verification. What we want is onsite inspection, because we do not believe we can take care of it through "national technical means," with these satellites, telephones, or whatever. We have to have onsite inspections because we do not know what is going on in those buildings.

It is not exactly a parallel, but since we have this concern about life-threatening issues, it seems to me that we ought to be really concerned about trying to verify something over a telephone or by mail.

Dr. DAVIS. I can understand your concern, Senator Cohen. Let me clarify that mail or telephone checks would be for paper types of deficiencies. For example, when a facility that had been surveyed did not have minutes approved, did not have a written plan of utilization review, or some policies were missing from its books. It is for those minor kinds of problems that we could use the mail or telephone as a followup; they could submit those reports by mail.

Senator COHEN. Thank you, Mr. Chairman.

Senator HEINZ. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

The gentleman here—and I was not here to get your name—but you said that this was not a budget-related proposal. I would accept that, but in order for further clarification on that, is this proposal something that has surfaced just since the Reagan administration has taken over, or is this something that was present in the thinking of people in the professional bureaucracy before this administration?

Mr. BOURQUE. Senator Grassley, this was a proposal that was considered very seriously by the previous administration. In fact, in 1980, a series of hearings were held around the country with respect to this in all of our regions. There were about 10 or 12 issues upon which testimony was received.

If you look at the Carter administration's final budget just prior to this administration coming into office, you would find that it addressed the flexible survey cycle at some length and indicated that it would support legislation to make the changes that the Congress made last year in eliminating time-limited agreements. The previous administration also stated that it was going to submit in a regulatory manner some changes with respect to the requirements as we have done.

Senator GRASSLEY. But obviously there is going to be less expenditure of public funds. So, maybe the motive is not budget-related, but you are anticipating spending less money.

Mr. BOURQUE. There is the possibility that with more flexibility to the States, the States would find ways to conduct some of their survey activities more efficiently. But I think that will be a byproduct of this.

Senator GRASSLEY. OK. But what about costs to the Federal Treasury—more, less, or unrelated?

Mr. BOURQUE. Well, Senator, our budget next year goes up, and not down, because of our serious concern about maintaining this protection for our Federal beneficiaries.

Senator GRASSLEY. Using a private organization as a basis for determining compliance of nursing homes—has this been used in any individual State? Do we have any experience with any of the 50 States as laboratories for our governmental system that we are building on here, or is this completely an idea that has come from the Federal bureaucracy?

Mr. MORFORD. Senator, we have no direct experience in nursing homes, except to look at the facilities that the JCAH has already certified. There is some experience in addition to our experience with hospitals with the JCAH. The College of American Pathologists accredits numerous laboratories in hospitals for us under the Clinical Laboratory Improvement Act, and we have been relatively well satisfied with its performance on that.

Senator GRASSLEY. So, really, we are striking out here totally on new ground.

Mr. BOURQUE. Senator, there are 1,300 long-term and intermediate-care facilities that the Joint Commission now accredits, and it has been doing this since 1966.

Senator GRASSLEY. Well, I am aware of that, but as a regulatory aspect of governmental bodies, I am trying to make a determination of whether or not States have used this as a determinant in regulation.

Dr. DAVIS. States have used deeming for hospitals, but not for nursing homes.

Senator GRASSLEY. Not for nursing homes?

Mr. BOURQUE. Not for nursing homes.

Senator GRASSLEY. So, what you are suggesting here, then, we have no track record for, with any States trying to use this as a basis for regulation?

Mr. BOURQUE. We have not previously allowed JCAH to deem status for long-term care facilities, that is correct, sir.

Senator GRASSLEY. Mr. Chairman, that is all the questions I have.

Senator HEINZ. Senator Grassley, thank you.

Senator Burdick.

Senator BURDICK. Thank you, Mr. Chairman.

One of the things we hear about most from health care providers is the paperwork, which was touched upon today. Certainly, reduction in paperwork should be one of the goals of any streamlining effort. From what I understand of your proposal, however, the only major reduction addressed is a reduction of the frequency of the annual certification and surveys.

In fact, it seems to me that a nursing home in a deemed status program may just take on another layer of paperwork because of differences in Federal and JCAH standards.

Do you expect these regulations to decrease the paperwork now required of nursing homes?

Dr. DAVIS. Yes, Senator Burdick, we do expect that they will decrease the paperwork. I outlined several areas. I think that the reduction in the paperwork pertaining to the quarterly staffing reports is an important area.

When the regional hearings were held, some 32 States testified that they felt that the quarterly staffing reports were not useful for them and were in agreement with a more flexible staffing report cycle.

The other area that I mentioned earlier was the automatic cancellation clause, which is an area that also consumes a great deal of paperwork. Most of that paperwork burden is with the State agency which must put forth the papers to start on this automatic cancellation in case the facility does not have a record of having demonstrated some progress. All the facility needs to do is to demonstrate some achievement.

So, we feel that the particular automatic cancellation clause is not very effective. Well over 90 percent of those clauses are rescinded retroactively, which simply requires a lot more paperwork, and in many cases also requires an onsite visit in order to rescind them.

Senator BURDICK. Well, I entered the hearing room as you were talking about paperwork, and perhaps you did give other specific examples. Did you in your testimony?

Dr. DAVIS. I believe, Senator, that the automatic cancellation clause and the quarterly staffing reports were the two major paperwork burden reduction areas that I can recall.

Senator BURDICK. In other words, it is a fair statement to say that there are at least three or four examples that you could refer to of forms and reports that are required now, but will not be required under your proposal?

Dr. DAVIS. That is correct.

Senator BURDICK. I recently chaired a field hearing in North Dakota on long-term care in rural areas. One of the most troublesome problems for those who had trouble was difficulty in making complaints. It was often difficult for the patients or their families to articulate their criticisms or concerns in a proper manner. They were often intimidated by the system.

What would be the procedure for the JCAH to investigate a complaint from a concerned citizen?

Dr. DAVIS. The JCAH does have a system whereby it allows for a followup of complaints. It will investigate either by letter or onsite when there is a complaint received. I would point out that the complaint could be initiated and sent to either the State agency, to us, or to the local ombudsperson within that State, or even to the JCAH itself. So, there are a number of routes by which a complaint could get surfaced.

Mr. BOURQUE. The JCAH, Senator, has a 24-hour toll-free hotline that consumers can call with complaints. In addition, if we received a complaint with respect to a facility that has been given deemed status, we would forward that complaint to JCAH and it is required to submit to us a report of the deficiencies, if there are any, so that we can then respond to the complainant.

Senator BURDICK. And this hotline is in being and can be used at any time?

Mr. BOURQUE. I believe so, sir.

Senator BURDICK. Well, that answers that question. There is someplace that the citizens can go to. I assume that that would be

the same procedure that an individual would have to take in order to get some kind of an investigation of the complaints.

Dr. DAVIS. Yes.

Senator BURDICK. Thank you; that is all.

Senator HEINZ. Thank you, Senator Burdick.

Senator Bradley.

Senator BRADLEY. Thank you, Mr. Chairman.

Dr. Davis, let me just see if you agree with these general statements. JCAH accreditation standards are not set by Government. Do you agree with that?

Dr. DAVIS. That is correct.

Senator BRADLEY. JCAH has no regulatory authority. Do you agree with that?

Dr. DAVIS. Yes.

Senator BRADLEY. JCAH accreditation findings are not made public.

Dr. DAVIS. At the current time, they are not made public. However, under our proposal, they will be publicly posted in the nursing home.

Senator BRADLEY. In summary form?

Dr. DAVIS. In summary form? No, sir.

Senator BRADLEY. In great detail?

Dr. DAVIS. The exact copy of the material that they receive will be published.

Senator BRADLEY. But at the moment, they are not?

Dr. DAVIS. Well, at the moment, we do not deem JCAH accredited nursing homes either.

Senator BRADLEY. Then the Government does not set the accreditation standards. JCAH has no regulatory authority, and there is a question about the transmittal of the findings.

Dr. DAVIS. I have no question on the transmittal of findings.

Senator BRADLEY. Do you transmit it to the State agency involved, or do you just post it in the nursing home?

Dr. DAVIS. I simply said that it was posted.

Senator BRADLEY. So, you have to go to every nursing home in your State if you want to find out what the JCAH findings were. Is that correct?

Dr. DAVIS. As Mr. Bourque mentioned earlier, we believe that having it published in a public place is even better than it has been in the past.

Senator BRADLEY. Why are you not sending it to the States?

Dr. DAVIS. I think, sir, that some of the comments that we have received from some States so far do indicate that they would like us to require this as one option, and we will take it under consideration when we study all of our comments that come before we make our final proposal.

Senator BRADLEY. So, you are going to send it to the States?

Dr. DAVIS. No; I said that some of the State agencies, in writing their comments to us about the proposed regulations, have identified that one option for us could be to require that the individual facility send the material to the State just as they have posted it. And we will take under consideration as we prepare our final regulation.

Senator BRADLEY. When will you be making that decision?

Dr. DAVIS. The comment period ends July 26, and it will take us probably a couple of months after that to analyze the comments that have come in.

Senator BRADLEY. All right, let us go on. Is it true that the funds for survey support from the Federal level have been decreased roughly 40 percent in the last 2 years?

Dr. DAVIS. Yes, sir, the funds have been decreased over the last 2 years.

Senator BRADLEY. From roughly $29 to $27 million in HHS?

Dr. DAVIS. I think that figure would be about right.

Senator BRADLEY. Is it true that State funds for State surveys have been decreased over the last several years from 100 to 75 percent, and did not the administration propose that it be reduced to 50 percent?

Dr. DAVIS. Yes, those funds were decreased to 75 percent by Congress in 1980.

Senator BRADLEY. Well, in 1981, they were reduced to 75 percent under the Reconciliation Act.

Dr. DAVIS. That is correct.

Senator BRADLEY. The administration proposed reducing them further to 50 percent. The Finance Committee resisted that, however. But it was the administration's proposal, right?

Dr. DAVIS. Yes.

Senator BRADLEY. Have you proposed the elimination of the Professional Standards Review Organization—PSRO's?

Dr. DAVIS. Yes; the elimination of PSRO's is a separate issue. We do believe that there are other ways in which one can obtain utilization review activities.

Senator BRADLEY. So, let us take those facts. The JCAH has no regulatory authority. The JCAH accreditation standards are not set by Government. There is, to date, no sharing of the information with the State agencies responsible for enforcing the provisions. There has been a decrease in Federal funds by 40 percent over the last 2 years. There has been a decrease in State survey funds in the last 2 years, and you want to go deeper. And the administration recommends eliminating PSRO's.

Could you tell me, please, if you were a member of this committee charged with the responsibility of oversight for programs that affect the aging population of this country—in this case, particularly the issues of nursing home care—would you not feel a little uneasy about the administration's commitment to quality?

Dr. DAVIS. No, sir. I think that you are treading on emotions rather than on facts. Logic does not tell me that just because budgets do not increase that it necessarily means that there is going to be a decrease in overall protection of the health and safety of the individual beneficiaries.

It is clear that we have found in prior demonstrations some ability to show that focusing efforts with good teams can adequately take care of this both from the State agency's point of view and our own in terms of less than annual surveys.

Senator BRADLEY. What has California's experience been with the JCAH? I know we will hear later in the day from someone who is not satisfied with those focusing efforts.

Dr. DAVIS. Well, I would have to suggest that California ought to speak for itself. I am not familiar with its comments.

Senator BRADLEY. Well, let me talk about New Jersey then. You have said that you think that quality can be assured at no additional Federal cost. In New Jersey, the standards that we have are much higher than JCAH standards.

Now, unless we relax those standards, we still have to pay for the licensing surveys along with medicare. Yet, we are losing money for medicare surveys, and we are losing money for State surveys. Yet, we still have to regulate and enforce these surveys.

I mean, how can you claim that we will be paying less? We will be paying more, or we are going to have to reduce our standards.

Dr. DAVIS. Again, I indicated earlier that targeting on those facilities that have a poor history of compliance and focusing those reviews would be one of the State options. That is also true on deeming. You indicated earlier that the State of New Jersey had higher requirements. The choice is up to each individual State.

As we have clearly stated here, it is a State option, and each individual State would determine for itself whether it felt that its own procedures were higher.

Senator BRADLEY. Keep in mind that that quality was, in part, maintained in the past by regular surveys that were financed, in part, by Federal funds. Now, those funds are gone; they have been cut dramatically.

So, if you think quality depends on regular surveys and you are a State that has high standards, then you are going to have to pay for more and more of those surveys. Now, does that not pose a question with a State who has been responsible in trying to enforce high standards for nursing home care with the choice of either spending more State money or reducing the quality of the care?

Dr. DAVIS. I think, sir, it is a question of balance. I would dispute the fact that quality depends on regular surveys every year. What we are saying is that quality can be assured with less than annual surveys.

Senator BRADLEY. What is your evidence for that?

Dr. DAVIS. We have several demonstration projects going now in Wisconsin, New York, and Massachusetts.

Senator BRADLEY. Over what period of time?

Dr. DAVIS. The one in Wisconsin, sir, is just terminating. I think it has been in effect for 4 years.

Senator BRADLEY. And what about New York?

Dr. DAVIS. That has been in effect about 1 or 2 years.

Senator BRADLEY. So, on the basis of one demonstration project in Wisconsin, you are asserting that we do not need regular surveys nationwide?

Dr. DAVIS. I did not say we did not need regular surveys.

Senator BRADLEY. You said that there is no relation between quality——

Dr. DAVIS. May I finish my statement?

Senator BRADLEY. No; let me.

You say there is no relation between quality and regular surveys, and I asked you what your evidence was for that and you said the Wisconsin survey.

Dr. DAVIS. I said there was no relationship between quality and annual surveys.

Senator BRADLEY. What is your evidence for that?

Dr. DAVIS. What is your evidence that there is connection between the two?

Senator BRADLEY. You are the one who is asserting a change in the present circumstance in my State, and I am——

Dr. DAVIS. No, sir. I am trying to give your State the option to make its own determination as to whether it wants to have the opportunity for the deemed status.

Senator BRADLEY. Yes; you are giving my State the option to reduce its standards or increase the funds that we have to spend to do annual surveys. I have asserted, based on our experience and the officials in our State, that annual surveys are important to maintaining quality.

You have asserted that annual surveys are not important for retaining quality. I have asked you what is your evidence and you have said Wisconsin.

Dr. DAVIS. We had a series of hearings around the country. In those hearings in the 10 regions around the country, plus Washington, D.C., comments were made from many States that indicated that they too believed in a more flexible survey cycle.

I would assume that those comments coming from the various State agencies meant that they believed in less frequent surveys. We have the document right here that very clearly indicates to us that a number of the States would support the idea of more flexible survey cycles.

It is clear when they said that they favored less than annual surveys or more than annual surveys, depending upon the record of the facility itself.

Senator BRADLEY. Which States said that?

Senator HEINZ. Excuse me, Senator Bradley. We are going to have the States up in the next panel of witnesses in a minute. We will hear from the States exactly what their position is, if I might suggest that.

Senator BRADLEY. That is fine, Mr. Chairman.

Dr. DAVIS. We can provide a summary for the record for you, Senator Bradley.

Senator BRADLEY. Good; I would appreciate that.

[Subsequent to the hearing, Dr. Davis supplied the following information:]

During the series of hearings in the 10 regions and Washington, D.C. in April, May, and June of 1980, agencies representing the following 32 States testified expressing support for flexible survey cycles: Alabama, Arizona, Arkansas, California, Colorado, Florida, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

Senator BRADLEY. Could I ask just one more question, Mr. Chairman? I just want to follow up on Senator Cohen's point about—I did not understand when you said you were taking money away from State surveys, but you were going to make it up through entitlements.

Did you understand that?

Senator COHEN. No. [Laughter.]

Senator BRADLEY. Could you explain that?

Dr. DAVIS. Let me clarify, if I may. There are two different ways in which our budget is composed. One is from a direct appropriation; the other one is through the use of the trust funds.

If the survey is done by the JCAH, it would be a part of the cost of the administrative component. Those costs come in to us as part of the overall cost reports. That is paid for under the hospital insurance trust fund as opposed to a direct budget allocation which we give to the States to operate the survey activities.

Senator BRADLEY. So, though you have cut the State agencies, you are going to make that up in entitlements?

Dr. DAVIS. We have indicated that we will not reduce the line item because of the deeming. In fact, our budget for next year in this area will go up some, Senator.

But what we have said is that if the State wishes to use deeming, this will provide the State with some flexibility. They can then retarget some of those resources to more frequent surveys of the poor compliers.

Senator BRADLEY. Thank you, Mr. Chairman, I appreciate your patience.

Senator HEINZ. Senator Cohen has one followup question.

Senator COHEN. Just a couple of quick points, and they are not so much questions as perhaps recommendations.

One thing that was not clear to me, in addition to the question on spending, was the respose to Senator Heinz' question about your report back earlier this spring on the JCAH's performance record of 60 percent on one hand and 51 percent on the other. You indicated that those were really kind of minor differences between survey techniques and survey standards, whether one is using a State code or a Life Safety Code.

It occurs to me, in response to the line of questions of Senator Bradley, that we either ought to do one of two things. We either ought to have the Federal Government adopt the private agency's standards, or we ought to insist that the JCAH adopt the medicare-medicaid standards, so you have one standard.

The last thing we need is to have two or three different sets of standards about what is the minimum level or requirement. That would go a long way toward reducing this question—in my judgment—have one or the other; either they upgrade theirs, if it is upgrading, or we downgrade ours to theirs. But it seems to me we ought to have one standard.

Second, with respect to the question of the posting, I would recommend not that the nursing homes have the additional paperwork burden of sending along a copy of that report to the State agencies, but the people who conduct the survey mail out two copies. They have a bigger Xerox machine than most of the nursing homes do in the State of Maine. They simply can make two copies, one to go to the nursing home for posting and one to go to the State agency. That would eliminate a lot of paperwork on the part of the nursing homes.

Dr. DAVIS. May I respond to those?

Senator COHEN. Yes.

Dr. DAVIS. As far as asking the JCAH to send the information back, the JCAH has indicated very clearly that they are a voluntary accreditation agency. They believe that position then means that those individual institutions which have decided that they wish to be accredited by the JCAH should handle the responsibility of informing the public rather than the JCAH doing that. We would honor that commitment.

I think the other way of doing it would simply be to ask or require the institution itself—since it is going to post those findings in a public place—to send those findings to the State agency.

Senator CHILES. If I might make a recommendation——

Senator COHEN. There was a second question there.

Dr. DAVIS. I am sorry; I have forgotten your other question. Would you repeat it?

Senator COHEN. The other question was on having one standard.

Dr. DAVIS. Yes; as I said earlier, we did a very careful, side-by-side analysis, and it strikes me that one can demonstrate that something is equitable without having it be exact.

I think the particular confusion in our validation of the JCAH arose in the area of the Life Safety Code. One reason for some of the differences between the JCAH and the State agency surveyors is that State agencies have the opportunity to make a determination of which of the Life Safety Codes they use. The JCAH uses the 1973 version, while the States use the 1967 version.

Mr. Morford may want to elaborate on that.

Mr. MORFORD. I would suggest also that there are numerous reasons for the variations. First, there are significant differences between the 1967 and 1973 Life Safety Codes in terms of flexibility. The 1973 code provides more leeway in interpretation especially in terms of alternatives for assuring fire safety. The critical point is that both codes assure the same degree of safety; the 1973 code simply represents later developments in fire safety research. Another major reason for the difference is that anytime you do a resurvey of any facility—and it happens to us on some occasions when the Federal Government does a direct monitoring survey of a State-certified facility—you find differences for one of many reasons.

I think, though, that the bottom-line conclusion in terms of how we have looked at the JCAH and how the GAO has looked at the JCAH is that one can easily, at anytime, single out one instance in a facility or a group of facilities where you have a particular finding.

I think the preponderance of evidence weighs clearly on the side of the JCAH.

Senator COHEN. So, we should adjust our standards to theirs.

Mr. MORFORD. Well, the JCAH standards are optimal and ours are minimal in some cases. In other cases, they are pretty much equal.

Senator COHEN. Well, let me just understand. I do not want to take anymore time, but it seems to me, in your report, if they are higher than our standards, then they should not be cited in the report as being in noncompliance with our standards. Anything that is higher than ours ought to be praised and not cited as a divergence.

Mr. MORFORD. In some of those areas, that is true. In other areas where we found differences, there was a difference in terms of what simply the two different surveyors found at different points in time in a facility. Again, I would emphasize that none of those facilities were decertified.

They found problems. In some cases, the JCAH found very similar problems, but because of the way the system is run right now, the deficiencies automatically went into the State monitoring system.

Dr. DAVIS. Senator Cohen, it is very difficult, without having gone through an actual survey, to understand how detailed those surveys can be and how many variables they are measuring. But one can be cited for a deficiency, for example, for not having a locked narcotics closet, if you are there at that point in time; and it is not locked.

Now, it is very obvious that if one then corrects that deficiency by making it very clear to the nurses on duty that it must always be locked, then it is only when there is an error that occurs from a personal point of view that the same deficiency would then be cited the next time around.

So, that does account for some of these minor variations.

Senator COHEN. That is not what I am talking about. I am not talking about the differences and whether something is locked or not locked. What I am talking about is having standards remain the same, not whether the factual compliance or noncompliance with that ought to be the same standard.

Dr. DAVIS. I see where you are coming from.

Senator HEINZ. We have got, if I may say to my colleagues, eight more witnesses; this is our first. [Laughter.]

We do hope to finish some time today, so unless there are any other absolutely compelling questions——

Senator CHILES. I do not have a question, but I just have a brief recommendation to follow up Senator Cohen's recommendation.

I think rather than to get into this thing of standards, I would just recommend that you notify the Joint Commission on Accreditation of Hospitals that you thank them very much, but as they are a voluntary organization, as you have said, that we just not use them and that we do this ourselves. [Laughter.]

I do not think we should get Wackenhut to protect the President instead of the Secret Service. [Laughter.]

And I do not think we should get a voluntary agency to try to protect recipients of nursing homes who are depending on the State and Federal Government for that protection. I think a voluntary agency is not organized for that purpose. That is not their duty, and it should not be a duty that we should give to them.

Senator HEINZ. Dr. Davis, thank you very much.

Dr. DAVIS. Thank you. We appreciate the opportunity for having been able to clarify our positions.

Senator HEINZ. We hope that you have listened very carefully to what I think are the near unanimous opinions of the committee. As I listened to my colleagues both on the Democratic and the Republican side, I would have to say that you have just about zero support for using the Joint Commission on Accreditation of Hospi-

tals for what you have proposed for medicare and medicare-medicaid nursing homes though State option.

We hope you will take that under advisement and do the right thing.

Thank you very much.

Our next panel consists of Norman Pawlewski, Mildred Simmons, Edward Kuriansky, and Freida Gorrecht. I would like to yield to Senator Grassley to introduce the commissioner of health from the State of Iowa.

STATEMENT BY SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Mr. Chairman, I am going to ask that my prepared statement be inserted into the record.

Senator HEINZ. Without objection, so ordered.

Senator GRASSLEY. But I do want to call the committee's attention to Norman Pawlewski, commissioner of health for the State of Iowa. He has been in that position since 1973. He has been active in communication with me, as I am sure your State administrator has, of concerns over the proposed regulations.

He has also been active in being a good administrator of health, and concerned about standards of care in our nursing homes in Iowa. When I was a member of the State legislature, I worked closely with him on this, prior to his taking over his present position in 1973. In 1971 and 1972, when I was chairman of the legislative rules and review committee, I had an opportunity to work closely on rules that are still basically applicable to the regulation of nursing homes in my State.

At that point, we upgraded our regulations to a point, where I think I can claim, as Senator Bradley did for his State, that our regulations are far higher than even what the Federal Government today demands.

I hope that we can learn from our States the extent to which they feel that this might lead to a deterioration of Federal supervision of State regulation of nursing homes. To that extent, I welcome all of the State representatives here, but particularly my own.

Thank you, Mr. Chairman.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman, for calling this hearing on nursing home survey and certification. Since the comment period for the Health Care Finance Administration's proposed regulations in this field ends on July 26, you and your staff are to be congratulated on the timeliness of this hearing.

This issue has consumed a good share of my legislative time during my 16 years in the Iowa Legislature, my 6 years in the House of Representatives, and now 2 years in the U.S. Senate. Clearly, there have been significant improvements over the past 25 years in the quality of care offered in our Nation's nursing homes. I know, because I have witnessed such changes in visits to nursing homes in my home State where a high level of care presently obtains. Trouble spots remain, however, especially within the survey and certification process. Like my colleagues, I have heard these concerns voiced by responsible State officials and others within the nursing home field. For this reason, I recently joined other members of this committee in sending a letter to Secretary Schweiker, in which we suggested changes in the proposed regulations for the nursing home inspection program. Our objective was to send a clear signal to the industry that there would be no letup in careful monitoring of those nursing homes with real or potential standards problems.

I am glad that HCFA Administrator Carolyne Davis is here this morning to present the administration's position on the subject regulations. I am also glad that my colleagues will have the benefit of the views of my fellow Iowan, Norman Pawlewski, commissioner of health for the State of Iowa. I have worked with Norm in the past on just this sort of regulatory measure when I was in the Iowa Legislature. I know Norm is concerned about certain aspects of the proposed regulations covering survey and certification of health care facilities. He wrote to me in June of these concerns, and I welcome him and the opportunity this hearing presents to him to state his insights with other members of the Aging Committee and Administrator Davis of HCFA.

Senator HEINZ. Let me ask Mr. Pawlewski to be our first witness. That clock will start green and will end up red after 5 minutes.

STATEMENT OF NORMAN PAWLEWSKI, DES MOINES, IOWA, COMMISSIONER OF HEALTH, STATE OF IOWA, REPRESENTING THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

Mr. PAWLEWSKI. Thank you very much.

Good morning, Senators and ladies and gentlemen. My name is Norman Pawlewski, and I am commissioner of health for the State of Iowa. I speak for my State today. I also speak for the 56 other chief health officers of the States and territories of this country—the Association of State and Territorial Health Officials.

We are unanimous and of one accord. We consider this occasion a mission of utmost consequence and importance. To illustrate more clearly how we see the changes proposed by HCFA, allow me to use an analogy.

Senators, let us pretend for a minute that you are the Senate Armed Services Committee and I am chairman of the Joint Chiefs of Staff. Having been discharged a corporal, I kind of like that pretend. And I am here to persuade you that I have a great idea for running the Army—an idea that will save huge amounts of money—a do-it-yourself army; do away with all sergeants.

This is how we would talk to our troops.

Men, it is your army and you are going to run it yourselves. Police yourselves; see to it that your boots are polished, that you exercise, run obstacle courses, pop right out of bed when reville sounds. Hold your own inspections; do not go AWOL, and do not get drunk at the PX. Is that not great, men?

Now, somebody will call you now and then to see how you are doing, and if you are naughty, you might get a letter or a telephone call telling you to knock it off. But, basically, it is your army and we trust that you will do the right thing without all those mean old sergeants.

Think of all the money we can save, Senators. Do you know how long that army will last? About as long as a handful of M&M's with E.T. [Laughter.]

I submit, Senators, that that is precisely what will be the fate of the Nation's nursing homes if the Federal presence in the control and operation of those facilities is reduced to the level presently proposed.

I speak to you now from the frontline trenches—out there where there is mud and rain and wet feet and bad food—not from the command post. The view is much different down here, and we are getting ambushed by our own comrades-in-arms. The directives from Carolyne Davis are shooting us down, and scaring us to death, I might add.

Her idea of saving Federal money is to cut out fire inspections by trained fire inspectors. Let the nurses do them, she says. Tell me, Senators, what nursing school teaches nurses about fire inspections? That is all we need—a big nursing home fire caused by safety violations because some nurse did not know what to look for, and lacked the confidence to evaluate what she saw. The tradeoff in terms of Federal funds is peanuts compared to the potential for headline-making disaster.

I am irresistably drawn to a remark once made by a contributor to our society, who occupied a seat in the U.S. Senate, J. William Fulbright, who said, "We must dare to think about unthinkable things, because when things become unthinkable, thinking stops, and action becomes mindless."

I give you an unthinkable, Senators: It is unthinkable that we abandon our elderly to the vagrant belief that there is an inherent goodness beating in the breasts of men that will propel them to good deeds. And it is delusional to think that the world's dark deeds are the exclusive province of the high and mighty. One quick look at the front page of any newspaper, in any city, in any country of the world today, should quickly relieve you of that erroneous conclusion.

It is not that evil men get together and say, "Let us open up a nursing home so we can abuse elderly people." The abuse comes about one step at a time. Less than 10 years ago, we had some real pits in Iowa. Some of them were operated by pillars of respectability in their communities—church members, service clubs, fund drives, the chamber of commerce—the works, you know the types.

One operator was very influential in his political party, and was even a close friend of a highly placed elected official. Nobody would believe that this man was capable of operating a degrading, filthy, inhuman hole until they saw the photographs we had taken. Even the official refused to believe it until he saw the pictures.

Yes, Senators, it could happen again. Take away the funds that prevent such things and you guarantee it will happen again. In the last 2 years, our medicare funds have been cut 60 percent, medicaid 20 percent.

On March 20 of this year, Secretary Schweiker announced, "I will not imperil senior citizens in nursing homes, our most vulnerable population, by removing essential Federal protection. I will not turn back the clock."

But the directives of the Health Care Financing Administration, of which Carolyne Davis is the Administrator, are moving back the hands, and we are going to get chopped to bits if it does not stop. In 1974, the Federal Government stepped in with the necessary muscle—money—and helped us clean up a deplorable situation. That is as it should be—a partnership, a joint effort.

After all, the nursing home industry is an industry created by the Federal Government by virtue of medicare and medicaid. The States have not created this industry, but we do bear the major burden of monitoring now that it exists.

I will tell you how to move the hands of the clock backward. With two moves, you can shove us back into the dark ages of long-term care.

Backward move No. 1: The Federal proposal to grant so-called deemed status for health care facilities by JCAH, the Joint Commission on Accreditation of Hospitals, instead of by State agencies. That backward move has more holes in it than 100 pounds of Swiss cheese. It is like a mother saying to a bunch of hungry kids, "I am going shopping for the day, and do not get into the cookie jar."

JCAH has no regulatory authority whatsoever. It is without muscle. It could do nothing about violations. JCAH represents nonprofit interests, and they therefore have no particular incentive to cut costs. Private, long-term care facilities are profitmaking entities with strong incentives to cut costs and corners, and cutting corners in most cases means reducing needed services.

Backward move No. 2: The Federal proposal to put nursing homes on a 2-year cycle with no mandatory revisit; a phone call or a letter or a Xeroxed copy of deficiencies, but no reinspection to see to it that deficiencies are eliminated—the kids in the cookie jar. Can you imagine what abuses could develop?

With a staff turnover averaging about 50 percent, who would say anything? Who could say anything? The patients? They are at the mercy of their caretakers. They fear the retaliation, and the retaliation runs deep in these homes. Oh, there are many creative little ways to retaliate against tattletale patients.

This is a joint effort, Senators—the States and the Federal Government. You cannot pull the plug on us. You cannot start the ballgame and then quit. You give us the muscle; we will do the work. We are the only ones who can do this properly. We are the only ones who are in there watching out for the welfare of our—no, your elderly.

We are the only bulwark between them and the unscrupulous operators who are sure to surface, and quickly, if you are going to default this game. I can promise you here and now, if that happens, there will be a very heavy price paid by both the State and the Federal Government. If you think crippling us is going to cut any costs, it is the falsest kind of economy.

In closing, I am borrowing from Sophocles, who said centuries ago, "You have this good within your hands. Do not lose it."

Thank you.

Senator HEINZ. Thank you very much, Mr. Pawlewski.

I would like to ask Mildred Simmons to address us.

STATEMENT OF MILDRED GLOVER SIMMONS, R.N., SACRAMENTO, CALIF., DEPUTY DIRECTOR, LICENSING AND CERTIFICATION DIVISION, DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA, REPRESENTING THE ASSOCIATION OF HEALTH FACILITY LICENSURE AND CERTIFICATION DIRECTORS

Ms. SIMMONS. Good morning, Mr. Chairman and Senators. My name is Mildred Glover Simmons. I am a registered nurse, and I am the deputy director of the California Department of Health Services, responsible for the licensing and certification of health facilities within the State of California.

As the members of the committee may be aware, California currently licenses and inspects over 2,700 health care facilities, including 1,200 long-term care facilities. I am pleased and privileged to be

here today to present testimony both for the State of California and as a representative of the Association of Health Facility Licensure and Certification Directors. My verbal testimony is only a small portion of the testimony that I am requesting be made part of this committee's record.

Senator HEINZ. Without objection, your entire testimony will be part of the record.[1]

Ms. SIMMONS. Thank you.

We feel that, in general, many of the specific proposals would not compromise the survey and certification process. We would like to comment, though, on two major issues.

The flexible survey cycle: Recently, region IX of HCFA considered an analysis of facilities within the State of California, ranking them "A", "B", and "C", meaning "A" twice a year, "B" facilities inspected annually, and the "C" facilities which could be surveyed every 2 years.

We do not know if our facilities are any better or any worse than those in any other State, based on compliance with conditions of participation. However, a review done by region IX, HCFA, in early 1982, indicates that we will be making many more visits under this flexible survey cycle than we would normally be making if we visited each of our 1,200 facilities only once during the year.

In California, HCFA suggests that there are more facilities requiring two visits a year than there are facilities requiring a visit every 2 years. While the intent is commendable, the actual cost for certification would be increased.

We would question that statement in the Federal Register that hospitals generally have fewer deficiencies than other types of facilities and need less frequent monitoring. This simply has not been the case in California.

In California, we are associated with the Joint Commission on Accreditation of Hospitals and the California Medical Association in surveying general acute care hospitals according to schedules and timeframes selected by the Joint Commission. This has been a survey gathering only data, with licensure and accreditation decisions being made independently by the State and the Joint Commission.

We agree that hospitals have a much more sophisticated organizational structure both through the structure of an organized medical staff and hospital governance committees. However, the layers of review or the monitoring do not assure that any hospital is problem-free or conforms to State, Federal, or accreditation requirements.

Interestingly, in each of the recent instances where State action has been taken against the license of a general acute hospital, the internal review and monitoring that was assumed to have been taking place was totally absent or inoperable.

The proposal for deemed status is the primary reason why I am pleased to be here as one of the presenters at this hearing. Initially, I would like to state that California supports the concepts expressed in the position paper developed by region III of the Association of Health Facility Licensure and Certification Directors.[2]

[1] See page 40.

[2] See appendix 1, item 5, page 113.

And to that end, I am including their paper as a part of my official testimony.

On April 15, 1976, the California department entered into the first of the surveys with the Joint Commission and the CMA. The intent of our survey effort was clear—the elimination of the potential for a duplicate survey and to reduce the time spent in the facility.

At the time the agreement was signed by the Joint Commission, the California Medical Association and the department, it was agreed by all parties to the contract that validation surveys would be performed.

Recent validation surveys show, in facilities ranging in size from 78 to 203 beds, and involving 15 identifiable services, that there were major differences existing in the identification of problem areas within the facility. During the past 6 years, we have had numerous complaints on general acute care hospitals that were currently accredited by the Joint Commission.

Licensing investigations found serious conditions existing in hospitals which resulted in licensure action and the ultimate closure of hospitals. Most recently, the Joint Commission accredited four acute hospitals within our State, with a total licensed bed capacity of 1,144 beds, which, after our State inspection, resulted in one hospital being closed and the three others being placed on long-term license probation.

The CALS—consolidated accreditation licensure survey—process has been in effect for the past 6 years. It has become increasingly more apparent that the critical information regarding facility deficiencies, particularly in the area of governance and medical staff performance, have not been reported to the department by the Joint Commission. We have reason to believe that during the time of the surveys, the problem areas or areas of questionable behavior were known by the Joint Commission evaluators during the previous CALS survey and were either discussed during a medical staff conference, at which the department staff is excluded, or were included as a part of the recommendations that are provided to the facility which are not available to the department of health services.

In either case, the department lacked any necessary information to protect the health and safety of patients in those particular facilities for over 2 years.

In our review of the deemed status proposal, many individual issues are of vital concern to California and I would like to touch on just a couple of these.

The announced visit: We have extreme concerns that facilities will be notified in advance of the date of their survey, approximately 4 weeks ahead of the survey time. In California, all visits are unannounced. This obvious announcement allows facilities to be seen at their very best and as they wish to be seen.

The public notice of survey: While it is commendable that a public notice be placed in the facility announcing a survey, one must weigh the value of any discussion interviews that appear to take away from the 1-day survey that will be given.

The display of information: Our concern is, is this display going to be merely the plaque, or is it going to be a listing of any identi-

fied recommendations? Remember, they are not deficiencies. And will it also include the provider's plan for correcting such problems? We do not know.

Current California statute requires the posting of all statements of deficiencies, and they must remain posted for 1 full year.

In the area of complaint investigations, the Joint Commission procedure involves notifying the facility that there has been a complaint registered, and asking the facility to investigate and to respond; with no confidentiality of the patient's name. This allows for a facility to self-certify that they really have no problems.

By contrast, California statute requires that initial contact with the complainant be made and investigations commence within 10 days. We find nothing in the Joint Commission manual, of which I am aware, that would ever require reports of complaints to be provided to a State agency.

In California, we do have a citation system, and we feel that the Joint Commission deemed status survey with no enforcement capability could never have the impact on the improvement of health care that we have with our own system.

I will go to my conclusion. We have done an analysis where we have found that in areas of survey procedure, the actual in-facility survey time will be less than 6 hours with the Joint Commission.

We find the accreditation process is and would remain voluntary. The philosophy of the Joint Commission is that providers of health care should voluntarily assess the quality of care they render. I quote from their manual, "The Joint Commission assumes the role of evaluator, consultant, and educator." Nowhere do they use the words "enforcer of regulations."

There can be no argument that the standards of the Joint Commission are equal to those requirements in the conditions of participation. The argument comes when survey skills and costs for the survey are considered. In this area, the Joint Commission will never be equal to a State survey agency.

In conclusion, as a private organization which charges the facility a fee for a survey, the Joint Commission is accountable to member facilities, and therefore raises not only an accountability question, but also questions their objectivity. The enforcement process would be weakened because it separates the State agency from the certification process. This leaves patients potentially subjected to, or even more accurately, victims of substandard care.

It is our opinion that the Joint Commission is neither equipped, staffed, nor located in a manner conducive to conducting meaningful, patient-oriented surveys.

Professional standards review organizations are private entities funded by the Federal Government with the delegated authority to perform utilization review in health facilities. The current Government position is to phase out this affiliation. The primary reason given for the change is the Federal Government's position of a demonstrated lack of accountability and reporting responsibilities which should be incorporated into any governmental program utilizing taxpayers' money.

It is hoped that a careful consideration will be given to this experience so that the deemed status will not be a repetition of problems previously identified with the PSRO affiliation.

For these reasons set forth, including all of the attachments, California strongly requests that those regulations relating to deemed status be withdrawn.

Thank you.

Senator HEINZ. Ms. Simmons, thank you very much.

[The prepared statement of Ms. Simmons follows:]

PREPARED STATEMENT OF MILDRED GLOVER SIMMONS

Good morning, Mr. Chairman, my name is Mildred Glover Simmons. I am a registered nurse and the deputy director for the California Department of Health Services responsible for the licensing and certification of health facilities in the State of California. I was appointed to this position in April 1981 following 6½ years as a surveyor, supervisor, and assistant chief in the section responsible for developing department licensing regulations.

My current responsibilities as deputy director include the supervision of a staff of approximately 250 field surveyors hired by the State of California and approximately 100 field surveyors employed by the county of Los Angeles working under contract to the State of California. This staff is augmented by clerical and managerial positions bringing the total staff responsible for licensure and certification activities within the State to over 400 persons. The division activities are decentralized into five district offices, four subdistrict offices, and Los Angeles County having five individual subcounty offices.

As the members of the committee may be aware, California currently licenses and inspects over 2,700 health care facilities, including general acute care hospitals, acute psychiatric hospitals, long-term care facilities, adult day health care centers, clinics, laboratories, home health agencies, and referral agencies. As a matter of interest, our 600 general acute care and psychiatric hospitals have a total licensed bed capacity in excess of 120,000 beds and our 1,200 long-term care facilities have a licensed bed capacity of over 125,000 beds for a total of 245,000 licensed beds within the State. The remainder of the complement of the 2,700 facilities is composed of clinics, adult day health care centers, laboratories, home health, and referral agencies.

I am pleased and privileged to be here today to present testimony both for the State of California and as a representative of region IX of the Association of Health Facility Licensure and Certification Directors. My verbal testimony is only a portion of the testimony that I am submitting to this committee and request that my full statement be placed in the record. The time alloted for verbal presentation allows only for a brief overview of the concerns that we wish to present to this committee. We have reviewed the specific proposals published in the Federal Register on skilled nursing facilities of Thursday, May 24, 1982, and which are suggested to be adopted as proposed rules. We feel that, in general, many of these specific proposals would not compromise the survey and certification process and would facilitate the administration of a more flexible program, without jeopardizing the health and safety of patients (attachment No. 1).[1]

Beverlee A. Myers, director of the California Department of Health Services, has responded directly to Carolyne K. Davis expressing her personal concerns relative to these regulations (attachment No. 2).[2]

Specific proposal No. 1: Consolidation of medicare and medicaid survey and certification provisions. We propose to consolidate medicare and medicaid survey and certification process requirements into a single part of 42 CFR chapter IV. The current requirements for survey and certification of providers for participation in medicare are found in 42 CFR part 405, subpart S. The requirements applicable under medicaid are found in 42 CFR part 442, subpart C.

California endorses this proposal and we concur that the combining of the nearly identical regulations into a single set of procedural requirements will eliminate the problems that currently face State survey agencies and health care providers. We believe that the consolidation of the survey and certification provisions both for medicare and medicaid would not compromise quality health care services and would eliminate duplicative and confusing requirements.

Specific proposal No. 2: Quarterly staffing reports. The regulations at 42 CFR 405.1904(a) currently require all facilities to submit staffing reports routinely. We propose to modify the current policy and require those reports only when the State

[1] Retained in committee files

[2] See appendix 1, item 4, page 110.

survey agency requests them because the facility has a history of staffing deficiencies or was found not to meet all staffing requirements during its most recent certification survey. However, all facilities would now be required to have information about their staffing available when they are surveyed.

Currently, all facilities are required to submit reports that set forth the average number and types of personnel on each tour of duty during at least 1 week of each quarter. The week is selected by the survey agency and differs from quarter to quarter. The survey agency is required to evaluate the reports and to take appropriate action when the reports indicate inadequate staffing.

California supports the proposal to modify the current policy on quarterly staffing reports. It is our feeling that these reports have never been a true reflection of actual staffing. An accurate picture of a facility's actual staffing can only be obtained by an onsite visit. Completion of the staffing reports is a time-consuming task and, absent a specific requirement for hours per patient day is a futile effort at enforcement of adequate staffing. California may be unique among other States in that we have a State requirement which mandates a minimum of 2.8 hours of nursing care per patient day on a daily average be maintained in skilled nursing facilities. This 2.8 average is determined through onsite review during the facility survey. Should the staffing be less than the mandate minimum requirement, the State has the options of issuing deficiencies, assessing civil penalties or where indicated, initiating suspension or revocation of a facility license.

Federal regulations do not require correction of an inadequate staffing deficiency even though submission of a staffing report is mandated. By contrast, California regulations mandate the submission of the report as well the correction of staffing deficiencies by requiring an increase in facility personnel.

Specific proposal No. 3: Mandatory 90-day resurveys. We propose to eliminate the requirement that a facility approved for participation on the basis of a plan for correction of all deficiencies found at the time of survey be subject to a mandatory resurvey after 90 days. The regulations would be amended to require (a) followup at a time when correction or progress in correction can be assessed most realistically, and (b) an onsite visit only if there is no other way to verify correction of the deficiencies.

Currently, whenever a provider or supplier is certified on the basis of an acceptable plan of correction, the survey agency must conduct another onsite survey within 90 days to verify the corrective action is completed or progressing at a reasonable rate (42 CFR 405.1903). The purpose of this requirement was to insure the correction of cited deficiencies.

California supports the elimination of the requirement for a facility resurvey within 90 days to verify that all deficiencies found at the time of initial survey be verified for compliance. During the past 6 months, based on severe reductions in Federal funding, California has been placed in a position of considering alternative methods to assure compliance with regulations. One of the methods has been to allow facilities to provide information telephonically or by mail when a plan for correction could be realistically assessed in this manner. An onsite visit has only been made when there was no other way to verify that correction of a deficiency has taken place. We would concur with the analysis that many corrections do take longer than 90 days and in these instances, multiple visits may be necessary to verify correction of a deficiency. This is indeed costly to both the facility in staff time spent with the surveyor and to the State survey agency in terms of surveyor time, travel, and salary. This allowance for verification of correction by mail does not apply to any deficiency which poses a threat to the health, safety, or security of any patient.

Specific proposal No. 4: Time-limited agreements. We propose to eliminate the requirement that agreements with SNF's and ICF's be limited to a period not to exceed 12 months.

The 1972 amendments to the Social Security Act (Public Law 92-603) established the requirement that a medicare provider agreement with a SNF could not exceed 12 months. The agreement could be extended for 2 additional months if doing so did not jeopardize the health and safety of patients. In order to have uniform procedures for both programs, the requirement for time-limited agreements was extended by regulation to SNF's and ICF's under medicaid.

In 1981, Congress enacted section 2153 of Public Law 97-35 amending section 1866(a)(1) of the act to remove the 12-month limit on agreements with skilled nursing facilities. The law was changed because program experience since the inception of time-limited agreements, has indicated that they are not necessary to insure compliance with the conditions of participation.

California supports the elimination of the time-limited agreements. However, the elimination of the requirement that agreements with skilled nursing facilities and intermediate care facilities be limited to a period not to exceed 12 months would be in conflict with current State statutory requirements for licensure as contained in the California health and safety code. Presently, all licensing and certification surveys are combined into a single survey visit. The proposed Federal regulation amendment would increase the time period for recertification surveys in long-term care facilities with the exception of intermediate care facility-mentally retarded (ICF-MR) from an annual survey to a biannual survey. For hospitals, the survey would only be conducted once every 3 years. If this proposed Federal regulation is adopted, the combined recertification and licensing survey would only be conducted every other year in long-term care facilities and would only be accomplished every third year in a general acute care hospital. It has always been the opinion of my staff, and I concur, that the combined licensing and certification annual survey has been the most efficient and effective method to review a facility. In addition to assessing the quality of care which is provided by a health facility a combined licensing and certification survey has been highly effective in identifying areas of fraud and abuse relative to State and Federal moneys.

In California, these visits are unannounced. This affords the greatest opportunity to view a facility as it actually operates on a day-to-day basis and not as it would choose to be viewed on an announced visit scheduled many months in advance. While we recognize that many facilities have established a record of consistent compliance with all conditions of participation and do not require a frequent survey and the monitoring associated with a yearly visit, we have found that facilities may change, from a highly conforming facility into a grossly deficient facility in less than 12 months. The elimination of a fixed or time-limited agreement tends to remove the possibility of "notice" to the facility prior to the survey. In California, we have suggested legislation that would eliminate a single yearly licensure visit and instead substitute the requirement that all facilities receive a full survey on an annual basis that may be accomplished in two or more visits. This would allow one, two, or three shorter visits; each time completing a portion of the survey and getting a more realistic view of those particular areas under circumstances that are usual and normal for that facility's operation.

Specific proposal No. 5: Cancellation clause provisions. We propose to eliminate the requirement that a SNF or ICF provider agreement, accepted on the basis of a plan for correction of deficiencies, be automatically cancelled unless the deficiencies have been corrected by the predetermined date.

California supports the elimination of the cancellation clause for Federal certification purposes. California supports the proposal as suggested.

It has been our experience that State sanctions have been much more effective in forcing facilities into corrective action rather than a threat of an automatic cancellation of their agreement. The automatic cancellation date is almost always rescinded, and even should it go to the ultimate conclusion, the facilities are, of course, afforded reconsideration by the HCFA. By elimination of this requirement, State survey agencies would be able to tailor the monitoring and the use of sanctions which are based in accordance with the severity of the deficiency that is identified. We support that any life-threatening deficiencies should continue to be the cause for immediate termination procedures. This would coincide with the philosophy of my particular State agency.

Specific proposal No. 6: Flexible survey cycle. We propose to eliminate the requirement that all facilities be subject to annual surveys with the exception of ICF's for the mentally retarded (ICF/MR). Current regulations require the State agency to survey all providers and suppliers at least annually to insure continued compliance with program requirements.

The elimination of this requirement seems to tie into the elimination of the time-limited agreement and allow "good" facilities to be surveyed according to "a reasonable survey cycle" based upon the facility's compliance history. As previously mentioned, California statutes require all facilities to be surveyed on an annual basis so this requirement for the certification survey, of course, would have a less severe impact on our long-term care facilities. I would like to reiterate that facilities that may appear "good" during a particular time frame may quickly turn to being "poor" or to becoming totally "substandard" in a relatively short time based on the absence of qualified staff, the changing of the director of nursing, the sale of the facility to a less conscientious owner, the adoption of a new management philosophy, or curtailment of services due to facility economies.

Recently region IX, HCFA, considered an analysis of facilities within California, ranking them A, B, and C. This criteria was defined as follows: A facilities, those

which must be surveyed semiannually; B facilities, those which must be surveyed annually; and C facilities, those which could be surveyed biannually.

We do not know if our facilities are any "better" or any "worse" than those in any other particular State based on compliance with the Federal conditions of participation. However a review, done by region IX, HCFA, in early 1982, indicated that we will be making more visits under this flexible survey schedule than we would normally be making if we visited each of the 1,200 facilities once during each year. In California, HCFA suggests there are more facilities requiring two visits in a single year than there are facilities requiring the one visit every 2 years. While the intent is commendable, the actual cost for certification would be increased (attachment No. 3).[3]

We would question the statement in the Federal Register that "hospitals generally have fewer deficiencies than other types of facilities and need less frequent monitoring." This has simply not been the case in the hospitals that have recently been evaluated based on complaints. In California, we are associated with the Joint Commission on Accreditation of Hospitals and the California Medical Association in surveying general acute care hospitals according to schedules and time frames preselected by the Joint Commission. This has been a data-gathering survey with licensure and accreditation decisions being made independently by the State and the Joint Commission. State validation surveys, although not in the number that we had proposed to perform, based on limited staff availability, have indicated that the time frames or number of survey days allocated for doing the surveys, precludes the identification of problems which should be identified and plans of correction obtained. We agree that hospitals have a more sophisticated organizational structure both through the structures of an organized medical staff and hospital governance committees. However, these layers of review and/or monitoring do not assure that the hospital is problem free or conforms to State, Federal, or accreditation requirements. Interestingly, in each of the recent instances where State action has been taken against the license of a general acute care hospital, the lack of internal review and monitoring that was assumed to have been taking place was either inoperable or totally absent.

Specific Proposal No. 7: Deemed status for SNF's, ICF's (Excluding ICF's for mentally retarded and HHA's accredited by the Joint Commission on Accreditation of Hospitals (JCAH). Under current regulations, hospitals accredited by the JCAH may be deemed to meet the conditions of participation of medicare and medicaid. We propose to extend this provision so that survey agencies may accept JCAH accreditation of SNF's, ICF's and hospital-based HHA's as sufficient evidence that the facilities meet Federal health and safety requirements, and may participate in medicare or medicaid without an additional State agency survey.

This proposal is the primary reason why I am pleased to have been included as one of the presentors at this hearing.

Initially, I would like to state that California supports the concepts as expressed in the position paper developed by region III of the Association of Health Facilities Licensure and Certification Directors. This paper contains, in my opinion, a well-developed detailed analysis on the proposal for deemed status. I will not reiterate the specifics except in those areas where our experience in California may provide further elaboration and clarification. I am including this paper as part of my testimony (attachment No. 4).[4]

On April 15, 1976, the California Department of Health Services began the first of the surveys in a joint arrangement with the California Medical Association and the Joint Commission of Accreditation of Hospitals. This survey process, known as the consolidated accreditation and licensure surveys (CALS), is authorized under existing State statute. This statute of the law allows the department to enter into a contractural arrangement with those organizations known to have performed quality of care surveys. A copy of that cooperative agreement is attached to this testimony (attachment No. 5).[5]

It was felt at the time, that the concept of the combined survey would be a unique data gathering experience as each of the survey participants would have a specific area of responsibility and for which each surveyor would evaluate the facilities' compliance with Joint Commission standards, the State regulations and, in addition, any CMA quality of care guidelines. The intent of this survey effort was clear: The elimination for the potential of duplicate surveys and to reduce the time spent in

[3] Retained in committee files.
[4] See appendix 1, item 5, page 113.
[5] See appendix 1, item 6, page 123.

the facility. A task assignment sheet approved by all parties details the areas that are surveyed by each of the survey participants.

A schedule of visits was developed using the time frames established by the Joint Commission based on the licensed bed capacity of the hospital (1 to 100 beds, 1 day; 101 to 349 beds, 2 days; and over 350 beds, 3 days). The Joint Commission, in their usual accreditation survey, allows a 3-day survey for only those hospitals that are in excess of 500 beds. However, California has a large number (28) of supplemental and special permit services. It was agreed that the licensed bed capacity would not be the determining criteria under which the number of survey days was established.

Recently, we have had numerous requests for comments on our participation in this unique tripartite survey arrangement and we have prepared a letter detailing the composition of the team, the procedure that the team follows and some general concerns relating to the survey process. A copy of this letter is also included as a part of this testimony (attachment No. 6).[6]

At the time this agreement was signed by the Joint Commission, the CMA, and the California Department of Health Services, it was agreed by all parties to the contract that validation surveys would be performed by the State. Recent validation surveys in seven acute care hospitals ranging in capacity from 78 to 203 beds and involving 15 services, demonstrated that major differences existed in the identification of problem areas in the facility.

During the past 6 years, we have received numerous complaints on general acute care hospitals that were currently accredited by the Joint Commission for a 2-year period. Licensing investigations found serious conditions existing in the hospitals which resulted in licensure action and the ultimate closure of the hospitals. Most recently, the Joint Commission had accredited four acute care hospitals with a total licensed bed capacity of 1,144 beds, which, after State inspection visits resulted in one hospital being closed and the other three placed on probationary status.

The CALS process has been in effect for the past 6 years. It has become increasingly more apparent that critical information regarding facility deficiencies, particularly in the areas of governance and medical staff performance have not been reported to the department of health services by the Joint Commission. We have reason to believe that during the time of the above surveys, the problem areas, or areas of questionable behavior, were known by the Joint Commission evaluators during the previous CALS survey and were either discussed during a medical staff conference at which the Department was excluded or were included as a part of the Joint Commission recommendations to the facility which were not provided to our department. In either case, the department lacked the necessary information to protect the health and safety of the patients in those particular hospitals for at least 2 full years.

In our review of the deemed status proposal, many individual issues are of such a vital concern to California and to other States, that we have chosen to present them for your consideration under specific headings.

ANNOUNCED VISITS

We have a concern that facilities will be notified of the date of their survey approximately 4 weeks in advance. This cannot occur in California where State statutes require that all licensing visits to long-term health care facilities be unannounced. As a result, the probabilities of surveying the normal day to day operation of the facility are greatly enhanced. This situation also currently exists for the Federal recertification survey as dual licensing and certification surveys are performed in our State.

PUBLIC NOTICE OF SURVEY

A review of the Accreditation Manual for Long-Term Care Facilities, indicates the Joint Commission allows public information interviews. These may be requested by any interested person, in writing, to the Joint Commission. One would have to believe that this is the only chance for an interface with those groups that are so frequently associated with the long-term patient, i.e., the advocate and ombudsman groups. However, one must weigh the value of discussion interviews when this appears to take away from the actual in-facility survey time. The accreditation

[6] Retained in committee files.

manual does state specifically that interviews must be requested in writing, implying that there will be no "drop in" or family interviews allowed. This is contrary to the State survey protocol whereby our California State surveyors are available to discuss concerns with any family members or patient advocate groups during the course of the facility survey.

DISPLAY OF INFORMATION

In the proposed rulemaking, there is an indication that as a condition of deemed status, the facility will be required to display information relative to the Joint Commission survey. The accreditation manual (page xi), states that all material from the survey is considered confidential between the facility and the Joint Commission and that the contents of the survey and the report are revealed only to the facility. Is the display to be the posting of a plaque indicating a 2-year accreditation or will it actually be a listing of any identified recommendations and the facility's plan for correcting the problems? Current California statute requires the posting of all statements of deficiencies and the providers plan of correction until the time of the next survey; in California the posting of deficiencies is for 1 full year.

COMPLAINT INVESTIGATION

The present mechanism for the Joint Commission to investigate a complaint is very time consuming and laborious on everyone's part.

The investigation of a complaint is usually done by the facility. JCAH notifies the facility that there has been a complaint registered and asks for the facility to respond. There is no confidentiality of the complainant's name. This allows the facility to self-certify that there are no problems.

California statute requires that an initial contact with the complainant be made and investigations are to commence within 10 days of receipt of the complaint and the names of patients and complainants remain confidential. In 1981, California investigated 3,400 complaints. Is the JCAH staffed and equipped to handle such a workload in a professional and timely manner? It is likely that a complaint sent to the JCAH will not be investigated until the time of the next survey * * * perhaps 2 years hence even for those situations which may be life threatening.

There appears to be no allowance for any advocates or ombudsman to accompany a surveyor as there currently exists in many States, California included.

Note: Nothing in the JCAH manual, or procedures, of which I am aware, would require that reports of complaints received by them be forwarded to the State agency that might do something about the problem quickly. We believe this is one of many major faults of the JCAH process.

In California, the citation system has been of the utmost value in the improvement of the quality of patient care. Going to statistics again, there were 144 A citations (violations of State regulations subject to civil penalties of from $1,000 to $5,000 each), and 1,136 B citations (violations of State regulations assessed at $50 to $250 per citation if not corrected within the time specified on the plan of correction).

This citation system affords protection to patients in long-term health care facilities from being placed in imminent danger relative to their health, safety, or security. It is folly to suggest that such a protective mechanism could be compared to the voluntary "monitoring of facilities," if these proposed regulations are adopted. The citation system calls for not only the citation being followed up by the surveyor, but insures that corrections are completed to the satisfaction of the enforcement agency. We have seen that this process, since its inception in 1976, has resulted in a decrease in the number of decubitus ulcers (bed sores), falls, injuries, as well as other hazardous conditions.

Conversely, we have seen an increase in quality of care, better diets and improved daily living conditions which enhances the quality of life for all long-term care patients, based on followup surveys and strict surveillance in the facilities by a regulatory agency using enforcement jurisdiction. The JCAH deemed status survey with no enforcement capability could not possibly have this impact on the delivery of health care to the people we serve.

SURVEY PROCESS

The JCAH schedule allows for surveys based upon number of licensed beds. Below is a comparison of survey hours by the JCAH versus California.

Number of days	Days	JCAH hours	State hours
1 to 149	1	8	[1] 24–48
150 to 349	2	16	48–64
350 and over	3	24	+80

[1] Average is 32.

COSTS

We believe the deemed status approach is not cost effective. There will be Federal dollars expended with absolutely no assurance of an adequate assessment of patient care. Our calculations show that, on an initial survey, the JCAH will send two nurses at a cost of approximately $187.50 per hour. Repeat accreditation surveys, utilizing only one nurse will cost $109 per hour paid by the skilled nursing facilities.

Presently in California, the cost per hour for licensing and certification survey is $32 of which $13 is the Federal titles XVIII and XIX cost. Even considering 4 days for California, the Federal cost is only $52 or 28 percent of the JCAH amount for an initial survey, or 51 percent of the cost for an ongoing JCAH survey (attachment No. 7).[7]

From this, one must realize that the taxpayers are receiving less in the way of facility review and paying more tax dollars. There is reduced survey time, and fewer qualified staff who are licensed or certified in all of the States where they will be surveying and who are probably unfamiliar with the specific State licensure laws as they relate to the practice of all health professionals.

As part of this testimony, I am submitting a copy of a resolution adopted by the board of examiners of the nursing home administrators of the State of California in which they express concerns on the impact the deemed status would have on their access to information as it relates to licensed nursing home administrators (attachment No. 8).[8]

The knowledge of individual health practice acts is especially important now with the emerging role of the nurse in the expanded role, the increased use of the physician assistant and the increase in the number of allied health professionals. The acts would, of course, differ from State to State.

SURVEY PROCEDURE

The entrance conference remains the same, in essence, as any entry conference as done in all States by announcing the beginning of a survey. However, the assumption must be made that the JCAH conference will be more lengthy because the surveyor will be unfamiliar to the facility and general logistics of the survey and the geography of the facility must be explained. This certainly will take 30 minutes to 1 hour of the 8-hour survey day. The JCAH Accreditation Manual (page ix) states:

"The facility will be assessed by using the following methods: Statements from authorized and responsible facility personnel; documentary evidence or certification of compliance provided by the facility; answers to detailed questions concerning the implementation of an item or examples of its implementation, that enable a judgment of compliance to be made; and onsite observations by surveyors."

(Does not indicate that there is a choice or option of selecting one or more, hence, all would be assumed to be used.)

During the course of the day, the surveyor is expected to do all of the above which includes review of building and grounds relative to the construction statement that was previously submitted to the JCAH in Chicago, assess all patient areas for adequate size and equipment, including lighting levels; a thorough review of the dietetic services including a review of the food handler permits and an assessment that there are sufficient staff to prepare and serve the meals in a timely manner; verification of the emergency power source; review of the facility ownership; review all administrative and personnel policies; review facility procedure for handling patient moneys and valuables; review policies and procedures in dental services, fire and disaster, utilization review, infection control, laboratory and radiological services; nursing services; medical services; medical records administration, pharmacy and the patient activities program. This should be combined with observing patient care, observation of a meal being served and observations to the extent that assurances can be made that all patients are afforded their personal rights to considerate and respectful care.

[7] See appendix 1, item 7, page 126.
[8] Retained in committee files.

As stated by Maggie Kuhn, founder of the Gray Panthers, in the July/August issue of Forum magazine: "The concerns should focus on the humanization of patient care * * * To begin with, each patient admitted to a hospital should have the bill of rights for patients interpreted as a routine procedure. This should be just as routine as assigning a room or getting a case history." One must wonder on a 1-day, 1-person survey how much attention or review could be done in regards to patients rights (attachment No. 9).[9]

This "review," which is proposed could not include direct patient observation, staff interviews, consideration of physical plant size, layout and composition and the elements of safety for the patient and staff. Simply reviewing policy and procedure manuals does not assure that those policies and procedures have been implemented or even read by the facility staff. During the course of the day, medical records should be reviewed as they are the most significant data source to assure policies are being implemented.

The JCAH surveyor day begins, I assume no earlier than 8 a.m. and if one considers a lunch break and time for the summation conference that is required by JCAH policy, the actual number of in-facility survey hours of a 149-bed skilled nursing facility is less than 6 hours. It is inconceivable to me, as a former and occasional current participating field surveyor, how any evaluator could cover this material, in a new location, with this number of items to review and assess, and make any meaningful recommendations in a single 8-hour workday. The survey cannot be in-depth and will only report what a facility would like to have reported. Any and all problems could be covered up, or "temporarily fixed," for a single 8-hour period. In no way, could this type of survey ever be "deemed" to be equal to the current certification survey done by the State agencies.

The benefit of the State-based surveyor is the knowledge of the professional standards and classifications of the nurses, therapists, and other health care disciplines of that State and the ability monitor those activities and substantiate any detrimental care to the patient. Only State agency surveyors are aware of the preventive health and infection control issues including disposal of hazardous wastes which are of primary importance to the citizens of the particular locality/community and other indigenous matters.

INCREASED REGULATIONS

For California facilities, the "learning" of a new set of regulations will not be difficult. In my view of the JCAH Accreditation Manual for Long-Term Care, I note an almost total restatement of California's licensing regulations. However, for any other State with less specific regulations, there would be a proliferation of regulations to which they must adhere. This is not consistent with being in an era of deregulation.

VOLUNTARISM

The accreditation process is, and would remain voluntary. The philosophy of JCAH is that providers of health care should voluntarily assess the quality of the care they render. I quote the Commission's Accreditation Manual for Hospitals:

"The JCAH assumes the role of evaluator, consultant, and educator. Its function is to help hospitals identify both their strengths and weaknesses in regard to JCAH standards, and to provide guidelines for improvement through consultation and education. A request by a hospital for a survey signifies a professionally motivated, voluntary commitment to self-evaluation and self-improvement.

"The voluntary approach will survive if health care providers support and comply with principles, standards, and procedures that are sufficiently detailed and comprehensive to assure all that a higher quality of care is being provided, and that deviations will be identified and addressed

"Of paramount importance to the voluntary approach, then, is the continuing examination, the appropriate revision, and the proper implementation of these standards."

I have read this manual from cover to cover many times and have yet to see the word "inspect." However the commission voluntarily enters into agreements with State after State to participate in joint licensure and accreditation surveys with no apparent attempt to be an "enforcer" of regulations.

Because of these concerns, California has given serious consideration to the continuing of such a joint survey arrangement and has notified the JCAH, early in

[9] Retained in committee files.

May 1982, of California's intent to withdraw from the process beginning on January 1, 1983.

In the summary of the Federal regulation proposal, it states that "In 1980-81, HCFA conducted an analysis and determined that the JCAH standards for SNF's, ICF's, and hospital-based HHA's are equivalent to the requirements set forth in the Code of Federal Regulations (42 CFR parts 405, 442 and 490) for participation in medicare and medicaid. HCFA analyzed the JCAH decisionmaking process and determined that it is adequate." This analysis has not been made available for review to determine the basis for this conclusion. There can be no argument that the standards of the JCAH are equal to those requirements in the conditions of participation for the medicare/medicaid program. The argument comes when survey skills and costs for the survey are considered; in this area, the JCAH will never be equal to the State survey agency.

The potential for "deemed status" raises a "red flag" to States, such as California, where the investigation of a complaint is the cornerstone of our enforcement policy. When a complaint is received by a State agency concerning an accredited hospital, the State agency must seek the permission of the regional HCFA office to review the complaint in terms of titles XVIII and XIX participation and reimbursement. In numerous instances, there has been a refusal to the State agency to be authorized to investigate because of its accreditation. Lengthy discussions followed about the "State's right to be in the facility." This has created a "locked-out of our own facilities" feeling by many of the State staff. Now, with the potential of a "deemed status long-term care facility," this poses the threat of being "locked out" of the very facilities that are most in need of surveillance.

IN CONCLUSION

As a private organization, which charges the facility a fee for survey, JCAH is accountable to member-facilities and therefore raises not only an accountability question but also questions their objectivity. The enforcement process would be weakened because it separates the State agency from the certification process and limits the availability of information through prolonged turnaround times, thus creating an interim period where no action is taken on recommendation already identified. This leaves patients subjected to, or even more accurately, victims of substandard care.

It is our opinion that the JCAH is neither equipped/staffed nor located in a manner conducive to conducting meaningful patient oriented surveys, timely onsite complaint investigations or having any involvement with patient advocate and community action groups.

Careful scrutiny must be afforded to a proposal which by its terms would permit Joint Commission Accreditation of Skilled Nursing Facilities as the sole criterion needed to meet Federal health and safety requirements of conditions of participation. Such an approach would seriously jeopardize the monitoring mechanism by which California, through its facilities licensing statutes assures maintenance of optimum standards of patient care.

Professional standard review organizations (PSRO) are private entities funded by the Federal Government with the delegated authority to perform utilization review in health facilities. The current Government position is to phase out this affiliation. The primary reason given for the change in the Federal Government's position is the demonstrated lack of accountability and reporting responsibility which should be incorporated in any governmental program utilizing taxpayers' moneys. It is hoped that careful consideration be given to this experience so that "deemed status" will not be a repetition of problems previously identified with the PSRO affiliation.

For the reasons set forth in this testimony including the attachments, California strongly requests that those regulations relating to "deemed status" be withdrawn.

Senator HEINZ. Mr. Kuriansky.

STATEMENT OF EDWARD J. KURIANSKY, NEW YORK, N.Y., DEPUTY ATTORNEY GENERAL FOR MEDICAID FRAUD CONTROL, AND SPECIAL PROSECUTOR FOR NURSING HOMES, HEALTH AND SOCIAL SERVICES, STATE OF NEW YORK

Mr. KURIANSKY. Thank you, Mr. Chairman. My name is Ed Kuriansky and I am the special prosecutor and deputy attorney general for medicaid fraud control for the State of New York.

I am very pleased to appear before you today and have the opportunity to speak on the newly proposed Federal survey and certification regulations. In the past, this committee has contributed mightily not only to the battle against fraud and abuse in the health care industry, but perhaps even more importantly, to the fight for quality care for our elderly citizens—the subject which I believe is truly at issue in these hearings. My office is extremely grateful for your committee's support in recent years, and I hope that we, in turn, can be of some assistance to you today.

As you know, my office is responsible for investigating and prosecuting the entire spectrum of provider fraud in New York's $4 billion-plus medicaid program—the largest in the Nation. The area in which we have brought the greatest number of criminal prosecutions and probably received the most public attention is, of course, that of medicaid fraud.

We have become well-versed over these past 7 years in the variety of schemes conceived by man and woman to defraud the medicaid program. To date, we have arrested more than 560 defendants and convicted 90 percent of those we have prosecuted.

But beyond the investigation of fraud and corruption, and I think even more essential, is the work of our patient abuse program. Indeed, it is the findings of this investigation that prompt my comments today and make me fearful that we are now being asked to turn our back, and to turn the clock back, on the bitterly learned lessons of the last 15 years.

I am submitting two documents along with my testimony today. The first is a report issued by my office in December 1981, entitled, "Nursing Home Patient Abuse: Realities and Remedies." [1] This report summarizes the findings of 5 years' investigation of more than 1,100 cases of patient abuse and neglect in New York's nursing homes. This report also details our recommendations for new criminal statutes and regulatory change aimed specifically at curbing mistreatment and neglect in nursing homes.

The second document is a report by an August 1978 Queens County grand jury,[2] and although my office, will, in several days, submit a more detailed analysis of all the proposed Federal regulations, I want to direct my remarks today to several of the more disturbing proposals which I believe are brought painfully into focus by this Queens County grand jury report. Ironically, as you will see, the grand jury's findings stand in stark contrast to the naive and potentially dangerous proposals under discussion today.

Let me just briefly tell you what that grand jury found. In July 1978, during an oppressive heat wave in New York City, the air-conditioning system in a Queens County nursing home broke down. Two of the home's patients died and 17 others required emergency hospitalization for heatstroke and dehydration. Almost 70 of the home's patients suffered heat-related fevers.

The grand jury conducted a 4-month investigation. It heard testimony from more than 90 witnesses, whose descriptions of the conditions existing in the home were in sharp contrast to one's ideal image of a health care facility.

[1] See appendix 1, item 8, page 127.
[2] Retained in committee files.

For example, emergency service technicians found cardiac patients with 106° and 107° fevers who were living in rooms with closed windows. Another patient was discovered under a blanket and quilt, wearing a flannel nightgown, stockings, and a bonnet. In addition, the emergency medical team found a patient whose fecal impaction was literally choking off her ability to breathe.

To prevent such a tragedy from ever happening again, that grand jury recommended immediate reforms, and it is those recommendations which bear heavily on our discussion today.

The grand jury urged, for example, that staffing reports containing an assessment of patient nursing needs be submitted every 4 months. In New York, such assessments classify patients as needing "partial care" or "total care," and calculate the number of required staff for each nursing home. The last staff assessment at the Queens nursing home had been completed 9 months before the July heat emergency. And while the State health department had set the required number of nursing staff at 61, the home consistently operated with only 57.

More significantly, however, this 9-month-old staff assessment was based on only 39 "total care" patients, whereas on July 23, 1978, in the midst of this killing heat wave, almost 140 of the home's patients were in need of total care. I should emphasize that such an increase in "total care" patients is not at all uncommon in nursing homes where patients and their conditions change with striking rapidity.

The newly proposed Federal regulations would remove the current requirement of even quarterly staffing reports. It has been our experience, however, that maintaining sufficient competently trained staff is a critical problem in nursing homes. Often, as a consequence of severe staff shortages, facilities are forced to hire per diem employees who are unfamiliar with the patients and their needs, and who frequently become involved in incidents of abuse and neglect.

Staffing reports, which review a week at random each quarter, are potentially an excellent source of information without being an excessive burden on the facility. Moreover, any inconvenience is surely outweighed by the fact that the quality of life in long-term care facilities is, in large measure, determined by its staff. Personnel shortages and rapid turnover can have a disastrous effect on patients in a very, very short period of time.

Two years is simply too long to wait to discover that staff levels are inadequate, particularly when the average resident remains in a nursing home for only 2 years. If our State health department had known about the staff shortage at the Queens nursing home before the heat wave, the situation might never have reached crisis proportions.

The Queens grand jury also recommended that an unannounced inspection schedule of at least three visits per year be instituted for each nursing home. By contrast, the proposed Federal regulations would eliminate the requirement that a facility be inspected annually, and provide instead, that a facility be surveyed once every 2 years.

In addition, the new regulations would remove the requirement of a mandatory resurvey after 90 days, and require onsite verifica-

tion visits only when there is no other way to check up. These proposals are at direct odds with the grand jury's finding that it is only through a system of frequent, unannounced, and presumably unpredictable inspections that the day-to-day functioning of a facility can be properly observed.

Regular inspections at the Queens nursing home would have revealed that the home did not have a functioning emergency backup system. Unfortunately, as the grand jury found, reliance is all too often inappropriately placed on affidavits of compliance from nursing home operators and the air-conditioner service companies with which they do business. The grand jury concluded that without visual verification, there is no way to ascertain whether a home is in compliance with all applicable regulations.

I would submit, therefore, that relying on the good faith of providers to telephone or send a letter confirming that deficiencies have been corrected is simply not good enough. It was precisely this kind of blind reliance on the preposterous and unverified medicaid reimbursement claims of nursing home operators in the early 1970's that led to fiscal fraud on a massive scale and resulted, in New York alone, in indictments touching one-third of our State's proprietary nursing homes.

It is similarly naive to expect that a facility operator, no longer under the threat of automatic cancellation for failure to correct deficiencies by a date certain, would have any real incentive to bring his home up to code.

Curiously enough, HCFA acknowledges that in 90 percent of the cases, deficiencies are corrected before the provider agreement is canceled. This figure alone would appear to demonstrate quite graphically the efficacy of the current cancellation policy.

It is a tragic footnote to the report of the Queens County grand jury that none of their warnings were heeded, and that 2 years later, in July 1980, 15 more patients died in a Bronx nursing home during another blistering summer heat wave.

The Queens County investigation is but one of over 1,100 cases of abuse and neglect that we have investigated since the dark days of New York's nursing home scandal. Our recent report which I submit today, based on this 5-year investigative experience, provides persuasive proof that nursing home patients are just not capable of speaking out in their own behalf.

Patients and their families deeply fear retaliation and may endure abuse or poor conditions rather than risk the consequences, real or imagined, of reporting their plight. Many patients, afflicted with varying degrees of senility, are altogether unaware that they have even been abused or of the conditions existing around them. Other patients do not report because they are blind or deaf and unable to identify an abuser.

All these barriers to the reporting of patient abuse apply with equal force to the reporting of poor facility conditions. The summary comments to the proposed regulations note that ICF/MR's will be surveyed at least annually because "most of the patients in these facilities * * * lack the necessary experience or capability to bring quality of care problems to the attention of outside authorities."

Although this is a persuasive justification for frequent inspections of ICF/MR's, the distinction between these facilities and nursing homes is a distinction, I submit, without a meaningful difference, for the typical nursing home patient is no more capable or experienced than the ICF/MR patient and, accordingly, the same standard of inspection should apply.

Indeed, it is precisely because the vast majority of nursing home residents lack the ability to bring their problems to the attention of outside authorities that nursing homes need more, rather than less surveillance.

In sum, Mr. Chairman, I must confess to a certain uneasiness about a set of regulations which substantially abdicate surveillance responsibility to a privately controlled industry watchdog, which tell us that a once-every-2-year checkup is good enough to protect the vital interests of our increasingly helpless nursing home population, and which blithely accept the proposition that nursing home operators can be trusted not to capitalize on an advance-warning inspection policy, and that if they are ever caught misbehaving, we can count on them to advise us forthrightly as soon as they have cleaned up their act.

The thrust—indeed, the underlying assumption—of the proposed regulations is that the nursing home industry in this country can police itself. With all due respect, Mr. Chairman, one need not be too much of a cynic to suggest that this unstated assumption runs directly contrary to our history, our experience, and our commonsense.

Improvements in fraud control and quality care did not spring forth spontaneously in the 1970's. Rather, these relatively recent advances are precisely traceable to the imposition of strict governmental regulation and the creation of independent enforcement and review mechanisms, such as the medicaid fraud control unit program.

In my view, we cannot afford to repeat the monumental miscalculation of the original medicaid-medicare program, wherein millions of dollars were appropriated to fund a noble and needed program and not 5 cents was allocated to safeguard the moral and fiscal integrity of that very same program. Left unsurveilled, uninvestigated, and inadequately regulated, nursing home profiteers literally riddled the medicaid system with fraud and abuse.

What we must have learned from the scandals of the past decade is that this is an industry and a program which require rigorous public and governmental scrutiny. We also learned that there are no cheap or easy shortcuts. And while fiscal chicanery is one thing, the assurance of quality care for our old people is quite another. For although we may be able, belatedly, to recoup the ill-gotten gains of corrupt operators, and even on occasion send them to jail, I am much less sanguine about our ability, after the fact, to right the wrongs inflicted upon our institutionalized elderly by substandard conditions that go uncorrected in facilities that are insufficiently inspected.

In closing, Mr. Chairman, I can only say that while cost containment and the elimination of unnecessary regulations are unquestionably laudable goals, the findings of our patient abuse investigation over the past 5 years demonstrate unequivocally the critical

importance not only of preserving, but of strengthening, those regulations that directly impact on patient care and patients' rights.

Any reduction of Federal standards, and particularly of Federal reimbursement, in these essential areas would only serve as a dangerously tempting precedent for already financially strapped State governments and as an ominous signal to our vulnerable elderly of a possible return to the scandal-scarred, unenlightened days of the recent past.

Some years ago, the French writer Simone de Beauvoir was prompted to observe, astutely, and I think not without a certain degree of cynicism, "By the way in which a society behaves toward its old people, it uncovers the naked and often carefully hidden truths about its real principles and aims."

I submit, Mr. Chairman, that the generosity and swiftness of our response today to the fundamental needs of thousands of our dependent fellow citizens will surely be the measure by which future generations judge us.

Thank you.

Senator HEINZ. Mr. Kuriansky, thank you very much.

[The prepared statement of Mr. Kuriansky follows:]

PREPARED STATEMENT OF EDWARD J. KURIANSKY

Mr. Chairman, members of the committee, I am very pleased to appear before you today and to be given the opportunity to speak on the newly proposed Federal survey and certification regulations for long-term care facilities. In the past, this committee has contributed mightily not only to the battle against fraud and abuse in the health care industry, but perhaps even more importantly, to the fight for quality care for our elderly citizens—the subject which I believe is at issue in these hearings. My office is extremely grateful for your committee's support in recent years, and I hope that we, in turn, can be of some assistance to you today.

Before discussing the proposed regulations from the vantage point of our experience as a statewide investigatory and prosecutorial agency, I would like briefly to set our work in historical context. My office was established by Governor Carey in 1975, in the wake of a terrible and highly publicized nursing home scandal in New York State. Initially, we were know as the Office of the Special Prosecutor for Nursing Homes, and given authority to investigate nursing homes, health-related facilities, patient abuse, and official misconduct. Charles J. Hynes, who testified before this committee 4 years ago this month, was the first special prosecutor and deputy attorney general in charge. When Mr. Hynes, whom I had the privilege to serve as chief assistant for over 2 years, was named New York City's Fire Commissioner some 18 months ago, Attorney General Abrams appointed me to succeed Mr. Hynes. Since the creation of our office in 1975, our jurisdiction has gradually expanded to include adult homes, hospitals, individual providers, and a civil division to sue for the recovery of medicaid funds improperly taken.

Additionally, as this committee is well aware, Public Law 95-142 was passed by Congress and signed into law in October 1977. This legislation established a program of long-term control of fraud in the health care industry and provided substantial Federal reimbursement to my office and the 30 or more other State medicaid fraud control units now established across the country. We were proud to have been cited by both Houses of Congress as the model for other States to follow in their antifraud efforts.

Our office is based in seven regional locations throughout New York State, and we currently have on staff some 340 employees, including approximately 50 attorneys, 100 investigators, and 100 auditors. We utilize a team concept approach to the audit/investigation of health care fraud—in that attorneys, auditors, and investigators are assigned to cases at their inception and work together through to completion. Today, we are responsible for investigating and prosecuting the entire spectrum of provider fraud in New York's $4 billion-plus medicaid program, the largest in the Nation.

The area in which our office has brought the greatest number of criminal prosecutions and probably received the most public attention is, of course, that of medicaid

fraud. We have become well-versed over these past 7 years in the variety of schemes conceived by man and woman to defraud the medicaid program. To date, we have arrested more than 560 defendants and convicted 90 percent of those we have prosecuted. Actual restitution paid to Federal, State, and local governments as a result of this office's cases amounts to approximately $20 million, and there are over $21 million in civil lawsuits currently pending against health care providers for the recovery of additional medicaid overpayments.

But beyond the investigation of fraud and corruption, and, I think, even more essential, is the work of our patient abuse program. Indeed, it is the findings of this investigation that prompt my comments today and make me fearful that we are now being asked to turn back the clock, and to turn our back, on the bitterly learned lessons of the last 15 years.

I am submitting two documents along with my testimony today. The first is a report issued by my office in December 1981, entitled "Nursing Home Patient Abuse: Realities and Remedies." [1] This report summarizes the findings of 5 years' investigation of more than 1,100 cases of patient abuse and neglect in New York's nursing homes. This report also details our recommendations for new criminal statutes and regulatory change aimed specifically at curbing mistreatment and neglect in nursing homes, and discusses our efforts, in conjunction with New York consumer groups, such as the Ad Hoc Coalition for a Single Standard Code, to achieve better care in these institutions.

The second document is a report of the August 1978, Queens County grand jury,[2] and although my office will, in several days, submit a more detailed analysis of the proposed Federal regulations in response to HCFA's request for public comment, I want to direct my remarks today to several of the more disturbing proposals which I believe are brought painfully into focus by the Queens County grand jury report. Ironically, as you will see, the grand jury's findings stand in stark contrast to the naive and potentially dangerous proposals under discussion today.

Let me briefly tell you what the grand jury found. In July 1978, during an oppressive heat wave in New York, the air-conditioning system in a Queens County nursing home broke down. Two of the home's patients died and 17 others required emergency hospitalization for heatstroke and dehydration. Almost 70 of the home's patients suffered heat-related fevers. The grand jury conducted a 4-month investigation into these deaths and heat-induced injuries. It heard testimony from more than 90 witnesses, whose descriptions of the conditions existing in the home were in sharp contrast to one's ideal image of a health care facility. For example, emergency service technicians found cardiac patients with 106° and 107° fevers living in rooms with closed windows. Another patient was discovered under a blanket and quilt wearing a flannel nightgown, stockings, and a bonnet. In addition, the emergency medical teams found a patient whose fecal impaction was literally choking off her ability to breathe, as well as other patients with multiple bedsores and urinary tract infections.

The evidence before the grand jury revealed that the care rendered to the elderly patients of this nursing home by its administrative, medical, and nursing staff was ineffective to meet the crisis conditions brought about by the heat wave. While many factors—including a lack of sufficient and adequately trained staff, an absence of emergency procedures, a failure of leadership, and, in some cases, an inexplicable insensitivity to human suffering—may have contributed to this terrible tragedy, the grand jury concluded that no particular individual or entity could properly be charged with criminal conduct. It did however, recommend immediate reforms to prevent such a tragedy from ever happening again, and it is these recommendations which bear heavily on our discussion today:

(1) The grand jury urged, for example, that staffing reports containing an assessment of patient nursing needs be submitted every 4 months. In New York, these assessments classify patients as needing "partial care" or "total care" and calculate the number of required staff for each nursing home. The last staff assessment at the Queens nursing home had been completed 9 months before the July heat emergency. While the State health department had set the required number of nursing staff at 61, the home consistently operated with only 57. More significantly, however, the staff assessment was based on only 39 "total care" patients, whereas on July 23, 1978—9 months later and in the midst of this killing heat wave—almost 140 of the home's patients were in need of total care. I must emphasize that such an increase in "total care" patients is not at all uncommon in nursing homes where patients and their conditions change with striking rapidity.

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[1] See appendix 1, item 8, page 127.
[2] Retained in committee files.

The newly proposed Federal regulations would remove the current requirement of quarterly staffing reports. It has been our experience, however, that maintaining sufficient, competently trained staff is a critical problem in nursing homes. Often, as a consequence of severe staff shortages, facilities find themselves forced to hire per diem employees who are unfamiliar with the patients and their needs, and frequently become involved in incidents of abuse and neglect. Staffing reports, which review a week at random each quarter, are potentially an excellent source of information without being an excessive burden to the facility. Any inconvenience, I would submit, is more than offset by the fact that the quality of life in long-term care facilities is in large measure determined by its staff. Personnel shortages or rapid turnover can have a disasterous effect on patients in a very short time. Two years is simply too long to wait to determine that staff levels are inadequate, particularly when the average resident remains in a nursing home for only 2 years. If our State health department had known about the staff shortage at the Queens nursing home before the heat wave, the situation might well not have reached crisis proportions. Had more staff been available, they could have prevented patient deterioration by forcing fluids, removing unnecessary clothing, bathing patients, and taking vital signs at frequent intervals.

(2) The Queens grand jury also recommended that an unannounced inspection schedule of at least three visits per year be instituted for each nursing home.

By contrast, the proposed Federal regulations would eliminate the requirement that a facility be inspected annually and provide instead that a facility be surveyed once every 2 years and "as often as necessary to insure compliance." In addition, the new regulations would remove the requirement of a mandatory resurvey after 90 days and require an onsite revisit only when there is no other way to verify corrections. These proposals are at direct odds with the grand jury's finding that it is only through a system of frequent, unannounced, and presumably unpredictable inspections that the day-to-day functioning of a facility can be properly observed. Regular inspections at the Queens nursing home would have revealed that the home did not have an air-conditioning maintenance contract or a viable emergency backup system. Unfortunately, as the grand jury found, reliance is all too often inappropriately placed on affidavits of compliance from nursing home operators and the air-conditioner service companies with which they do business. The grand jury concluded that without visual verification, there is no way to ascertain whether a home is in compliance with all applicable regulations.

Relying on the good faith of providers to telephone or send a letter confirming that deficiencies have been corrected is simply not good enough. It was precisely this kind of blind reliance on the preposterous and unverified medicaid reimbursement claims of providers in the early 1970's that led to fiscal fraud on a massive scale and resulted, in New York alone, in indictments touching one-third of our State's proprietary nursing homes.

It is similarly naive to expect that a facility operator no longer under the threat of automatic cancellation for failure to correct deficiencies by a date certain, would have any real incentive to bring his home up to code. Curiously enough, HCFA acknowledges that in 90 percent of the cases, deficiencies are corrected before the provider agreement is canceled. This figure alone would appear to demonstrate, quite graphically, the efficacy of the current cancellation policy.

It is a tragic footnote to the report of the Queens County grand jury that none of their recommendations were adopted, and that 2 years later, in July 1980, 15 more patients died in a Bronx nursing home during another blistering summer heat wave. And now yet another long hot summer—with its own potential for human tragedy—is once again upon us.

The Queens County grand jury investigation is but one of over 1,100 cases of abuse and neglect that we have investigated since the dark days of New York's nursing home scandal.

Our recent report, "Nursing Home Patient Abuse: Realities and Remedies," based on this 5-year investigative experience, provides persuasive proof that nursing home patients are not capable of speaking out on their own behalf. For example, the process of investigating abuse cases in New York was immeasureably aided by the enactment in 1978 of a patient abuse reporting law, which requires facility employees to report incidents of abuse, neglect, and mistreatment. Prior to this time, incidents of abuse and neglect frequently went unreported. The fundamental explanation for this phenomenon goes to the very nature of the nursing home patient/employee relationship; namely, a nursing home patient depends totally on staff to respond to his or her basic needs.

Patients and their families deeply fear retaliation and may endure abuse or poor conditions rather than risk the consequences, real or imagined, of reporting such

conduct. The physical and mental condition of patients also contributes to the low rate of reporting. Many patients, afflicted with varying degrees of senility, are altogether unaware that they have been abused or of the conditions around them. Other patients do not report because they are blind or deaf and unable to identify an abuser. In addition, even if patients know to whom they should address a complaint, the mechanics of reporting often prove too taxing. Few patients have telephones in their rooms, and public telephones located in hallways afford only minimal privacy. A complaint by letter can be even more difficult for an elderly patient who can no longer write or who fears interception of the letter. All these barriers to the reporting of patient abuse apply with equal force to the reporting of poor facility conditions.

The summary comments to the proposed regulations note that ICF/MR's will be surveyed at least annually because "most of the patients in these facilities (many of whom are children) lack the necessary experience or capability to bring quality of care problems to the attention of outside authorities." Although this is a persuasive justification for frequent inspections of ICF/MR's, the distinction between these facilities and nursing homes is a distinction without a meaningful difference. For the typical nursing home patient is no more capable or experienced than the ICF/MR patient, and, accordingly, the same standard for facility inspection should apply. Indeed, it is precisely because the vast majority of nursing home residents lack the ability to bring their problems to the attention of outside authorities that nursing homes need more, rather than less surveillance.

In sum, Mr. Chairman, I must confess to a certain uneasiness about a set of regulations which substantially abdicate surveillance responsibility to a privately controlled industry watchdog, which tell us that a once-every-2-year checkup is good enough to protect the vital interests of our increasingly helpless nursing home population, and which blithely accept the proposition that nursing home operators can be trusted not to capitalize on an advance-warning inspection policy, and that if they are ever caught misbehaving, we can count on them to advise us forthrightly as soon as they have cleaned up their act.

The thrust—indeed, the underlying assumption—of these regulations is that the nursing home industry in this country can police itself. With all due respect, Mr. Chairman, one need not be too much of a cynic to suggest that this unstated assumption runs directly contrary to our history, our experience, and our commonsense. Improvements in fraud control and quality care did not spring forth spontaneously in the late 1970's. Rather, these recent advances are precisely traceable to the imposition of strict governmental regulation and the creation of independent enforcement and review mechanisms such as the MFCU program.

In my view, we cannot afford to repeat the monumental miscalculation of the original medicaid/medicare program, wherein millions of dollars were appropriated to fund a noble and needed program, and not 5 cents was allocated to safeguard the moral and fiscal integrity of that very same program. Left unsurveilled, uninvestigated, and inadequately regulated, nursing home profiteers literally riddled the medicaid system with fraud and abuse. What we must have learned from the scandals of the 1970's is that this is an industry and program which require rigorous public and governmental scrutiny. We also learned that there are no cheap or easy shortcuts. And while fiscal chicanery is one thing, the assurance of quality care for our old people is quite another. For while we may be able, belatedly, to recoup the ill-gotten gains of corrupt operators, and even on occasion send them to jail, I am much less sanguine about our ability, after the fact, to right the wrongs inflicted upon our institutionalized elderly by substadard conditions that go uncorrected in facilities that are insufficently inspected.

In closing, Mr. Chairman, I would only say that although cost containment and the elimination of unnecessary regulations are unquestionably laudable goals, the findings of our patient abuse investigation over the past 5 years demonstrate unequivocally the critical importance not only of preserving, but of strengthening, those regulations that directly impact on patient care and patients' rights. Any reduction of Federal standards (and, particularly, of Federal reimbursement) in these essential areas would only serve as a dangerously tempting precedent for financially strapped State governments and as an ominous signal to our vulnerable elderly of a possible return to the scandal-scarred, unenlightened days of the recent past.

Some years ago, the French writer Simone de Beauvoir was prompted to observe, astutely and not without a certain degree of cynicism: "By the way in which a society behaves toward its old people, it uncovers the naked, and often carefully hidden truths about its real principles and aims." I submit, Mr. Chairman, that the generosity and swiftness of our response today to the fundamental needs of thousands of

our dependent fellow citizens will surely be the measure by which future generations judge us.

Senator HEINZ. Ms. Gorrecht.

STATEMENT OF FREIDA GORRECHT, DETROIT, MICH., PRESIDENT, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Ms. GORRECHT. Thank you, Senator. My name is Freida Gorrecht. I represent the National Citizens' Coalition for Nursing Home Reform, a coalition of 98 member groups in 28 States, and with over 300 individual members across the Nation. Our members share common goals to improve the long-term care system and the quality of life for nursing home residents.

The coalition is pleased to have this opportunity to offer its views concerning recently proposed Federal regulations which would significantly alter the medicare and medicaid survey and certification process. We commend your committee for making the forum available to those concerned with the continuing viability of Federal oversight for the over $10 billion tax dollars which are expended on nursing home care yearly.

The least that the public should expect from this enormous investment is that adequate, appropriate, and decent care be provided to a population which the Secretary of Health and Human Services himself has described as our most vulnerable.

In framing our comments today, the coalition relies upon the wealth of day-to-day nursing experience of our membership groups. In addition, we have regular and substantial contact with most State long-term care ombudsman programs.

For example, I represent my group, the Citizens for Better Care in Michigan, which is a statewide organization in Michigan and which has the responsibility for the State ombudsman program. We are further guided by the thoughtful comments of dozens of State survey inspectors and officials who responded to a recent coalition questionnaire about the proposed subpart S regulation. Copies of this questionnaire and the survey analysis will be submitted to the Health Care Financing Administration as part of the coalition's formal comments on the proposed regulations. We will also submit this information to the committee as soon as it is completed.

Today, we bring this written testimony and, with it, a position statement initiated by the coalition.[1] The statement has been endorsed by 44 national organizations and over 100 State and local organizations. This statement was delivered to Secretary Schweiker on July 12. It calls upon the Department to rethink its subpart S proposals, which endanger essential protections for nursing home residents.

Representative groups signing the position statement include the American Association of Retired Persons, the National Council of Senior Citizens, the National Gray Panthers, the National Caucus and Center on Black Aged, the National Council on Aging, and the Consumer Federation of America.

[1] See appendix 1, item 11, page 213.

There is no question that current standards of care and the survey and certification process need improvement. However, the proposals at hand compound the current inadequacies, severely weakening an already anemic system. This would leave nursing home residents in far too many facilities with fewer safeguards to insure that the minimal care which they now receive will not be decreased in quality or quantity. Thus, safeguards must be maintained.

There are several reasons why we believe that leadership in an effective enforcement system must come from the Federal level. Clearly, the Federal Government's fiscal stake is substantial. Fifty percent of all nursing home revenues derive from its coffers from medicare and medicaid alone. On top of this amount, millions more are expended through other Federal programs. The minimal moneys now spent and projected for Federal and State survey and certification programs is merely a drop in the bucket compared to the billions spent annually. There must be accountability for these expenditures.

The 1981 White House Conference on Aging stressed the role of the Federal Government in one of its recommendations regarding long-term care, and this is the recommendation, and I quote:

> Quality assurance is essential to the provision of appropriate, effective and efficient services to the at-risk elderly. Care should be of sufficient quality and intensity so as to provide the degree of care needed by the individual to remain as independent as possible. Federal policy must continue to provide minimum standards of care to include a meaningful protection of rights of the individual to appropriate services.

To implement this recommendation, the participants stated that:

> The Federal Government must continue to provide meaningful conditions of participation under medicare and medicaid statutes, strengthen and upgrade such rules, and review statutes to insure protection.

Clearly, citizens concerned about nursing home residents understand the need, and advocates for consistency and uniformity for the national system are complex. Reported problems are similar from State to State. As a result of our mobile society, many families are separated from one another. Persons with relatives or close friends placed in facilities in different States have a justifiable expectation that maintenance of a uniform system will assure at least a minimal level of care and protection.

I see that my time is up. I would like to say that we are submitting a rather lengthy document, and I would like to read, if I may have this opportunity, a communication from a woman who happens to be a resident in a nursing home. There is a residents' group in New York State, and in reply to some of our questions—they belong to our coalition—Grace Spanover, who is the president of a residents' group in a nursing home, sent this to us.

She said:

> Please tell Senator Heinz and the rest of the people this is what I say. We need annual surveys and we need automatic surveys. It is hard for us to listen to the administration speak in an offhand way about concentrating only on life-threatening situations and poor facilities. Who is going to define what is a life-threatening situation, and what makes a facility poor?
>
> You can be sure it will not be us, the nursing home residents, who know what threatens us and what it is like to live in a bad facility. We would question the administration as to whether a resident who has to wait hours to go to the bathroom,

or is left in wet clothes, or is inadequately clothed—whether these are life-threatening conditions or simply inconveniences.

Certainly, no one in the community would put up with these conditions, and yet we, the nursing home residents who have lived so long, have to grit our teeth and do the best we can. The least that Government can do is to survey our homes once each year to make sure deficiencies are corrected within a specific time.

We urge congressional leaders to continue to forcefully direct HHS to change its course. The citizens of this country will support congressional leaders in this effort, and will do their part to help build a better system based on more rational, human proposals.

Senators, I will defer the rest of my comments on other specific proposals because they have been so ably addressed this morning. However, we urge you to review our written comments to the Department.

Thank you very much.

Senator HEINZ. Ms. Gorrecht, thank you very much. And, without objection, all of your prepared statement will be made a part of the record at this time.

Ms. GORRECHT. Thank you.

[The prepared statement of Ms. Gorrecht follows:]

PREPARED STATEMENT OF FREDIA GORRECHT

My name is Freida Gorrecht. I represent the National Citizens' Coalition for Nursing Home Reform, a coalition of 98 member groups in 28 States, with over 300 individual members across the Nation. Its members share common goals to improve the long-term care system and quality of life for nursing home residents.

The coalition is pleased to have this opportunity to offer its views concerning recently proposed Federal regulations which would significantly alter the medicare and medicaid survey and certification process. We commend this committee for making this forum available to those concerned with the continuing viability of Federal oversight of over 10 billion tax dollars which are expended on nursing home care yearly. The least that the public should expect from this enormous public investment is that adequate, appropriate, and decent care is provided to a population which the Secretary of Health and Human Services himself has described as "our most vulnerable."

In framing our comments today, the coalition relies upon the wealth of day-to-day nursing home experience of our membership. In addition, we have regular and substantial contact with most State long-term care ombudsman programs. Further, we are guided by the thoughtful comments of dozens of State survey inspectors and officials who responded to a recent NCCNHR questionnaire about the proposed subpart S regulation. Copies of this questionnaire and its analysis will be submitted to HHS-HCFA as part of the coalition's formal comments on the proposed regulations. We will also submit this information to the committee as soon as it is completed.

Today, we submit with this written testimony, a position statement initiated by the coalition which has been endorsed by 44 national and over 100 State and local organizations.[1] This statement, delivered to Secretary Schweiker on July 12, calls upon HHS-HCFA to rethink its subpart S proposals which endanger essential protections for nursing home residents. Representative groups signing the position statement include the American Association of Retired Persons, National Council of Senior Citizens, National Gray Panthers, National Association of Area Agencies on Aging, National Caucus and Center on Black Aged, the National Council on Aging, the Consumer Federation of America. In addition, several religious organizations, unions, and other varied organizations are included in the list of endorsements attached to the position statement.

There is no question that current standards of care and the survey and certification process need improvement. However, the proposals at hand compound the current inadequacies, severely weakening an already anemic system. They would leave nursing home residents in far too many facilities with fewer safeguards to insure that the minimal care which they now receive will not be decreased in quality or quantity.

[1] See appendix 1, item 11, page 213.

There are several reasons why we believe that leadership in an effective enforcement system must be at the Federal level.

(1) Clearly, the Federal Government's fiscal stake is substantial, 57 percent of all nursing home revenues derive from its coffers—from medicare and medicaid alone. On top of this amount, millions more are expended through other Federal programs which among other benefits have provided substantial construction loans to facilities. The minimal moneys now spent and projected for Federal/State survey and certification programs is merely a drop in the bucket compared to the billions spent annually.

(2) Recent information from the General Accounting Offices reveals that a projected increase in the population of nursing homes who will be sicker, much older, and more vulnerable because of disabling conditions.

(3) Recognizing these demographics, the 1981 White House Conference on Aging also stressed the role of the Federal Government in long-term care. Recommendation No. 176 stated: "Quality assurance is essential to the provision of appropriate, effective, and efficient services to the at-risk elderly. Care should be of sufficient quality and intensity so as to provide the degree of care needed by the individual to remain as independent as possible. Federal policy must continue to provide minimum standards of care to include a meaningful protection of rights of the individual to appropriate services. To implement this recommendation, the Federal Government must continue to provide meaningful conditions of participation under medicare and medicaid statutes, strengthen and upgrade such rules and review statutes to ensure protection."

(4) Federal oversight is obviously needed because enforcement capabilities very dramatically among the States. Few States have the ability, without active Federal support and guidance, to adequately assure that the system is working properly.

(5) Clearly, the public which is concerned about nursing home residents understands the need and advocates for consistency and uniformity within a complex national system where reported problems are similar from State to State. As a result of our mobile society, many families are separated from one another. Persons with relatives or close friends placed in facilities in different States have a justifiable expectation that a uniform system will exist which assures at least a minimal level of care and protection.

(6) Furthermore, families often interact with facilities in their State which are managed or controlled by persons or corporations sometimes several States removed. Nursing home owners, small partnerships, or small corporations may own nursing home facilities in several States around its home base. Furthermore, the growth of large corporate-owned nursing homes has been astronomic in recent years and is accelerating. Corporations based in one State may own and operate hundreds of facilities throughout the Nation. It is clear the Federal uniform standards, enforcement procedures and capabilities which reinforce State systems are necessary to keep up with this national trend. Clearly, industry business practices would be simplified were the large chains able to rely on nationally uniform standards and enforcement procedures.

Consumers—medicaid and medicare beneficiaries—often have no practical means of exercising wise marketplace decisions. Routinely, the choice of a facility is made by others, and it is made not so much on the basis of seeking the best care, but rather on the basis of funding the only available bed. It is entirely wishful thinking on the part of HHS to believe that marketplace incentives for a facility to maintain its standards of care will substitute for the minimally adequate federally mandated monitoring which in the past has not been uniformly sufficient to insure the receipt of decent, quality care for over 1 million nursing home residents.

HHS contends that its proposals result from the following goals: Reducing the unnecessary paperwork and burdensome regulations, containing spiraling health care costs, and providing State enforcement agencies with appropriate flexibility to enhance their efficiency and effectiveness. These are all laudatory goals, in the abstract.

We contend, however, that these catchwords, as they are portrayed in the proposed regulations, are invitations to disaster for nursing home residents. Deregulating, shifting greater responsibilities to the States, or indeed, allowing a private, health care industry-oriented agency to hand out claim checks to the Federal cash window to medicare and medicaid (providing long-term care facilities) are not the answers for any current flaws in the enforcement system.

The principal shortcoming of the current standards enforcement system is also its most basic. It simply does not measure what residents receive for the billions spent on nursing home care. It merely focuses on paper compliance and assumes that if

the facility has the capacity to deliver care (during the week or so of annual inspection time) then, in fact, adequate care is being delivered.

Countless studies, investigative reports of grand juries, legislative committees, and academics, as well as numerous HHS publications, and the practical experience of ombudsman programs and citizen programs throughout the country, belie this deductive relationship.

The main problem with the current system, which remains unaddressed by the HHS proposals, is that it does not focus on the quality of care actually received by residents. Inspections of nursing homes should be geared to determining whether residents are properly assessed, whether the care they receive is commensurate with their needs and that it is of high quality. The procedures offered by the Department are seriously inadequate to protect the care of many vulnerable people in nursing homes.

Our testimony today will address three primary issues raised by the proposed regulations: I. Potential changes in the actual procedures to be used by State enforcement agencies, II. The availability of funding to insure inspection capability; and III. The proposed option of deemed status whereby homes accredited by the Joint Commission on Accreditation of Hospitals would be eligible for certification under medicare, and, if a State so opts under medicaid as well.

I. POTENTIAL CHANGES IN THE ENFORCEMENT PROCESS

Under the guise of introducing flexibility into the survey process and reducing the burden of regulation on business, HHS is proposing, among other things, to do away with mandatory annual certification surveys, eliminate mandatory site revisits to check the correction of deficiencies, excuse the reporting of quarterly staffing records, and relinquish the current automatic termination of certification for facilities which fail to meet timely targets for deficiency correction. In this testimony we have chosen to address the proposals relating to annual surveys, facility site revisits, and the automatic cancellation clause.

ANNUAL SURVEYS

In the early 1970's, reports of the Subcommittee on Long-Term Care of this committee reported that as many as 50 percent of all nursing homes were regularly out of compliance with Federal survey standards and that same number were plagued by life-threatening conditions. A 1975 HHS study conducted under the nursing home improvement campaign made similar findings. Recently, an official of the Health Care Financing Administration stated at the NCCNHR annual conference that 35 percent of federally certified facilities had serious deficiencies. He contended that only 20 percent of facilities actually met all minimal health and safety requirements. The coalition's experience and the sordid public history of nursing home problems demonstrates clearly that even annual surveys are not sufficient to maintain standards in a substantial number of facilities.

The coalition's questionnaire to State surveyors asked whether surveys influenced compliance with standards and whether facilities would maintain standards if surveys were less frequent than the currently mandated annual review. Ninety-six percent (47 of 49 respondents) replied that annual surveys did influence compliance with standards and 97 percent (46 of 47 respondents) felt that less frequent surveys would lead to lower standards maintained by facilities. According to one of our surveyor responses from New Jersey, "Compliance with standards would not be the rule but the exception if annual surveys were not done. Standards which impact on finances would be complied with marginally until cited at survey time."

A Missouri surveyor reported that, "program experience has shown that facility operations change from one survey to another due to personnel problems, competition, financial difficulties, etc."

HHS proposes a 2-year survey cycle purportedly leaving States the flexibility to inspect historically problem facilities more frequently. Notwithstanding the fact that many State survey agencies have already been decimated by Federal budget cuts, this proposal misses the mark of rationality. The Coalition of Institutionalized Aged and Disabled, a coalition of 100 nursing home resident councils in New York, in its written remarks which we now submit to this committee, offers a compelling reason against the proposed HHS 2-year survey cycle.[2]

[2] Retained in committee files.

CIAD comments that nursing homes are volatile, fluid environments. Staff turnover throughout the industry is notoriously high. Changes in key staff—administrators, directors of nursing, dietary supervisors or housekeeping usually have dramatic, overnight impact on the care delivered in that nursing home. "Good" facilities which overnight might acquire new staff and go for 2 years without an inspection may breed outrageous conditions during that period. Additionally, the failure to survey would deprive the new staff of the guidance and consultation of experienced surveyors. The need for regular, comprehensive and frequent surveys is best stated by the residents' coalition:

"We need annual surveys and we need automatic surveys. It is hard for us to listen to the administration speak in an offhand way about concentrating only on life-threatening situations and poor facilities. Who is going to define what is a life-threatening situation and what makes a facility poor? You can be sure it won't be us, the nursing home residents, who know what threatens us and what it is like to live in a bad facility. We would question the administration as to whether a resident who has to wait hours to go to the bathroom, or is left in wet clothes, or is inadequately clothed, whether these are life-threatening conditions or simply inconveniences. Certainly no one in the community would put up with those conditions, and yet we, the nursing home residents who have lived so long, should have to grit our teeth and do the best we can. The least the Government can do is to survey our homes once each year to make sure deficiencies are corrected within a specific period of time."

Daily, the coalition receives similar comments from all over the country which decry this proposal for a less than annual survey. It is ironic that the Federal Government would go so far to relieve nursing home owners and operators—who are voluntary contractees—of the necessity of oversight rather than to insure that contractees fulfill their agreements to provide decent care under medicare and medicaid.

Assuming even the best of intentions among nursing home operators, the Secretary owes the elderly and disabled, the frail and infirm, a broader degree of caring. HHS must preserve rather than destroy the safety net which assures minimal implementation of standards.

New and tested changes could offer improvements

Based on our own analysis and from information recently received from State survey agencies, there are clearly changes which could be considered relating to the frequency and quality of surveys. For example, a South Carolina surveyor recommends: "Facilities should have a full survey at least every other year with a partial survey on the alternate years. If not surveyed at least partially on a yearly basis, most facilities become lax in some areas. The partial survey alternating with the full survey could spot any weak or potentially weak areas in 1 year which could be surveyed more closely on the following year."

Another surveyor from North Carolina suggested, "90 to 95 percent of all [facilities] should be surveyed annually or within a time frame of from 9 to 15 months. This would allow more flexibility in the survey schedule, and it would be more difficult for a facility to pinpoint the approximate date of our next visit."

Another innovation which would significantly improve the HHS standards enforcement system would be its refocus on the actual care delivered to nursing home residents. HHS has the capacity to provide facilities with the necessary information and instruments to systematically assess residents, assess appropriate goals for them, periodically evaluate progress toward those goals, and reassess resident needs. Indeed, since the early 1970's HHS has spent millions of dollars developing, refining, and successfully field-testing the PACE (patient assessment/care evaluation) program.

In 1980, HHS proposed a patient care management system based on the PACE program. This proposal was never issued in final form—even with considerable public support. In a new draft conditions of participation for nursing homes, developed in 1981 and ultimately withdrawn, HHS promoted a patient care management system largely along these lines. At the time although the coalition endorsed the concept of PCMS, we found its expression to be utterly valueless in the context of the entire conditions which were substantially diluted. We therefore opposed its adoption in that form.

The principal value of PCMS would be the integration of an ongoing comprehensive facility-based resident assessment and review program with an enforcement system designed to determine that nursing home residents are being accurately assessed that care is appropriately planned, and that a reasonable quality of care is actually provided. Such a system would assure that the conditions of residents are

continuously reevaluated and care plans accordingly modified. In this manner, surveyors could determine the effectiveness and quality of the care actually received by the beneficiaries of Federal programs. The level of care provided would surely improve (as many test facilities in the PACE program found). Certification decisions would finally be made on the basis of rational inquiry into the fruits of the massive expenditure of our tax dollars.

90-day revisits and the automatic cancellation clause

Currently, nursing homes found to be deficient during annual surveys are revisited within 90 days to determine that the problems noted have been corrected. While such revisits do not guarantee compliance with standards, their very existence poses a potent threat to those who might otherwise avoid compliance.

Allowing States to forego revisits and rely instead on telephone or documentary notice of corrections may be appropriate in limited circumstances. These situations, however, must be clearly specified if residents are to remain adequately protected. Too often an apparent "paper deficiency" or "isolated" problem may be a symptom of more serious systemic problems which only a revisit would detect.

Proponents of flexibility assert that a correction often takes longer than 90 days to complete, making a 90-day revisit fruitless. One thing is for certain: A revisit would document the progress that is being made (if any), or what interim action is being taken to correct the situation. Often, a pending revisit will stimulate an otherwise forgetful or obdurate nursing home operator to move toward compliance.

We have also heard arguments that many deficiencies cited are trivial and do not merit a revisit at all. Interpretations of triviality vary according to whose ox is being gored. But instead of eliminating an important enforcement tool, HHS should focus on the real problem and encourage and provide surveyor training to avoid citations for "trivial" deficiencies.

Of course, States should schedule revisits when necessary and timely. The coalition fears, however, that with revisits made optional, along with a longer survey cycle and smaller budgets, revisits will become rare, and diminished facility accountability will result.

The automatic cancellation clause is another enforcement tool eliminated by these proposed regulations. This provision is like a switch with a 60-day timer that the State agency will "switch on" after it determines that a facility has repeatedly failed to correct deficiencies. In 60 days, the timer "runs out," and the provider agreement is automatically canceled. The facility must correct the problem within 60 days in order to convince the State to switch the timer off. Whereas the burden has been on the regulatory agency, once the switch is "thrown" it falls to the facility to act.

Ninety to ninety-five percent of the time that switch is turned off before the provider agreement is canceled. HHS argues that this is an indication of its ineffectiveness. In fact, this statistic proves how well it works—most facilities make the necessary corrections before the "timer" runs out.

Proposed regulations direct States to allow facilities "a reasonable time" to correct these types of deficiencies, which is consistent with the Federal policy of making many present requirements optional. But when money is tight, the budget may dictate program decisions. Minimum becomes maximum; optional can mean almost never. In fact, HHS has acknowledged this crucial tie-in between budget and program in a March 1981 memo (already in the possession of the committee staff). This memo urged States to adopt many of the current proposals as a way to live within the budget reductions of the past 2 years.

II. BUDGET ISSUES

While the specific makeup of the enforcement system is obviously related to the quality of care received by nursing home residents, poor funding for that system can effectively neutralize even the strongest provisions. Federal funding for medicare/medicaid survey and certification has decreased steadily since 1980. In that year, it was funded at a level of $67 million, with a 100 percent Federal match for medicaid survey and certification expenditures. By 1982, the figure had dropped to $49.4 million with approximately a 70 percent match for State medicaid costs.

In a recent telephone discussion with a HCFA official, NCCNHR requested specific data on costs of surveys under the current system. From this data, we computed the cost of surveying all facilities at the legal minimum to be $121.2 million. HCFA verified this figure. Yet, the administration proposes funding this program at a level of $51 million for 1983.

Congress has the opportunity to provide an adequate funding level for these programs. The underfunding of the survey program is already diluting the impact of

the survey system and causing States to adopt the proposals now before us on a de facto basis. States are sending smaller, less qualified survey teams out for shorter periods of time to conduct abbreviated surveys. A survey conducted by NCCNHR in March 1982 found that State agencies' loss of personnel has ranged from 15 to 50 percent. Five States specified loss of Life Safety Code experts. Without expertise in the Life Safety Code or in any other professional specialty, the quality of the survey will deteriorate; leaving open the possibility that poor care will go unchecked.

Furthermore, drastic cuts have been made in the staff of regional offices of HCFA. These offices have the responsibility to perform "validation surveys" of surveys conducted by States and by the Joint Commission on the Accreditation of Hospitals. A recent internal report by HCFA points out that loss of 27 commissioned corps staff in eight regions has led to a 39 percent cut in the total number of surveyors performing full-time direct Federal surveys. According to the report, these cuts "would seriously jeopardize the continuation of responsible monitoring surveys" by the regional offices. In addition, the national office of HCFA has received cuts in staff with more cuts projected.

We question the good sense of defunding programs which are constructed to provide quality assurance and hold providers accountable to the public. $121 million is less than 1 percent of the public moneys spent on health care services. Yet, this is the money which insures that the billions of dollars spent on health care are spent well.

III. THE PROPOSAL REGARDING DEEMED STATUS

The administration's proposal to allow "deemed status" to facilities accredited by a private agency represents a dangerous abandonment of vulnerable nursing home residents as well as an enormous dilution of the accountability to which facilities should be held. A detailed analysis of this proposal will be submitted to HHS as part of the coalition's formal comments. A copy of these comments will also be made available to this committee. In our testimony today, we will only summarize some of the important issues which are of public concern.

It is our firm belief that a system for the enforcement of nursing home standards which assures quality care and rallies the public's faith and confidence in it must have certain vital components. Among these are:

(1) Cohesive, coordinated mechanisms for (a) the review of conditions, services and care; (b) the correction of noted deficiencies; and (c) response to complaints and questions by consumers.

(2) Maximal public information about the care provided by community facilities.

(3) Convenient access by the public and consumers to those responsible for determining compliance with standards.

(4) Clear, specific and unambiguous standards which are easily understood by facility staff, surveyors, residents, and the public.

(5) The inclusion of the public in the development and implementation of standards and the survey system.

(6) A broad range of appropriate powers to assist in correcting the diverse problems identified in nursing homes.

(7) A rational interrelationship between agencies responsible for enforcement of standards and payment for services.

(8) Day-to-day accountability to the public, and to its elected and appointed officials, for the expenditure of tax dollars.

(9) Clear responsibility for assuring the protection and delivery of Federal rights granted by Federal statutes to nursing home residents.

In our opinion, no private agency can or should develop these components or assume these responsibilities of the Government. Certainly, the proposal to grant "deemed status" to facilities accredited by JCAH does not fulfill these requirements.

Through its criticism of this proposal the National Citizens Coalition for Nursing Home Reform (and to its knowledge no other organization who supports our position) does not intend to quarrel with or question the routine work or goals of the Joint Commission on Accreditation of Hospitals. That organization undoubtedly fulfills an important function for those nursing homes which voluntarily choose to purchase its consultative and accrediting services.

We do oppose the proposed role of the JCAH in the Federal survey and certification process. JCAH is a private organization dominated by health care provider interests. It has no enforcement or regulatory powers, nor does it feign interest in a regulatory role. The results of its surveys are confidential. The posting of accreditation reports by facilities, which HHS proposed mandating only in response to public outcry, will merely provide summaries of the most recent survey finding. It is un-

clear what information will be made available to State and Federal regulatory agencies and in how timely a fashion. JCAH will be paid for its surveys by participating facilities (primarily out of Government reimbursement funds). It may be severely strained to revoke an accreditation it has granted. JCAH has limited capacity to investigate complaints and incorporate its own complaint findings, or those of the ombudsman program or the State licensing agency, in its accreditation decisions. Its only office is in Chicago, Ill., making it virtually unaccessible for consumers, long-term care ombudsmen, and consumer representatives. Meaningful relationships among ombudsman programs, consumer groups, and State surveyors will potentially be destroyed or become irrelevant.

JCAH does not conduct annual surveys. The limited amount of information it will share with the public and State, regional, and Federal enforcement agencies would seriously undermine efforts to validate the effectiveness of its reviews. Enforcement and regulatory activities by State and Federal agencies would by necessity duplicate survey procedures, severely straining budgets and already decimated staffs.

Of the surveyors responding to the coalition's questionnaire, 79 percent of the respondents reported experience with JCAH accredited facilities. Of these surveyors, 93 percent thought the quality of JCAH surveys or the facilities they accredit to be poor. Many reported that JCAH, in their experience, did not respond well to complaints. Typical comments received from these surveyors are included in appendix 1, item 10, page 210.

The HHS proposal to allow "deemed status" is just plain bad policy and remains unsupported by rational evidence. JCAH experience in the accreditation of hospitals, which according to the coalition's survey is not uniformly endorsed by the States, cannot and should not be used as a justification for its application to nursing home certification. It would place important decisions about the distribution of vast sums of public dollars in private hands. It would extinguish the availability of essential public information about the care practices of publicly financed nursing homes. It would, we believe, result in poorer care for thousands of nursing home residents. Most importantly, it would cripple the ability of public agencies to respond effectively to our elderly citizens who call out for protection and assistance.

The fact is that we already have a nationwide Federal/State system for survey and enforcement of standards. Given the obvious difficulty of JCAH to operate from a central location in Chicago, it would be reasonable to assume that JCAH will, and indeed it will be necessary for JCAH to establish a State and regional presence and capacity. In other words, we may be witnessing the sowing of seeds of a duplicative, but private bureaucracy. Surely with our limited public funds the Secretary of HHS does not propose taxpayer financing to fuel this wasteful and unnecessary replication of, or more ominously, substitution for, the already existing public system.

In closing, let us say that we were reassured by the commitment Secretary Schweiker made to the American public on March 22, 1982, when he stated that he would not remove essential Federal protections. "I will not turn back the clock," he said. In fact, it is clear that every Secretary of this Federal agency over the last 15 years has taken steps to improve this system. These moves have often been at the urging of congressional leaders who have upheld Federal responsibilities established under the Social Security Act. In fact, every congressional hearing on this issue has been conducted to review and affairm Federal priorities in this area. As in the beginning of this testimony, we commend this committee for this significant hearing. The coalition was privileged to be able to present our views before Senator Heinz at his similar hearing on related issues in 1978.

Now we urge congressional leaders to once again provide direction to HHS to change its course. As we said in our position statement, "It is our belief that the rule changes proposed by the U.S. Department of Health and Human Services on May 27 would, over time, imperil nursing home residents."

The citizens of this country will all support congressional leaders in this effort and will do their part to help build a better system, based on more rational, humane proposals.

Senator HEINZ. Let me thank all of our witnesses for extremely good testimony. I am delighted to see Ms. Simmons here because a few months ago, this committee held hearings on the both absolutely tragic and shocking state of affairs at the Community Hospital of the Valleys in Perris, Calif., with which I think she is rather familiar.

But for those of you who were not at the hearing, we received testimony that fairly conclusively proved, at least to my satisfac-

tion, that there were deficiencies at this JCAH-deemed status facility, which included, among other things, the deaths of 16 patients in 16 weeks, not one of which was reported to authorities.

These deficiencies included generally unqualified personnel. They included lack of supervision. They included no review of poor quality of care. The hospital had equipment that was not fit for its intended purpose. It did not have proper emergency procedures. It had, as I say, an emergency room that was an emergency if you ended up in it because you had a very good chance of ending up dead, in spite of your condition.

Is it not correct that this was a JCAH-approved facility?

Ms. SIMMONS. That is correct. It was a survey of a facility by the joint survey process, including the Joint Commission, the California Medical Association, and the Department.

Interestingly, in that particular facility, the areas that should have been reviewed, that would have determined that the deaths that had occurred in the intensive care unit and the emergency room, were in the areas of assignment that would have been surveyed and reported to us, hopefully on our forms, by the Joint Commission. This did not come to us.

Senator HEINZ. Now, I suppose someone could say, "Well, that is just an isolated instance, Senator. You are just taking one dramatic instance"—and indeed it was dramatic—"and blowing it out of all proportion."

So, let me ask you, is that, in your experience in California, an isolated example? Are there any other examples?

Ms. SIMMONS. In my own personal experience, I have been deputy director for the last 1½ years in California, and it is not an isolated instance. Unfortunately, the numbers of these facilities and the numbers of actions the State has taken have dramatically increased in the last 18 months, due to the increase in the number of complaints that we have had on facilities.

I am sure that many of our facilities have been in the papers on the east coast as well as the west coast. We only have to look at the erratic behavior that occurred in an operating room in California. We only have to look at the university medical center. We have to look at many other facilities in which the State has had to take action.

Interestingly, while I am here at this hearing, I have two State teams currently working in facilities in California. One is at a nursing home, ironically, at this point. It is one of the worst nursing homes that I have ever seen in my experience. I have spent 30 years in the health care profession and I had been a surveyor with the State prior to becoming the deputy director. On this particular survey, I also participated at the request of one of our State legislators.

It is the worst facility I have ever seen in the State, and on its wall, interestingly, is a plaque from the Joint Commission.

Senator HEINZ. Well, we do not need any more of those kinds of good housekeeping seals of approval, if that is what they signify.

What about Raleigh Hills?

Ms. SIMMONS. The Raleigh Hills situation right now is under investigation by the State. Two of the Raleigh Hills units, which are the alcoholic detox units, are located in hospitals. I believe that,

today, one of the units is going through an investigation by the coroner's office. We believe that the program, although reviewed during the course of the survey, had been previously reviewed or accredited.

We assume they are going to come up with a verdict this afternoon of death by the hands of another, and this should have been reviewed in the unit. It should have been discovered on survey.

Senator HEINZ. Well, I do not wish to belabor this point, but I think you have helped make a point that getting a plaque or something else from the JCAH, no matter how well-intentioned that private institution may be, does not really do the job that I think we would like to see done.

Ms. SIMMONS. If I may, may I add one thing, Senator?

Senator HEINZ. Yes.

Ms. SIMMONS. Because of our experience with the Joint Commission in this joint survey process and our concerns with their 3- and 2-year accreditation in those facilities that we feel need closer surveillance, California has given notice to the Joint Commission that we will be terminating our arrangement with them. We have already put them on notice that we will be running a parallel system starting in the beginning of the year to a total phaseout, so California will no longer be associated with a joint survey process.

[Note: Subsequent to the hearing, the following letter was received by the committee concerning testimony given by Ms. Simmons:]

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1248

September 23, 1982

Honorable John Heinz
Chairman, Special Committee on Aging
The United States Senate - Room 6233
Washington, D.C. 20510

Dear Senator Heinz:

In reference to the July 15, 1982 hearing which you held on the subject of: Nursing Home Survey and Certification: Assuring Quality Care, Mildred G. Simmons of my staff testified at your request. It has been brought to my attention by the JCAH that some of the statements made in her testimony need clarification or correction, and I am hereby submitting for your record that clarification.

On page 106, beginning on line 13, of Mrs. Simmons' testimony, she stated that, "It is the worst facility I have ever seen in the state, and on its wall, interestingly, is a plaque from the Joint Commission".

This statement was in error. The referenced facility has never been accredited by the JCAH. This error was brought to our attention when we shared with the JCAH the name of the facility. Mrs. Simmons and Department surveyors had viewed a certificate similar to that of the JCAH, but failed to ascertain its authenticity. I am most disturbed that this erroneous statement was made at a public hearing before your Committee, and I apologize to you, your Committee, and the JCAH for any damage done to the good name of the Commission because of this.

It should also be clear that the Department's testimony was not meant to deprecate the JCAH in its normal duties of evaluation, education, and consultation. The thrust of the testimony was to point out the California Accreditation and Licensure Survey (CALS) problems in attempting to use the JCAH in an unfamiliar function, that of enforcement. It is the enforcement function that would come with the "deemed status" proposal of the DHHS that was the subject of your hearing. I wish to make it clear that Mrs. Simmons spoke for me and this Department in her testimony and, therefore, I take full responsibility for any errors.

I do hope that our error in relation to one part of the testimony does not detract from the main point we were trying to make. Thank you for your attention to this correction and clarification.

Sincerely,

Beverlee A. Myers
Director

cc: Dr. John Affeldt, President
Joint Commission on Accreditation
of Hospitals

Senator HEINZ. I would like to ask Mr. Kuriansky, whom I thank for an extremely articulate and forceful statement—we have heard over the years from nursing home industry representatives about the excessiveness of Federal regulations, whether it is a question of door widths and water temperatures, or whether it is staffing reports every 3 months; that this is an unconscionable Federal intrusion into private business.

Could you tell us, in your experience, what the positive value of that kind of specificity is, and also, if this is relevant, since you are a prosecutor, how your prosecutions would or would not suffer if you did not have those kinds of reporting requirements or other standards against which measurements are made?

Mr. KURIANSKY. Well, our prosecutions are already suffering even under the current state of the law, Mr. Chairman. In this patient abuse report we issued a couple of months ago, in fact, we recommended strengthening the laws in the State of New York, and I do not think the situation is very much different in most other States, to develop some laws and regulations that directly go to the problems of the elderly.

I think you will note if you look at the statutes on the books that in most States there are laws protecting children and mentally incompetent people. There are, in most States, no similar laws specifically aimed at protecting the elderly. And we have found, as I have testified, that they are equally, if not more so, vulnerable to abuse and neglect in nursing homes.

I have a great deal of difficulty with the proposition that the place to look to cut back on paperwork and reduce unnecessary regulation is in the area of patient care. I think we have to make some choices in this society, and that would not be the area that we have found can stand very much reduction. In fact, as I indicated, we think that inspections ought to be increased. Not only should they be annual, but they should be unannounced.

I mean, it is absolutely ridiculous to call up a nursing home 6 weeks ahead of time and say, "OK, we are coming in; get ready." They can shape up their act very quickly on that kind of notice.

The six or seven proposals that have been put forth to achieve that kind of diminution of overregulation just do not stack up against experience.

Senator HEINZ. My time is expired. Senator Cohen.

Senator COHEN. Thank you, Mr. Chairman. I want to commend all of the witnesses this morning for their not only passionate but very persuasive testimony. I was interested in the chairman's questioning about the situation in California, and it occurred to me that there is no real monopoly on ineffectiveness in terms of oversight or enforcement.

Mr. Kuriansky, when you were describing the grand jury's investigation of that Queens nursing home, the question came to mind of who accredited that nursing home. Was it the State of New York?

Mr. KURIANSKY. The State of New York, under more severe regulations than we are now being asked to accept.

Senator COHEN. So, it is endemic to the system. It is not that the Joint Commission has some monopoly on nonenforcement or even superficial enforcement. All institutions perhaps suffer from that.

I also was interested in your testimony of how the grand jury pointed out, for example, that where the nursing home, in particular, should have had 61 people on hand, they had 57, historically. But it occurred to me also that even if you had an increase of four staff people, that would not have been sufficient to compensate for the kind of severity of conditions and the dramatic change in temperature that was brought about by the failure of the air-conditioning system.

So, even if you had 61 people, chances are you would have had almost as much insensitivity to the kinds of needs that were required at that time. But I do think it was evidence of the fact that if four people make a difference in ordinary times, you would need much more in extraordinary times.

Mr. KURIANSKY. Exactly, and I think the more telling point is that while staffing reports as they now exist are helpful, it would be even more helpful if they were tied to the nursing home population in a particular facility. It may be that you need 61 if the patients in the home are only partial care patients, but if they are patients in need of total care, you may need more than 61.

You need more than just a listing of how many kinds of employees there are. You need to know the kind of patients in a home and the kind of care they need.

Senator COHEN. Finally, Mr. Pawlewski, I do serve as a member of the Armed Services Committee and I am afraid you will not make it as Chairman of the Joint Chiefs, even though there are some bizarre suggestions made from time to time in that forum. [Laughter.]

Thank you for your testimony. That is all I have.

Senator HEINZ. Senator Grassley.

Senator GRASSLEY. Thank you.

Norm, you are usually very reserved in the things you say and you were much more forceful today. So, I want to point out to the chairman that obviously, as you could tell, he feels very strongly. He does not always speak like that. Yet, he is a man of conviction on everything that he says.

Has the State legislature made up any of the funds that have been lost as a result of the cut in medicaid funds for inspection?

Mr. PAWLEWSKI. No, they have not, Senator. We have attempted to get them to do that, but we——

Senator GRASSLEY. So, is your personnel less for the year you are in than previously?

Mr. PAWLEWSKI. Yes, we have cut back considerably on our survey staff.

Senator GRASSLEY. Could you give us a percentage or a number of people?

Mr. PAWLEWSKI. I could not tell you offhand, but I would say that at least 10 surveyor positions are vacant.

Senator GRASSLEY. OK. There has been a cut in the number of professional people in the regional offices of HCFA. Have you noticed any of that impacting upon the relationship between you and the regional offices that affects accreditation in those sorts of surveys?

Mr. PAWLEWSKI. I do not think that we would notice if there were nobody in Kansas City, Senator. [Laughter.]

Senator GRASSLEY. OK. From the standpoint that there has been a cutback at that level, it has not affected you like the cutbacks here?

Mr. PAWLEWSKI. No; it is the cutbacks where the action is that affect us, Senator, not where all the falderal goes on.

Senator GRASSLEY. Well, there has been a reduction of professional staff at the HCFA regional offices and, of course, you have answered my question.

Mr. PAWLEWSKI. That may have helped us in the past year. [Laughter.]

Senator GRASSLEY. By the way, I was not looking for any particular answer; I just wanted to get these facts out.

I wanted to ask Mr. Kuriansky his judgment of whether or not the JCAH-deemed status certification of nursing homes satisfies the statutory mandate that any accreditation decision provide, and I quote from the statute, "reasonable assurances that the conditions of participation for skilled nursing homes are met."

I want to ask that from a legal and statutory standpoint, not from your judgment, of whether or not these proposed regulations are good public policy. I think you can separate your thoughts.

Mr. KURIANSKY. Yes; I see what you are saying. I think, obviously, from a policy point of view, I have got a lot of problems with it.

Senator GRASSLEY. And I want your view of whether or not you even think that the regulations meet the Federal guidelines set by congressional enactment.

Mr. KURIANSKY. Well, I think it would be presumptious of me at this point to say they do not. Dr. Davis just testified that she compared them to exactly what is on the books now, and they are as good, if not better. So, I really would not be in a position to make a legal comment on that now.

I imagine, legally, they probably do stand up, but that is really not, in my view, what is at issue today.

Senator GRASSLEY. Well, obviously, it is from my standpoint, and I do not expect you to answer if you feel you cannot. But from my standpoint in the oversight capacity, as an individual Senator, to see that congressional policy is followed, I am interested in it as much from that standpoint as I am from whether or not it is good public policy, although obviously my cosignature on some of the letters that have gone out of this committee would indicate that I do not necessarily think it is good public policy.

Mr. Chairman, I think that answers all my questions.

Senator HEINZ. Thank you, Senator Grassley.

I want to announce the presence of Senator Glenn. John, if you have any opening remarks——

STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. I do, which I would like to have included in the record, Mr. Chairman, if I might, please. I will not bother reading them.

Senator HEINZ. Without objection.[1]

[1] See page 73.

Senator GLENN. My comments will be brief here. I am sorry I could not be here for the whole hearing. I want to commend you for having the hearing. I think this is something that is very much needed with regard to the proposed regulations.

I think this is a problem that is not going to go away. Our population is living to an older age. We are going to have more nursing homes in the future. We have already seen a dramatic increase across the country in numbers of nursing homes. So, we are going to be increasingly plagued with fly-by-night operators who are in it for a fast buck and could not care less about the human care and concern for the people that they have in their homes. So, if anything, there is a need for tightening regulations and shortening inspection periods, not lengthening them out.

But while we have experts, such as yourselves here, who are dealing in this field every day, I would only ask one question, and that would be along this line. In view of the fact that the States are being hindered in their nursing home survey and certification activities by the budget cuts in medicare and medicaid, are there any alternatives that you can propose which would insure quality care and which would avoid some of the unnecessary regulations that burden the providers who are doing a good job? Is there any other way than the inspections and so on? Do you have any other alternatives that you could suggest to us, any of you? Anybody who wants to answer can.

Ms. SIMMONS. California did develop a pilot project, and instead of surveying for the 541 elements that are currently in the Federal conditions, we only survey 134—clearly, only 25 percent of the existing ones, those that are directly related to patient care. So, that is an alternative to decreased funding and still doing the annual survey.

Also, we are proposing in California legislation that will require an annual licensing survey, but it will be done in two or more visits. Therefore, it will be the quick, unannounced visit, doing a partial survey each time. At the same time, we could be doing part of the certification survey at that same time. This is one alternative that we feel is a viable one.

Senator GLENN. Anyone else?

Mr. KURIANSKY. I would add one thing, Senator. This might be viewed as a long-term solution, in a way. That same Queens County grand jury recommended another proposal, and that was that nurses' aides and orderlies in nursing homes be trained and certified.

Aides and orderlies in nursing homes give 80 to 90 percent of the hands-on care. They are also responsible for 80 to 90 percent of the incidents of patient abuse and neglect in nursing homes. I think if they were subjected to proper training and certification requirements, we might find the care in nursing homes improving in the long run to the point where we would not need the State to intrude itself as often as is now necessary.

Senator GLENN. Thank you. Anyone else?

Mr. PAWLEWSKI. As a part of California's testimony, I believe they submitted a position paper by the region III nursing home regulators, and in that document I think you will find an answer to your question, Senator—deemed status for State licensure pro-

grams whose rules and regulations meet or exceed the Federal standards. Iowa is one such State.

We have cut our survey document down to about 30 items or elements. The Federal document is somewhere around 60 to 70 pages, and ours is somewhere around 13 or 14. We are looking at outcomes rather than processes. This is going to be difficult to do because we have got to retrain people to look at their job in a different way, but it can be done.

It is being done at the State level. These innovations are not being done at the Federal level; they are being done at the State level. That is where the deemed status ought to be; not to a private, nonprofit corporation, but to the States, who are your partners.

Ms. GORRECHT. I would like to respond, too, by saying this is a long, painful process—improvement. If there is one thing this whole situation has done for me, it has made me be a little kinder in my thoughts to our State bureaucracy, because we are on the same wavelength at the moment. We know that much of this is wrong, and we believe it together.

The State authorities who monitor and enforce regulations are not guardian angels either, you know; they make a lot of mistakes. And consumer groups have been working with the State organizations, and what we had behind us was the surety of the Federal commitment to good care. And what is frightening the daylights out of me, at the age of 65, is that they are going to take it away. I think this is what it comes down to.

You can move this regulation and not ask for that report. We can work that out, but stay with it.

Thank you.

Senator GLENN. Good. Thank you very much, Mr. Chairman, and thank you all for those excellent statements. I am not quite ready for a nursing home yet, but I guess a lot of us are heading there sometime. I want mine to be a good one when I get there.

Ms. GORRECHT. I hope so.

Senator HEINZ. You deserve it. [Laughter.]

Senator GLENN. I am not ready yet.

Senator HEINZ. All of us are interested in your future. [Laughter.]

I would like to be serious for a moment.

Senator GLENN. I thought you were just being serious.

Senator HEINZ. And I thought you would think that. [Laughter.]

[The prepared statement of Senator Glenn follows:]

PREPARED STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, I am pleased that the Senate Special Committee on Aging is holding this hearing on "Nursing Home Survey and Certification: Assuring Quality Care." Many nursing homes are providing excellent care to residents, but, unfortunately, quality care is not uniformly provided. We must continue our dedication to this Nation's over 1.3 million nursing home residents.

Five percent of our 65 and over population makes up 90 percent of nursing home residents, and the percentage of the total elderly population residing in nursing homes increases dramatically with age. Only about 1.4 percent of persons aged 65 to 74 reside in nursing homes, but 20 percent of persons aged 85 and over—the fastest growing segment of our population—reside in nursing homes. These elderly residents are often frail and unable to protect themselves. Therefore, they need our continued efforts to insure their health and safety.

Earlier this year, a great deal of concern was expressed about the U.S. Department of Health and Human Services' draft health and safety regulations. I joined my colleagues on the Aging Committee in contacting Secretary Schweiker, and I am pleased he decided not to propose regulations which would have weakened the Federal commitment to protect the health, safety, and human rights of nursing home residents.

We are now concerned about regulations proposed on May 27 which make changes in the nursing home inspection program. I believe that these proposed regulations would weaken the enforcement of minimum standards of care which have been established. Of particular concern are proposed regulations which would: (1) Eliminate mandatory annual surveys, (2) eliminate mandatory resurveys within 90 days, and (3) authorize deemed status for certification by the Joint Commission on Accreditation of Hospitals (JCAH).

Today, we will be hearing from many witnesses about the effects of the Department of HHS's proposed nursing home survey and certification regulations and about the impact on the States of reduced medicare and medicaid funding for nursing home services. I am hopeful that alternative proposals will be suggested that would improve the enforcement of nursing home standards of care and would reduce regulatory burdens on providers who are already doing an excellent job.

Protecting the rights of our most vulnerable elderly citizens must remain a priority task, and, again, Mr. Chairman, I commend you for calling this hearing.

Senator HEINZ. I would like to thank all of our witnesses—we have got four more—for your excellent testimony here today. It has been extremely valuable, and I know that all members of the committee will not only pay attention to what you said, but also the entire testimony that we put on the record. I know, in many instances, you have put much more extensive comment into the record, and we will all take a very careful look at it. We thank you all. We appreciate your being here.

Our next panel consists of John Affeldt; also, Jack MacDonald, Larry Lane, and Gailan Nichols. It is my understanding that the nursing home industry groups are going to present their testimony as one group, which is much appreciated by the chairman.

I would not want the witnesses to think that just because only the chairman is here that their testimony is in any way less important than any of the other testimony we have received. We just took a little more time, I am afraid, on the administration than we had planned.

Let me ask our first witness to be Mr. Affeldt. Mr. Affeldt, first of all, in spite of all the things we have said about your organization, whose name has been taken in vain many times here today—the Joint Commission on Accreditation of Hospitals—I do not know that anyone said anything bad about you; just bad about using you. And I hope you understand that any of the references that have been made by any of my colleagues on either the majority or minority sides of the aisle are in no way attempting to cast any aspersions on your organization or, for that matter, on nursing homes.

I do not think any member of the committee challenged the fact today, as put forth by Dr. Davis, that 20 percent of the nursing homes, according to her numbers, are excellent. Twenty percent are not; they are very bad. And everybody else is kind of in the middle, struggling. That is probably like the rest of us, you know.

So, just to put those facts on the record, I would like to ask you, Mr. Affeldt, to proceed.

STATEMENT OF DR. JOHN E. AFFELDT, PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, CHICAGO, ILL., ACCOMPANIED BY RALPH HALL, DIRECTOR, LONG-TERM CARE ACCREDITATION PROGRAM; AND PAUL MULLEN, DIRECTOR, GOVERNMENT RELATIONS

Dr. AFFELDT. Thank you, Mr. Chairman, and I appreciate your kind opening remarks to me, personally. I think it is evident that we, of the Joint Commission on Accreditation of Hospitals, are not sitting amidst a bunch of admirers here today, but we do appreciate the opportunity to present the views of the Joint Commission on the administration's proposal to you.

Behind me I have Ralph Hall, who is the director of our long-term care program, and Paul Mullen, who is the director of Government relations.

I do find some of the dire predictions that were made about the Department's proposal somewhat incongruous, as we look back at the history of the Joint Commission. We would just remind you that well over 60 years ago, the predecessor of the Joint Commission—namely, the American College of Surgeons—took on a program—the providers themselves took on a program—a burdensome task, an unpleasant task—of developing some standards and applying them to hospitals on a voluntary basis.

This became so successful that by 1951, they could not carry the total burden of the requests from the hospitals on a voluntary basis in this country, and they brought other major health care organizations to join with them, which is the Joint Commission on Accreditation of Hospitals today.

To hear these dire predictions of how terrible it would be and to look back and realize that the Joint Commission began this long before States even considered or began licensure of health facilities—you seem to make a distinction between hospitals and long-term care facilities. When we began with the hospitals, it was a bad scene and it took many years of those standards and their application for the hospitals to find out how to come up to higher standards and reach the point that they are at now.

Basically, the proposal is to say why should not and why cannot that work in the nursing home industry as well?

Specifically, the proposals by the Department—as we look at those, since there are reported to be about 320 skilled nursing facilities which participate in medicare only and no hospital-based home health agencies which participate in medicare only, these regulations mean that 320 facilities in the Nation would be allowed to seek JCAH accreditation and, if successful, to use evidence of such accreditation as an avenue for obtaining medicare certification, providing they agree to post JCAH survey comments and recommendations and subject themselves to medicare validation and complaint surveys.

As we understand it, this automatic recognition would not apply to the more than 17,000 skilled nursing facilities and intermediate care facilities or the 474 hospital-based home health agencies which participate in medicaid. As far as we can tell, none of the 1,300 long-term care facilities or 600 hospital-based home health agencies we presently accredit would be immediately affected by these pro-

posed regulations, because we believe they all participate in medicare and medicaid, in medicaid only, or in neither program.

We are aware that many publics are particularly critical of the accord of medicare deemed status to hospital-based home health agencies and SNF's accredited by the JCAH.

Senator HEINZ. On that point, if I may, I think there is some concern which maybe you will address, that budgetary reductions that will affect State agencies may have the effect of forcing State agencies to take the so-called option and go to you because of budgetary pressures on reimbursement of those State agencies.

Dr. AFFELDT. I do not know that I can really predict what might happen from that standpoint with the States, but I would observe that on the hospital side, there are now 36 States—and there is no financial incentive in this whatsoever for the States—36 States have now gone into a joint arrangement with us, and several other States are in the process of working it out with us. That is a trend that has been occurring over the past few years. I cannot specifically speak to the budget aspect.

Senator HEINZ. Very well. Please proceed.

Dr. AFFELDT. Some of the problems which we have heard identified include the matter of conflict of interest. Some critics suggest that the fact that JCAH must rely on survey fees for its viability represents a built-in conflict of interest because of nonaccreditation decision results in a loss of business.

We submit that JCAH regularly makes nonaccreditation decisions, and JCAH must apply its standards uniformly and rigorously in order to maintain credibility. You have heard that we are not regulators; that is correct. Our strength is our credibility.

Public responsibility: Some publics allege that the JCAH accreditation process is insensitive to the concerns of the publics served by the facility/program seeking accreditation, and that unlike the federally financed inspections, JCAH does not follow up on adverse survey findings or perform complaint investigations.

We submit that facilities/programs seeking accreditation are required to post public notice of impending surveys and of the opportunity for concerned publics to meet with JCAH surveyors in advance of the survey. JCAH surveyors in our long-term care program are instructed to interview patients concerning the quality of their care. JCAH does follow up on adverse survey findings and JCAH does perform onsite complaint investigations.

The issue of JCAH as a credible evaluator has been raised. It has been suggested that the annual reports to Congress on the medicare validation surveys are uniformly unfavorable to the JCAH, and hence provide persuasive evidence of the inappropriateness of extending medicare recognition to accredited long-term care facilities.

It is our view that the annual reports to Congress are not uniformly unfavorable to the JCAH. The reports recommend continuing recognition of JCAH accreditation. The reports note differing standards and differences in survey team composition, and suggest that differing findings should be expected. The results of a GAO investigation of the accreditation process suggests that JCAH is a credible evaluator.

Some have characterized the JCAH survey process as merely a review of resources, and hence undeserving of recognition by the Department. We submit that the JCAH accreditation process has always included a review of resources, such as adequacy of nursing staffing. The JCAH accreditation process has also always included an evaluation of process and outcome, as well as things like Life Safety Code compliance and effective infection control programs.

On the question of public accountability, it has been alleged that JCAH has neither consumer representation nor public accountability. We submit that JCAH has consumer representation on its board of commissioners, on its policy advisory committee, and on its long-term care professional and technical advisory committee.

JCAH is the subject of an annual report to Congress. JCAH has been subjected to an examination by the U.S. General Accounting Office. Facilities and programs seeking JCAH accreditation are required to post public notice of an impending survey, and JCAH investigates complaints about accredited facilities.

In conclusion, Mr. Chairman, we believe the Department's proposal, insofar as it addresses the JCAH, is entirely consistent with the Secretary's authority as outlined in section 1865 of the Social Security Act. We believe, Mr. Chairman, that the recognition proposed is insufficiently broad. The Department has spent over 4 years reviewing the JCAH standards and survey process with respect to hospital-based home health services, and over 2 years in the examination of our accreditation process for long-term care facilities. In both instances, we have been advised of tne secretarial finding that our accreditation process provides reasonable assurance that skilled nursing facilities and hospital-based home health agencies we accredit meet the medicare conditions of participation.

Considering these findings, we believe the Secretary should have proposed that skilled nursing facilities and hospital-based home health agencies accredited by JCAH which participate in medicare and medicaid be exempt from separate Federal certification surveys performed by State agencies. Such a proposal would have enabled up to 4,423 skilled nursing facilities which participate in both medicare and medicaid to seek JCAH accreditation and, if successful, to automatically use such accreditation as a vehicle for obtaining their medicare-medicaid provider certification.

We also believe such a change would enable the 474 hospital-based home health agencies we presently accredit to use this accreditation in lieu of their present separate State agency certification survey as an avenue to medicare and medicaid certification and thus eliminate this duplicate activity.

We believe these regulations provide an historic opportunity to enhance the quality of care in long-term care facilities in this country—an opportunity to bring the long-term care community into the mainstream of high-quality health care in this Nation.

A program of negative incentives has been imposed on the long-term care community since the advent of medicare. This program has undoubtedly wrought significant improvements. We believe the maximum benefits of this "stick" approach have been reached. In our view, the Secretary is now suggesting a "carrot and stick" approach to the achievement of quality long-term care. He has not only suggested mechanisms State agencies might use to reward

consistent excellence, but also a means of concentrating oversight on those facilities most in need of it. State agencies, under these proposals, will be able to husband their resources and engage in novel and imaginative initiatives designed to bring about positive change.

Mr. Chairman, I thank you for this opportunity. I would ask that my testimony and the prepared statement which we have already submitted to staff be placed in the record.

Thank you.

Senator HEINZ. Without objection, Dr. Affeldt, it will be. Thank you for your testimony.

[The prepared statement of Dr. Affeldt follows:]

PREPARED STATEMENT OF DR. JOHN E. AFFELDT

Mr. Chairman, I am John E. Affeldt, M.D., president of the Joint Commission on Accreditation of Hospitals (JCAH). With me today is Ralph Hall, director of our long-term care accreditation program and Paul Mullen, our director of government relations. I am pleased to have the opportunity to present the views of the Joint Commission on the administration's proposals to modify the medicare/medicaid provider survey and certification process. Considering the historic roles of the JCAH in the area of quality assurance and as a component of the medicare/medicaid hospital certification system, we believe it particularly appropriate that our views on these issues be included in the record of these proceedings.

JCAH HISTORICAL BACKGROUND

Before addressing myself to the subject of these hearings, I would like to present background information about the JCAH. In 1951, the American College of Physicians, the American Hospital Associations, the American Medical Association, and the Canadian Medical Association (which withdrew in 1959 to participate in its own national hospital accreditation program) joined with the American College of Surgeons to form the Joint Commission on Accreditation of Hospitals. The JCAH was incorporated in Illinois as a not-for-profit corporation.

In 1981, the American Dental Association became a member organization of the JCAH and in 1982 a public member, William D. Mitchell, president, Central Telephone & Utilities Corp., Chicago, Ill., was added to our board of commissioners.

In addition to its hospital accreditation program, the JCAH also establishes standards and offers voluntary accreditation programs throughout the United States for adult psychiatric facilities, children's and adolescent's psychiatric facilities, drug abuse treatment and rehabilitation programs, alcoholism treatment and rehabilitation programs, community mental health services, long-term care facilities, and ambulatory health care organizations. Collectively, the accreditation programs of the Joint Commission survey over 4,500 facilities, services, and programs in the course of a year, and approximately 7,300 facilities, services, and programs currently hold JCAH accreditation. Represented in this statistic are over 70 percent of the hospitals in the United States.

The JCAH standards for hospital accreditation as contained in the "Accreditation Manual for Hospitals," 1982 edition, have a long history of development. The first "Minimum Standard for Hospitals" was issued by the American College of Surgeons (ACS) in 1917. During the following 35 years, ACS conducted a hospital standardization program which caused a natural evolution in hospital standards. In 1952, when the JCAH survey program was implemented, these minimum standards of the ACS program were utilized.

The adopted minimum standards were revised six times by the JCAH board of commissioners between 1953 and 1965. Then in August 1966, the board of commissioners voted "to review, reevaluate, and rewrite the hospital accreditation standards and their supplemental interpretations to raise and strengthen the standards from a level of minimum essential to the level of optimal achievable and to assure their suitability to the modern state of the art."

Consequently, the standards underwent extensive revision, resulting in the 1970 edition, called, for the first time, the "Accreditation Manual for Hospitals" (AMH).

Since then, the manual has undergone continuous review and revision to keep abreast of the state of the art including the incorporation of standards for hospital-based home health services.

LONG-TERM CARE ACCREDITATION PROGRAM STANDARDS

The JCAH adopted a code of standards for extended care facilities in October 1965 and inaugurated an accreditation program in this area the following January. The program standards have been subject to continuous change with major changes in 1967, culminating in entirely new accreditation manuals in 1975 and 1979. Major reviews of our long-term care nursing and social services standards are presently underway. There are currently approximately 1,300 long-term care facilities in the Nation which are accredited by the JCAH; nearly 600 of these are integral to a hospital.

JCAH INVOLVEMENT WITH GOVERNMENT

In the years prior to 1965, the JCAH was the Nation's chief standard setting organization for hospital medical care. With congressional enactment of medicare, the Federal investment in hospital care rose dramatically. Included within the 1965 amendment to the Social Security Act was the provision that the Department (then DHEW) certify that institutional providers (including hospitals, extended care facilities and home health agencies) desirous of functioning as medicare providers meet certain health and safety standards. Although modeled after the then current JCAH voluntary requirements, these Federal conditions of participation signaled the beginning of Federal involvement in standards setting activity in health care facilities.

The 1965 amendment establish a special relationship between medicare and the JCAH hospital accreditation program. Under section 1865 of the act, an institution accredited as a hospital by the JCAH was considered or "deemed" to meet most of the certification requirements of medicare, essentially giving it automatic eligibility to participate in the medicare program.

Hospitals that did not choose to be accredited by the JCAH were surveyed by the Department which contracted with State agencies to apply the medicare conditions of participation in these hospitals, and to make certification recommendations to the Secretary.

In 1970, a suit was brought by a consumer group against the Department and the JCAH in which it has alleged that Congress had unconstitutionally delegated legislative authority to the JCAH, a private organization, i.e., the power to determine conditions for medicare participation. Eventually, Senate hearings were held on this issue resulting in enactment of section 244, Public Law 92-603, which authorized the Secretary to set standards for medicare participation higher than those adopted by JCAH, to conduct validation and complaint surveys, and to make an annual report to Congress on the results of such surveys. The suit was subsequently dismissed.

Section 1865 of the act not only stipulated that JCAH accredited hospitals would generally be considered as meeting the statutory requirements for medicare participation but also contained language enabling the Secretary to rely on the accreditation process of *any* (emphasis added) national accreditation body which provides reasonable assurance that one or more of the conditions of participation for hospitals, skilled nursing facilities and home health agencies are met for purposes of medicare certification. This brings us to a consideration of the issues being addressed by these hearings.

THE DEPARTMENT PROPOSAL

On May 27, 1982, the U.S. Department of Health and Human Services (DHHS) proposed to accept JCAH accreditation in lieu of a State survey for skilled nursing facilities and hospital-based home health agencies, that participate only in the medicare program. The Department further proposes to allow State agencies the latitude of according similar recognition to JCAH accredited skilled nursing facilities, hospital-based home health agencies, and intermediate care facilities which participate in medicare and medicaid or in medicaid only. The preconditions to the above described recognition are that the facilities post the JCAH accreditation report and be subject to a medicare/medicaid validation and complaint survey process.

Since there are reported to be about 320 skilled nursing facilities which participate in medicare only and no hospital-based home health agencies which participate in medicare only these regulations mean that 320 facilities in the Nation would be allowed to seek JCAH accreditation and if successful to use evidence of such accreditation as an avenue for obtaining medicare certification providing they agree to post JCAH survey comments and recommendations and subject themselves to medicare validation and complaint surveys. As we understand it this automatic recognition would not apply to the more than 17,000 skilled nursing facilities and intermediate

care facilities or the 474 hospital-based home health agencies which participate in medicaid. We understand, of course, that State agencies might choose to rely on JCAH accreditation in whole or in part as a part of their medicare and medicaid certification activities, subject to the preconditions outlined above. As we interpret this enabling authority a State agency might recognize accreditation as satisfying a part of its survey responsibility for a given medicare/medicaid standard or its survey responsibility of alternating years, or for selected "good" facilities only, or any combination of the foregoing.

As far as we can tell, none of the 1,300 long-term care facilities or 600 hospital-based home health agencies we presently accredit would be immediately affected by these proposed regulations because we believe they all participate in medicare and medicaid, in medicaid only, or in neither program.

We are aware that many publics are particularly critical of the accord of medicare "deemed status" to hospital based HHA's and SNF's accredited by the JCAH. We wish to take this opportunity to address some of the issues which have been raised with respect to this matter.

CONFLICT OF INTEREST

Some critics suggest that the fact that JCAH must rely on survey fees for its viability represents a built-in conflict of interest, i.e., JCAH is reluctant to render a nonaccreditation decision because such a decision results in a loss of business. To this, we would submit that the fact that JCAH regularly makes nonaccreditation decisions with respect to facilities/programs seeking accreditation clearly demonstrates JCAH commitment to make accreditation decisions which are inimical to its own financial interest. While we believe that only those facilities which believe they can meet JCAH standards apply for accreditation we also believe we must apply our standards rigorously if we are to remain a credible accrediting organization.

PUBLIC RESPONSIBILITY

Some publics allege that the JCAH accreditation process is insufficiently sensitive to the concerns of the public served by the facility/program seeking accreditation and that unlike the federally financed inspections JCAH does not follow up on adverse survey findings or perform complaint investigations. We submit that facilities/programs seeking accreditation are required to post public notice of an impending survey and of the opportunity for a public information interview with the survey team and JCAH surveyors are instructed to interview patients concerning the quality of their care. The JCAH does follow up on adverse survey findings and the JCAH does perform complaint investigations ranging from letters of inquiry to unannounced onsite surveys.

JCAH AS A CREDIBLE EVALUATOR

It has been suggested by some that the annual reports to Congress on the medicare validation surveys are uniformly unfavorable to the JCAH; hence provide persuasive evidence of the inappropriateness of current medicare recognition of accredited hospitals and certainly to the extension of this recognition to accredited long-term care facilities. It is our view that it is inaccurate to characterize these reports to Congress as being uniformly unfavorable to the JCAH. In the conclusion of all these reports the Secretary has continued to recommend that the DHHS continue to rely on JCAH accreditation. The reports have highlighted the differences between JCAH and State agency surveyor findings in the Life Safety Code area but also noted the use of differing codes (1967 version for HCFA versus 1973 version by JCAH) and the fact that the use of differing standards and differing team compositions are likely to produce differing findings. A complete review of this subject is contained in U.S. GAO report HUD No. 79-37, May 14, 1979, and this review may be characterized as being supportive of the Department's proposed extension of recognition of accreditation.

Some have characterized the JCAH survey process as merely a "review of resources"; hence a process undeserving of recognition by the Department. We wish to make it clear that although our accreditation has always involved an assessment of whether a hospital or long-term care facility had adequate resources, nurse staffing for example, it has also always focused on process and outcome as well. Effective infection control programs, tissue review functions, professional staff credentialing mechanisms and adequate Life Saving Code adherence, for example, have long been integral to the JCAH accreditation process.

Public accountability.—The Department's proposal to recognize JCAH accredited SNF's for medicare certification purpose has been criticized on the basis that JCAH has neither consumer representation nor public accountability. To this we would respond that the JCAH has consumer representation on its board of commissioners, on its policy advisory committee and on its long-term care professional and technical advisory committee. Further, it is not clear that the JCAH has no public accountability. The annual report to Congress on the results of the validation survey of JCAH accredited hospitals represent a very high standard of public accountability. In addition, the JCAH accreditation process has been subjected to an examination of the U.S. General Accounting Office, the investigative arm of Congress, and we would submit this is a form of public accountability. The JCAH accreditation process involves a requirement that the facilities/programs we survey for accreditation post public notice of our impending survey and of the availability of a public information interview with our surveyor staff. Finally, we believe our practice of investigating complaints from the public about institutions we accredit attests to the fact that we behave in a fashion consistent with the concept of public accountability.

Finally, we have heard that it has been alleged that a recent review conducted by New York shows that there are several JCAH accredited nursing homes that have been found severely deficient by State inspectors and that this circumstance argues against the Department's proposed recognition of accreditation. We have contacted officials of the New York State agency to obtain the results of this review. They deny knowledge of such a review; hence the meanings of the terms "several" and "severely deficient" are not clear and it is further unclear that the alleged review was made. If such a review was conducted and deficiencies were found in JCAH accredited long-term care facilities it is likely that the reviewer made a value judgment that such problems were severe. At the same time it is equally likely that JCAH found these same problems, that they may or may not have been characterized as severe and the facility's accreditation may or may not be contingent upon timely correction of these problems subject to verification by JCAH surveyors. It is important to note that JCAH accreditation does not mean that a facility/program has no deficiencies. In fact, the JCAH has yet to discover that facility/program meeting all our standards. It is also important to note that unless a program/facility is appropriately licensed by the State agency it is ineligible for JCAH accreditation.

CONCLUSIONS

In conclusion, Mr. Chairman, we believe the Department's proposal insofar as it addresses the JCAH is entirely consistent with the Secretary's authority as outlined in section 1865 of the Social Security Act. We believe, however, that the recognition proposed is insufficiently broad. The Department has spent over 4 years reviewing the JCAH standards and survey process with respect to hospital-based home health services and over 2 years in the examination of our accreditation process for long-term care facilities. In both instances, we have been advised of the secretarial finding that our accreditation process provides reasonable assurance that skilled nursing facilities and hospital-based home health agencies we accredit meet the medicare conditions of participation.

Considering these findings, we believe the Secretary should have proposed that skilled nursing facilities and hospital-based home health agencies accredited by JCAH which participate in medicare and medicaid be exempt from separate Federal certification surveys performed by State agencies. Such a proposal would have enabled up to 4,423 skilled nursing facilities (which participate in both medicare and medicaid) to seek JCAH accreditation and if successful to automatically use such accreditation as a vehicle for obtaining their medicare/medicaid provider certification. We also believe such a change would enable the 474 hospital-based home health agencies we presently accredit to use this accreditation in lieu of their present separate State agency certification survey as an avenue to medicare and medicaid certification and thus eliminate this duplicate activity.

We believe these regulations provide an historic opportunity to enhance the quality of care in long-term care facilities in this country; an opportunity to bring the long-term care community into the mainstream of high quality health care in this Nation. A program of negative incentives has been imposed on the long-term care community since the advent of medicare. This program has undoubtedly wrought significant improvements. We believe the maximum benefits of this "stick" approach have been reached. In our view the Secretary is now suggesting a "carrot and stick" approach to the achievement of quality long-term care. He has not only

suggested mechanisms State agencies might use to reward consistent excellence but also a means of concentrating oversight on those facilities most in need of it. State agencies, under these proposals will be able to husband their resources and engage in novel and imaginative initiatives designed to bring about positive change.

Mr. Chairman, I wish to thank you for this opportunity to express the views of the JCAH on these important issues. This concludes my prepared remarks. At this time, I would be pleased to answer any questions or furnish any other information members of the committee may request.

Senator HEINZ. I understand, Mr. MacDonald, that you are going to present testimony for yourself, Larry Lane, and Gailan Nichols.

Mr. MACDONALD. Yes.

Senator HEINZ. Very well. Let me welcome all three of you here, and let the record fully reflect that, although one person speaks, he speaks with three voices.

STATEMENT OF JACK A. MacDONALD, EXECUTIVE VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CENTERS, WASHINGTON, D.C.; ACCOMPANIED BY LAURENCE F. LANE, DIRECTOR FOR POLICY DEVELOPMENT AND IMPLEMENTATION, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, WASHINGTON D.C.; AND GAILAN NICHOLS, VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, D.C.

Mr. MACDONALD. I feel very pluralistic today.

Thank you, Mr. Chairman, I am Jack MacDonald.

Senator HEINZ. That is called the choir preaching to the clergy. Go ahead.

Mr. MACDONALD. With me today are Gailan Nichols, vice president of the American Health Care Association; and Larry Lane, director for policy development and implementation for the American Association of Homes for the Aging.

On behalf of our respective organizations, we appreciate this opportunity to present our views and recommendations on the proposed revisions to the survey and certifications process of health care providers under the medicare and medicaid programs.

We understand the committee's need to expedite this hearing by holding it in a timely fashion, and that the purpose of the hearing is to objectively examine the proposed revisions to the medicaid and medicare survey system. However, as providers of direct patient care services, we find nursing facilities being the subject of indirect criticism in the debate over the proposed revisions. We are sure that the chairman and the members of the committee understand and share our concern over that plight, and we appreciate your comments, Mr. Chairman, to the panel members earlier.

To better appreciate this concern and understand our positions, we draw to your attention the following factors:

First, the proposed revisions are not the product of just the current administration, but many of the proposals stretch back in their development over two previous Presidents, three Secretaries, and four Administrators of the Health Care Financing Administrations, as well as to its predecessor organizations.

Second, the development of the revisions was not initiated by the nursing home industry, nor was it initiated solely for budgetary purposes.

Third, the process by which these regulations evolved was entirely public. The issues were discussed in numerous public forums and

written comments were solicited from all concerned about the issue. This included comments by State and Federal officials, congressional committees, professional organizations, providers, and consumer representatives.

Fourth, governmental and private studies have developed significant evidence of severe problems with the current medicare and medicaid structure at the Federal and State level, as noted by Senator Cohen here earlier.

Fifth, the proposed revisions to the survey process represent but one of numerous efforts by Federal and State governments to address the documented problems in that process.

Sixth, the proposed revisions do not reduce the standards of care that providers must meet to participate in the medicare and medicaid programs, so that the direct regulatory costs to our facilities would not be changed in a significant way.

Seventh, our three organizations are publicly on record in favor of improving the efficiency of the survey process and reorienting it to be more responsive to patient needs.

Mr. Chairman, we would like to take this opportunity to invite the members of this committee to visit nursing facilities in their States to discuss the survey process with the staffs in those facilities. This is a subject that simply cannot be fully evaluated, in 5 minutes or 2 hours in a congressional hearing room in Washington, D.C. And we would compliment this committee on the fact that several members, as noted earlier by Senator Percy, have spent a great deal of time, as you have, Mr. Chairman, in visiting with patients and facility staffs.

In summary, our organizations have submitted, in detail, statements specifying our respective positions on the proposed revisions. These statements reflect a common endorsement for the key points in the proposed revisions. This includes the intent to provide for better targeting of limited resources of State agencies where they are most needed, and the option of deemed status for JCAH-accredited facilities.

However, we have each made specific recommendations as to how the proposed revisions and the survey enforcement process can be made more effective. These include many of those that you have heard earlier in this hearing by both committee members and witnesses. We view these proposals merely as a step in a continuing effort to improve the effectiveness of the survey process.

We urge your review of our recommendations and will be pleased to answer any questions which you or the members of the committee may have.

Thank you.

Senator HEINZ. Without objection, your entire individual statements will be a part of the record.

[The prepared statements follow:]

STATEMENT OF THE NATIONAL COUNCIL OF HEALTH CENTERS

Mr. Chairman and members of the committee, the National Council of Health Centers would like to submit for the record the following statement on the Department of Health and Human Services' proposed nursing home survey/certification regulations.

The National Council of Health Centers represents proprietary multifacility nursing home firms with more than 185,000 nursing home beds in 48 States and the Dis-

trict of Columbia. Our members also provide a number of other health-related services for our Nation's elderly, including home health, adult day care, drug and alcohol treatment centers, and retirement communities.

As multiservice providers of nursing home care, we believe we occupy a unique position in the health care community. We firmly believe in the specific responsibility of providing quality care for a reasonable and competitive cost. Our accountability is not confined solely to the Federal and State agencies which monitor and pay for much of the care delivered in our nursing homes. We are also accountable to our patients, their families, our investors, boards of directors, and to the communities in which we serve.

This concern for the well-being of our patients extends to the Federal regulations which govern our services and monitor the care, including the Department of Health and Human Services' proposed regulations for survey and certification of health facilities.

The current Federal requirements for survey and certification have been characterized by their rigidity and orientation to paperwork, with an underlying philosophy best expressed by Alex Gerber, clinical professor of surgery at the University of Southern California School of Medicine:

"Nursing home inspectors thrive on paperwork. The rule seems to be the thicker the chart, the healthier the patient. Top-heavy, bureaucratic teams of nursing, social services, dietetic, pharmacy, medical record, and rehabilitative activity specialists are busily interpreting volumes of Federal and State rules and regulations, all evidently oblivious to the overall health status of the patients. So much emphasis is placed upon charting and filling out forms that relatively little time is left for actual patient care."

The current burdensome and inflexible survey process only serves to perpetuate this system for there has been small allowance for innovation or progress. In our views the regulations proposed by the Department of Health and Human Services are an initial attempt to begin addressing the misplaced emphasis and to refocus on the actual care delivered.

The identification of shortcomings in the surveys process has been an ongoing project for years, perhaps beginning with the New York State Moreland Commission's report issued in 1976. This report criticized Federal regulations and State survey inspection efforts for their reliance on paperwork and on items which are immediately measurable, such as corridor widths and room sizes. Our member nursing homes have even had surveyors cite deficiencies for the temperature of water in fish tanks and the shape of placemats in the dining room.

Revisions in the survey process have been but one part of a phased plan to completely rewrite all Federal regulations pertaining to nursing home care, including the conditions of participation, interpretive guidelines, and survey procedures. The effort to revise the survey procedures which were begun in 1977 under then HEW Secretary Joseph A. Califano, was not conceived as a cost-cutting effort, but rather to address the glaring shortcomings of the system. Interestingly this effort was a part of what he called "Operation Common Sense."

In its report, "Long-Term Care Regulation: Past Lapses, Future Prospects," the Moreland Commission stated that State and Federal regulatory agencies:

"Have not developed sensible and workable regulatory programs. They have not even taken the essential first steps, which are to determine what is important to regulate in nursing homes, and how to measure what is important. Instead, regulation has been piled on regulation in bewildering detail, with little attempt made to determine which is essential and which superfluous."

As recently as 5 months ago, a report by the HHS Inspector General noted that "* * * the regulatory process has evolved into a paper-ridden exercise which often has little bearing on the actual quality of patient care. Survey teams spend little time talking with patients, their families, and staff."

As if to bear this out, one nursing home administrator in the same report remarked that in 1973 the surveyor spent 1 day in his nursing home—2 hours in the office reviewing paperwork, and the rest of the day with patients in the home. In 1981 the survey of the same facility lasted 7 days, 6½ days in the office, and one afternoon with patients.

Surely our priorities are misplaced if we continue to support a burdensome and inflexible system such as this. We believe that the proposals HHS has initiated, along with other projects it has underway, will begin to affect the necessary changes in this cumbersome system by refocusing the State and Federal agencies' resources on facilities most in need of assistance and on the one subject in need of the most attention, the patient.

Your committee's recent letter to Secretary Schweiker indicated support for the intent of these regulations. The National Council believes that the concerns you have expressed can be resolved through a combined effort of all interested and involved parties.

Before commenting on the specific proposals and offering our suggestions for modification and improvement, there are several points which we feel you should be cognizant of when evaluating the proposed regulations.

First, the existing Federal standards are often portrayed as minimal. We would suggest that a detailed review of each of the individual requirements demonstrates that Federal involvement in the day-to-day operations of nursing facilities and their staffs is neither minimal in number nor specifics. These 541 individual requirements may range from the width of doorways to the temperature of the water. The proposed survey process revision does not delete any of these detailed regulations, the facility's obligation to meet the standards, nor its liability for failing to meet the standards.

Second, each State has developed its own standards and requirements for nursing homes licensure and, in 40 States, the standards equal or surpass Federal certification requirements. This fact was borne out in a 1981 study conducted for the Health Care Financing Administration by the Association of Health Facility Licensure and Certification Directors. Licensure surveys are done annually and when a change of ownership takes place. In addition, complaints filed with the State health departments can trigger a survey at any point in time, thus a facility can be in jeopardy of losing its license or certification at any time, not just at the time of the annual survey.

Third, there are numerous other authorities, many at the State or local level, which may at any one time be engaged in surveying either the care delivered in nursing facilities, or the professionals providing that care. We have identified over 30 of these authorities which are listed in the attachment to this statement. The actual list may vary from nursing home to nursing home depending on location, patient population, services provided, or financing characteristics.

These various survey groups spend many hours every month in each of the medicaid and medicare certified nursing homes. Invariably, a nursing home staff member, and sometimes several, must accompany and assist the inspecting officials. Each hour spent with these individuals means one less hour of time available for direct patient care.

The fragmentation of the various agencies monitoring nursing home care diminishes their effectiveness and may lead to serious problems as described in LaPorte/Rubin's "Reform and Regulation in Long-Term Care":

"In many, if not most, States a facility is licensed and inspected by one agency, paid by a second agency, and assigned residents by a third. This system almost insures that homes with violations can continue to operate. In some cases the licensing and standard setting alone may be spread through several agencies. For example, in Pennsylvania, licensing and standard setting is carried out by one unit within the department of public welfare while approval for participation in the medicare program is the responsibility of the department of health. Responsibility for approval with reference to fire safety is the responsibility of the department of labor and industry * * * the net results of this fragmentation of authority is that a major opportunity for prodding the industry toward higher levels of performance by tying reimbursement levels to patient care needs and indexes of quality of care and quality of environment is lost."

Fourth, the problem of duplicative Federal and State standards for nursing homes was identified and addressed by a medicaid management study team in Wisconsin which concluded that 40 percent of the State and Federal regulations were duplicative. The team found that:

"The mandated annual facility survey, which is based on a checklist of 1,500 State and Federal regulations, involves approximately 620 regulations that unnecessarily duplicate other regulations or require collection of information from the survey that could be obtained more conveniently from another source—from the most current license application, for example."

It was precisely this type of duplication and overlap which HHS was hoping to eliminate in its efforts earlier this year to revise the conditions of participation. Eliminating or modifying unnecessary or ineffective regulations—while strengthening those that are essential—can only lead to better health care for a segment of our population that is increasing daily. HHS Secretary Richard Schweiker and his staff understand the importance of addressing some of the real problems facing nursing homes, rather than continuing paper regulations that have little relation to the care actually delivered.

With these comments as background, we would like to address the specific proposals the Department of Health and Human Services has made.

LESS THAN ANNUAL SURVEYS

We believe that the potential impact of this provision has been unduly magnified by some who would want you to believe that, absent the annual certification survey, no other regulators would enter a nursing home for up to 2 years. In fact, there is an annual licensure survey by State health departments that is every bit as demanding as the certification survey and in some cases, more so. As mentioned earlier, 47 States have nursing home licensure standards higher than the Federal standards. This licensure survey would continue to be conducted on an annual basis as would the myriad of additional surveys conducted by the other regulatory agencies involved in monitoring some aspects of nursing home care.

Progressive flexibility.—As an interim step or proposal to the 2-year survey cycle, we would suggest consideration of an option originally proposed by Secretary Califano, that of progressive flexibility. Under the concept of progressive flexibility, the survey cycle could vary from 12 months to 24 months, with an 18-month intermediate stage, based on the superior performance history of nursing homes as recorded on the most recent compliance survey.

As originally proposed by the Department of HHS, program participants would qualify for an 18-month survey cycle when there were no serious deficiencies recorded on the previous compliance survey. At the time of the 18-month compliance survey, if no serious deficiencies are again evidenced, or if a submitted plan of correction is acceptable, and a followup visit(s) reveals that the program participant has effected correction(s) in the manner and time specified in the plan of correction, the next survey would take place 24 months from the date of the 18-month survey. If, however, at the time of the 18-month survey, the program participant has failed to either submit an acceptable plan of correction, or to complete promised corrections, the program participant automatically reverts to a 12-month survey cycle and must again demonstrate a deficiency-free history in order to progress to the expanded (18-month) survey cycle.

To this proposal we would add the following: The Department would specify in regulations a system for identifying which facilities would qualify for extended surveys and also the minimum survey time spread should be 6 months, not 12 months, in order to permit States to focus more time and effort on noncomplying facilities.

Short-form surveys.—Alternatively or possibly in conjunction with this proposal for progressive flexibility, we suggest that "short-form surveys" be conducted on superior nursing homes. The shorter survey would be a focused review or screening process whereby essential elements of patient care are examined, such as nursing services, dietary, pharmaceutical services, and so on. These surveys would take less time and less survey staff, but still concentrate on assuring that the important requirements for quality care are met. If significant problems are identified, then a full-fledged survey would follow.

Some States have engaged in innovative projects such as this for several years and their success provides evidence that a more effective allocation of resources will not lead to a deterioration of care.

Deemed status for State licensure.—We also urge for your consideration, the deeming of State licensure surveys for Federal certification purposes. Given that State standards are in almost every case higher, the deeming should not present an unsurmountable obstacle. The main concern of States would be the need for assurances of continued Federal financial support. We would expect that this problem could be worked out, since both the State and Federal governments would benefit from significant savings and a reduction in paperwork.

By incorporating the "progressive flexibility option mentioned earlier, States which have been approved for deeming could be phased in to progressively longer survey cycles depending upon their demonstration of exemplary performance.

Validation surveys.—As a fail-safe for increased survey intervals, we would propose an increase in the Federal validation efforts. By conducting random, unannounced surveys to validate or verify the effectiveness of State survey efforts, we feel that a beneficial safeguard would be added with relatively little incremental cost.

Specifically, we propose a minimum of 20-percent validation surveys in each HHS region of all facilities including those with extended survey cycles. We have estimated that to do this for 20 percent of the 14,500 medicare/medicaid certified nursing homes would require only $10 million in added funds, an amount that would surely meet any cost-benefit test.

JCAH DEEMED STATUS

Much criticism has been directed at the proposal to permit surveys conducted by the Joint Commission on Accreditation of Hospitals to be deemed for medicare/medicaid certification. We are mystified why this proposal has caused so much reaction.

A number of important points seem to have been overlooked by critics of deemed status. JCAH has been successfully surveying hospitals for over 30 years, and long-term care facilities for 15 years. Further, Congress had sufficient confidence in the Joint Commission to enact deemed status for hospitals in 1966 as part of original medicare legislation. A 1979 evaluation of the program by the General Accounting Office concluded that JCAH did at least as effective a job as State survey agencies and recommended that the Department contract with JCAH to do all medicare certification.

The Department of Health and Human Services has provided a number of safeguards in its proposed regulations for JCAH deemed status, more than presently required of hospitals. It should also be pointed out that when hospitals have lost their accreditation or are about to, that fact becomes public knowledge and considerable public pressure is brought to bear on the hospital to regain its accreditation status.

As proposed, very few nursing homes could opt directly to seek accreditation with deemed status privileges. Specifically, these are the medicare-only certified nursing homes which comprise only 2 percent of the nursing home industry. In all other cases, States have the authority to decide whether nursing homes are eligible and indeed, to designate which homes are eligible. This decision may be revoked at anytime.

In response to the expressed concerns about the enforcement of nursing home standards by the Joint Commission, the Department of Health and Human Services made numerous modifications to the draft regulation including mandatory posting of survey results by nursing homes and validation of followup surveys by Federal/State survey teams. It is important to note that the Joint Commission is also making changes in their standards which will exceed the Federal standards in several important care related areas, such as patient care management and nursing services. Facilities which do not comply with JCAH standards will not be accredited and will be subject to an immediate review by the State agency. Simply stated, it is each State's choice whether it wishes the Joint Commission to be the accrediting body for the facilities in its State.

As an additional enforcement measure, we would extend our proposal for increased validation surveys for deemed facilities.

A good deal of concern has been directed at the lack of public accountability or consumer representation on the Joint Commission. To this we would respond that the membership of its governing body and long-term care advisory committee can scarcely be criticized for advocating any principle other than high quality care in all institutions. Its board of commissioners is comprised of five organizations: American Dental Association, American College of Physicians, American Hospital Association, American College of Surgeons, and the American Medical Association.

There are 15 organizations which act in an advisory capacity to the long-term care section, the Professional/Technical Advisory Committee (PTAC):

(1) American Association of Homes for the Aging;
(2) American Association of Retired Persons;
(3) American College of Nursing Home Administrators;
(4) American College of Physicians;
(5) American Congress of Rehabilitation Medicine;
(6) American Health Care Association;
(7) American Hospital Care Association;
(8) American Medical Association;
(9) American Nurses Association;
(10) American Podiatry Association;
(11) American Psychiatric Association;
(12) Center for Study of Aging and Human Development;
(13) National Association of Social Workers;
(14) National Association of State Mental Health Program Directors; and
(15) National Council of Health Centers.

While many of these organizations are provider or professional based, it would be an exaggeration to claim that they are biased in favor of nursing homes.

Each of the members of the PTAC advisory group seeks to assure the highest quality of care in nursing homes by contributing their expertise and experience to the development and application of standards. To imply otherwise is to question the

motives of 15 respected professional organizations and to denigrate the contributions they have made in setting quality standards for nursing homes.

To the Department's proposal to require JCAH-accredited nursing homes to post survey results, we suggest that nursing homes which are eligible to seek deemed status be required to send the survey information to its appropriate State agency. The results of the latest survey should be available to interested parties and this fact should be posted. We believe that facilities would wish to sit down with patients and families and discuss this information, which can be easily misinterpreted when just reading the statement of deficiencies.

Even as presently proposed, we seriously doubt whether States will be beating down the doors of the Joint Commission to seek accreditation due to the awarding of deemed status. Instead, we foresee a few States utilizing and evaluating it as an alternative to better address the patient care and services of facilities.

If public concern is still great even with modification we suggest that a several-State demonstration approach be utilized.

MANDATORY 90-DAY RESURVEYS

An issue which has been widely misinterpreted is the proposal to eliminate the mandatory 90-day resurvey. There seems to be confusion as to what exactly this proposal does and does not do. It does not eliminate the mandatory resurvey. It does eliminate the 90-day limit. To us this proposal is only common sense. If there is a serious deficiency in the nursing services of a particular facility, one should not under any circumstances wait 90-days to resurvey for its correction. Likewise, if a nursing home has a structural problem which requires construction to correct it, you may have to wait longer than 90 days. Eliminating the resurvey at a mandatory 90 day interval would address this type of situation.

To allay the concerns some have expressed, we recommend that the Department might specify which deficient conditions would qualify for longer or shorter resurvey intervals. However, we would not wish to see the regulation so specific that there would be no flexibility at all. That is a fault of the present regulations, and as we have found, it is simply not possible to specify in regulation every situation or example which may take place.

Regarding the proposal to permit resurveys by telephone or mail, we would point out that not only are States already doing it, but the policy was established and incorporated over 2 years ago in the State Operations Manual, under former HHS Secretary Patricia Harris.

QUARTERLY STAFFING REPORTS

The proposal by the Department of Health and Human Services to eliminate the quarterly staffing report for all but problem facilities is clearly aimed at reducing unnecessary paperwork. To require 100 percent of the nursing homes to submit this information when perhaps only 1 percent are the offenders, is senseless. It is even more senseless when one realizes that the information is rarely examined or evaluated. Surely there must be a more efficient method of ascertaining that facilities maintain compliance with staffing requirements.

In our view, submission of the quarterly staffing report is an excellent example of duplicate effort. Many States require monthly staffing reports as well as the quarterly reports. Further, the Department of Labor requires every nursing home to submit staffing information on an annual basis for its wage and hour reports.

Given the preceding, we support the Department's proposal to continue requiring quarterly staffing information only from nursing homes with histories of staffing deficiencies or for which verified complaints have been filed. We feel that the best source of information for this type of problem is through complaints, spot checks, and validation efforts, not from 50,000 pieces of paper which are filed away without review.

ADDITIONAL RECOMMENDATIONS

To our previous comments we would add several other suggestions for discussion purposes.

Survey and paperwork reduction.—We have described the numerous other surveys to which nursing homes are subjected and the enormous amount of staff time they consume. It is safe to say that a week does not go by that some type of survey is undertaken in each nursing home in this country as evidenced by the attached list.

We would propose the mounting of a combined effort to evaluate the various information requirements of these agencies. Its purpose would be to make recommen-

dations as to which surveys might be integrated, which information might be shared rather than duplicated on separate forms, and what problems or barriers exist to accomplish a consolidation of surveys and exchange of information. Much of this effort would have to be undertaken at the State/local level since they comprise the bulk of the surveys.

Seven years ago the President's Commission on Paperwork identified as one area for survey integration the Veterans Administration. Even though a nursing home may have only one or two veterans receiving benefits, it still must be subjected to a full-fledged survey and periodic followups, although the Federal certification procedure could well substitute for it. Nothing has ever come of this recommendation even though the proposal came from a Presidential commission. It provides a good example of the barriers or obstacles faced when working with a number of different agencies which have their own particular information requirements.

As a corollary to survey integration effort, an overall review of paperwork requirements should be initiated with the aim of eliminating one-quarter or one-third of the forms required. As an example, we have suggested previously that a medicare short-form cost report be developed, similar to the Internal Revenue Services' short form for income tax reporting. The rationale for this proposal is that because most nursing homes have so few medicare patients, the enormous paperwork requirements imposed act as a negative inducement to accept those patients. This fact was very well documented and described in the Urban Institute's recent report, "Medicare and Medicaid Patients' Access to Skilled Nursing Facilities." The consequences of this "paperwork barrier" are an inadequate supply of medicare-certified beds and a subsequent enormous backlog of nursing home eligible patients in expensive hospital beds.

CONCLUSION

Nursing homes have changed greatly over the last 10 or 12 years. The industry has, in effect, grown up. Facilities are modern and safe and the staffs are comprised of professionals and caring people. We are not without our problems, but at the same time, these problems are not pervasive. Frequently their resolution is not a question of more regulation, but rather enforcement of the existing regulations. We believe that when services and substantive deficiencies are found and remain uncorrected, States should exercise their enforcement rights which will remain in place and unchanged by Secretary Schweiker's proposals.

These may include imposition of fines, withholding medicare and medicaid payments and prohibition of new medicare/medicaid admissions. By no means will the States or Federal Government abandon their role as a result of these proposed regulations.

Rather than leading to a deterioration in the quality of care in nursing homes—as some of Secretary Schweiker's critics have maintained—we believe that the proposed revisions provide the States with the ability to focus on the real problems with the care provided by substandard facilities to assure that they make the necessary corrections.

We have tried to approach these issues in a positive and constructive manner and are hopeful that we can work with the members of your committee, concerned citizens, and the Department of Health and Human Services to arrive at an acceptable resolution of the problems involved.

LIST OF AUTHORITIES AND AGENCIES WITH INSPECTION JURISDICTION OF NURSING HOMES

The following is a listing of the authorites at the city, county, State, and Federal levels of government as well as private agencies which may or are required to survey a nursing facility. Some surveys are conducted on an individual basis while others are done jointly depending on the type of service provided by the facility, its financing structure, its program participation as well as the jurisdiction in which it is located.

(1) Beauty shop inspection by State board of cosmetology if facility has a beauty shop for its patients.
(2) Blue Cross inspection.
(3) City and county building inspections.
(4) City sanitation inspection.
(5) Civil rights inspection usually in conjunction with licensure-medicare-medicaid inspection, but can be and sometimes is separate.
(6) County health department inspection.
(7) Administration on Aging.
(8) Department of Education.

(9) Department of Labor, Wage and Hour Administration.
(10) Equal Employment Opportunity Commission.
(11) Federal Housing Authority annual inspection if facility has FHA mortgage.
(12) Federal life safety annual inspection.
(13) Financial audit survey by the medicare intermediary.
(14) Financial audit for medicaid patients by the State.
(15) Fire inspection by the city fire chief.
(16) Fire inspection by the State fire marshal.
(17) Fraud and abuse control units.
(18) Health systems agencies.
(19) Department of Housing and Urban Development.
(20) Licensure—annual medicare/medicaid inspection by the State.
(21) Medical evaluation survey by the State.
(22) Narcotics inspection by Federal Bureau of Narcotics.
(23) Nursing home association peer review.
(24) Nursing inspection by State board of nursing.
(25) Ombudsman.
(26) Occupational Safety and Health Administration.
(27) Pharmaceutical inspection by State board of pharmacy.
(28) Post-licensure medicare/medicaid followup survey.
(29) Professional standards review organization.
(30) Rate review commission.
(31) Safety inspection by workman's compensation.
(32) Utilization review—audit by medicare intermediary.
(33) Validation surveys by the Department of HHS.
(34) Veterans Administration.

This list is not intended to be all inclusive since as noted in the introductory paragraph each jurisdiction determines what is appropriate to meet its regulatory needs. Thus, some facilities may have additional or different governmental agencies involved in surveying and regulating them, from those listed above.

STATEMENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman and members of the committee, the American Association of Homes for the Aging is pleased to have the opportunity to express in this forum our views regarding revisions to the survey and certification regulations by which nursing home compliance with medicare and medicaid standards is determined.

AAHA is a national nonprofit organization representing 2,000 nonprofit homes, housing and health-related facilities for the elderly. AAHA member homes are sponsored by religious, fraternal, labor, private, and governmental organizations committed to providing quality services for their 300,000 residents and for elderly persons in the community at large. Among our members are many facilities that participate in the medicare program as skilled nursing facilities and in the medicaid program as skilled nursing and intermediate care facilities. As such, we have a vital interest in Federal regulations governing survey and certification of nursing homes. We believe that to assure a quality standard of care, nursing home surveillance must become a helpful and positive, patient-oriented process, rather than a burdensome, paper-complaint kind of imposition.

The regulations in question have been written in an effort to streamline the procedures by which facilities are approved for medicare and medicaid participation. In developing these rules, the Health Care Financing Administration has sought to eliminate current procedures that have proved cumbersome and expensive to administer, or ineffective or unnecessary in insuring the quality of health care services. The agency's intent is to retain regulations that have proved effective in protecting the health and safety of patients, while targeting available resources to facilities with compliance problems.

Let us say at the outset that the American Association of Homes for the Aging believes the suggested rules essentially accomplish these aims, and we are supportive. We do have some reservations and suggestions for alternatives to specific issues in the rules that will be enumerated below. First, however, attention needs to be given to the environment in which the rules are being established. Reactions to these regulations from all quarters, both as they were being developed and after publication in the Federal Register, signify to us that there are broad-based misconceptions—or inaccurate assumptions—about present-day long-term care facilities and those who administer them, assumptions which, regrettably have colored the environment in which regulatory reforms are being debated.

MISCONCEPTION: NURSING HOME REFORMS OF THE LAST DECADE ARE BEING SUSTAINED SOLELY THROUGH THE ENFORCEMENT PROCESS

Opponents of HHS's proposals inaccurately assume that, if adopted as final rules, these regulations would precipitate an across-the-board decline in the quality of nursing home care and increase the incidence of noncompliance with health and safety standards. This is an unfortunate myth that denies the good and often superior care being delivered by long-term care professionals, frequently under the most adverse conditions. Many facilities, both not-for-profit and proprietary, are providing quality care despite inadequate reimbursement, shortages of available personnel and changing public expectations of long-term care delivery. They are doing so because of a commitment to service and a desire to respond to human needs.

Let the true professionalization that has occurred in the field not be overlooked. A 1978 survey of AAHA's membership revealed that of the administrators who are college graduates, 34 percent have earned a master's degree, and 2 percent hold doctorates. For those administrators (12 percent) pursuing a degree or certificate at the time of the survey, health care administration (27 percent), gerontology (23 percent), and business administration (22 percent), were the most common areas of study. Moreover, the intensive educational conferences AAHA sponsors annually consistently draw record numbers of registrants who come to learn and to exchange innovative ideas that will lead to improved quality of care for residents. AAHA's conference in Atlanta October 10-13, 1982, will bring together more than 2,000 administrators, trustees, educators, and others, including residents. These participants will return to their communities equipped with valuable new knowledge and skills. The resources AAHA members have committed to the association's educational effort speak well of providers' desire to continually enhance their professionalism. The commitment to professional growth goes far beyond the mandates of the enforcement process and will continue regardless.

Mention needs to be made, too, of the voluntary efforts of homes for the aging to strengthen corporate practices through initiatives such as AAHA's program of "corporate self assessment." Other long-term care organizations report they are also pursuing initiatives related to community concerns or developing standards of accountability.

It is true that there are some facilities that need considerable consultation and assistance to reach more than a marginal level of service. These are the problem providers that HCFA wants to reach by targeting enforcement resources on facilities with a history of compliance problems. For the many good facilities with excellent compliance records, less frequent government monitoring will not precipitate a decline in the quality of care. These homes will continue their good service, not because of the enforcement process, but because of a commitment and accountability to their residents and the community at large. To say, as some have, that the proposed regulatory changes would prompt even the most compliant facilities to become lax is to denigrate the exemplary care being given in many homes for the aging.

MISCONCEPTION: THE ENFORCEMENT PROCESS AS IT EXISTS HAS BEEN A MAJOR DETERMINANT OF QUALITY CARE

The Wisconsin nursing home quality assurance project is often spoken of as representing the state of the art in quality assurance demonstrations. In a 1980 report of Wisconsin's pilot study, Dr. David Gustafson and his colleagues had some very cogent observations about the traditional method of evaluating nursing homes. The facility survey, they found, is "unnecessarily redundant" and "does not sufficiently discriminate between homes that deliver good care and those that do not, so that a facility survey team spends the same amount of time on both. Perhaps the time and expense would be justified if the survey served as a mechanism for keeping poor-quality homes from entering the certification and reimbursement system or as a mechanism for improving care in those nursing homes that were already certified, but such is not the case."

The quality assurance team concluded that "* * * (t)he emphasis has been on compliance with carrying out the letter of the law rather than on implementing the law's intent, which is to insure that quality nursing care is delivered."

The two major defects of the system, then, are "the excessive time and money spent in evaluating nursing homes without consideration of the fact that some homes warrant more time and others less, and the emphasis on compliance with the letter of the law rather than on implementing its intent." These approaches result in evaluation of a nursing home's ability to satisfy regulations instead of promoting real improvement in the way care is delivered.

These points are acknowledged by the Health Care Financing Administration, understating in the preamble to the May 27 proposed rules that "(t)he impact of the survey requirement on quality of care has become questionable." In identifying and eliminating requirements deemed unnecessary and ineffective, HCFA is taking steps to address the major defects in the system enumerated above.

AAHA recommends a close look at the Wisconsin project to ascertain the method's broader applicability. A cornerstone of the system is a screening instrument that can quickly determine where the care in a nursing home is breaking down so that resources can be focused on these problem areas. The results showed that the new screening model correlated well with general assessments.

Other States (Massachusetts is one) have designed or experimented with a similar survey process in which a screen of core regulations is used to determine if providers are complying with basic patient care standards. Regulations are then weighted according to their importance in providing quality patient care.

These projects also showed that time saved in the survey process made it possible for the survey team to provide onsite consultation, arrange to have State consultants assist the home in correcting problems and use measures other than citing a home to get problems corrected.

The Rensselaer Polytechnic Institute has done a comprehensive study of the regulatory process for residential health care facilities in New York State which AAHA also commends to the committee's attention. A 1980 report on needs assessment includes an excellent sourcebook of assessment instruments. Dr. Don Schneider, director of health systems management at Rensselaer, found a consensus that little innovation has gone on in the area of regulation. Symptoms of deficiencies tend to receive considerably more attention than the root causes. A screening process was recommended to shorten the time spent on acceptable providers, leading to greater concentration on poor quality facilities.

AAHA encourages the development and testing of a broadly applicable, problem-focused sample similar to the approach tested in Wisconsin. We see this as a natural outgrowth of HCFA's recognition of the need to concentrate limited resources on problems and problem homes.

MISCONCEPTION: ENFORCEMENT OF THE MEDICARE AND MEDICAID REGULATIONS TO DATE HAS BEEN STRINGENT AND EFFECTIVE

In recent weeks, the current problem-laden survey and certification system has found many champions. The committee should be aware, however, that budgetary levels approved by Congress have already forced most States to phase down nursing home survey activities. In a March 1981 memo to regional offices, the Health Care Financing Administration instructed medicare/medicaid program administrators to streamline the survey process in light of Federal budget realities. Officials were told to give first priority to skilled nursing facility surveys, allocating no funding to other providers or suppliers until all SNF surveys were funded. SNF surveys were to be conducted, whenever possible, by less than a full survey team. All-important consultation visits could be discontinued for the rest of the year. Followup visits need not be made to SNF's with 12-month provider agreements; for homes with conditional agreements, onsite visits to verify corrections could be foregone. Life Safety Code surveys could be discontinued except in the case of initial surveys or where structural modifications were made. Any funds left over should be allocated to the remaining facilities with the highest priority, HCFA said.

Health officials in many States confirm that Federal budget cuts have forced them to curtail nursing home surveillance. In March, officials interviewed by New York Times reporters in 30 States said inspection funds were reduced 25 to 65 percent this year. As a result, States have laid off registered nurses, pharmacists, architects, and other professionals who inspected homes. Many inspection staffs have been reduced by attrition. Survey teams are smaller and have fewer specialists. The Federal budget for survey and certification of medicare facilities plummeted from $27.6 million in 1980 to $24.7 million in 1981 to $13.6 million this year. The medicaid inspection budget dropped from $42 million in 1980 to $31.8 million this year. More cuts are in the works for 1983.

The current survey and certification regulations are not being stringently enforced, in large measure because legislators have not adequately funded the system.

If the key issue before government and the industry is how best to use limited resources to achieve high quality long-term care services—and AAHA submits that it is—then Congress must either adequately fund medicare and medicaid inspection or permit HHS and the States to shape the surveillance process to current fiscal reality.

AAHA is strongly supportive of the need for flexibility in the survey process, a point addressed in greater detail below. Were adequate funds committed to fully support annual inspection of all facilities, problems or no, our thinking might be different—not because we believe annual inspections are necessary but because of the concerns we have for the public's perception of the long-term care industry.

But the reality is that there are not adequate funds committed to this purpose. In our view, then, the only reasonable and effective recourse is to target scarce resouces where they are needed most rather than to spread resources so thin as to do cursory surveillance in every facility.

There is one more assumption we wish to address before turning to specific proposed changes in the survey regulations. It is an assumption we make ourselves, one we know to be factual, and one we believe should be an overriding concern of the Congress at this time. Because, important as long-term care standards are, adequate funding of patient care services will go much further toward assuring quality care than the enforcement process ever will.

FACT: THE MAGNITUDE OF BUDGET REDUCTIONS FOR LONG-TERM CARE CLEARLY AND PROFOUNDLY AFFECTS THE ABILITY OF NURSING HOMES TO PROVIDE QUALITY CARE TO MEDICARE AND MEDICAID RECIPIENTS

Congress cannot reform the admittedly expensive public pay programs by indiscriminately chopping away at the health care budget, not without causing severe disruptions in the lives of thousands of nursing home residents in this country. The effects will not be hidden, nor will they be confined to the ledger sheets of recipient facilities. Rather, the impact will be seen in reduced admissions, reduced quality of life within facilities, and reduced capacity to provide even minimally acceptable levels of care.

AAHA members take some small comfort in the fact that, in relative terms, long-term care has survived attempts thus far this year at truly debilitating budget cuts, though the process is far from over. Medicaid proposals currently under consideration could have an adverse impact on State costs, with resultant program reductions extending to long-term care. In addition, medicare proposals involve the shifting of costs to both providers and consumers, and many nonprofit homes stand to be affected by their assuming the burden of assisting residents in meeting the medicare copayment requirements.

Our homes are committed to providing quality care, but they are not miracle workers. Nursing homes must have adequate funds if they are to continue to serve medicare and medicaid residents well.

With that background on the regulatory and budgetary environment in which the proposed rules have been developed, AAHA offers the following comments on specific proposals in the May 27, 1982, notice of proposed rulemaking.

1. CONSOLIDATION OF MEDICARE AND MEDICAID SURVEY AND CERTIFICATION PROVISIONS

HCFA proposes to consolidate medicare and medicaid survey and certification process requirements into a single part in Federal regulations.

AAHA supports this simple consolidation. We concur with the department that having a single set of procedural requirements will alleviate interpretation problems that have arisen where requirements are almost identical but phrased differently. State survey agencies and long-term care facilities alike have cited this as a continuing problem.

2. QUARTERLY STAFFING REPORTS

The regulations currently require all facilities to submit staffing reports routinely. HCFA proposes to modify the current policy by requiring staffing reports only when the State survey agency requests them because the facility has a history of staffing deficiencies or was found not to meet all staffing requirements during its most recent certification survey. However, all facilities would be required to have staffing information available when they are surveyed.

AAHA supports elimination of quarterly staffing reports as a step toward cost-effectiveness and administrative efficiency. The quality of patient care depends, in large part, on adequate staff to give care. But counting numbers of personnel is no measure of staff quality or quality of care. Further, mandatory reporting is often redundant, since quarterly reports are a duplication of time sheets required by the Labor Department or reports required by State licensure regulations. Quarterly staff reports do not require verification of the information they contain, nor do they indicate how many persons are actually working, only how many were hired. State

agencies have little substantive use for the reports; they may be collected and routinely filed without ever being routed to the nursing home inspector.

AAHA does believe there should be onsite monitoring of staffing activities in marginal or deficient facilities. We believe the suggested revisions provide a useful compromise by requiring all homes to have staffing information available when they are surveyed. We do suggest one clarification: that a facility's usually kept staffing information, such as time sheets and payroll records, be adequate to meet the requirement that staffing information be routinely available at the time of a survey.

3. MANDATORY 90-DAY RESURVEYS

Currently, whenever a provider is certified on the basis of an acceptable plan of correction, the survey agency must conduct another site visit within 90 days to verify that corrective action has been taken or is progressing reasonably. HCFA proposes to eliminate this requirement in favor of a followup visit to be scheduled whenever the correction can be assessed most realistically and to permit followup by mail or telephone if the State deems onsite reinspection unnecessary to determine compliance.

We agree that if the planned time for correction is, for example, 4 months instead of 3 months, reinspection twice within the period can be mechanistic and costly to both the State and the nursing home. However, some deficiencies, though not life-threatening, may be serious enough to warrant interim monitoring to insure corrective action is progressing toward the completion date. The agency may feel telephone or mail verification that corrective action is underway is appropriate.

AAHA supports reinspection on an as-needed basis but with an outside limit of no more than 6 months for onsite resurvey of facilities with less than exemplary records of compliance. The system should be structured so as not to lead to unjustified postponement of corrective action. We think the latter point is crucial in light of the fact that States will be concentrating enforcement efforts on marginal facilities. States should not be permitted to abuse flexibility in the resurvey process out of budgetary considerations in cases of deficient facilities where frequent onsite inspection is needed.

A proposal that States be allowed to follow up plans of correction by mail or telephone has come under widespread criticism of late. To a degree, we understand these concerns and concur. AAHA suggests that the rules should spell out that followup by mail will be limited to specific items for which compliance is usually verified through documentation, be it minutes of a required meeting, a copy of personnel policies, etc. Items for which followup by mail would be permitted should be listed by HCFA so there is no question of what is required by States.

If a document can be mailed to a State agency, and therefore be proven to exist, it is a waste of time and money to require a surveyor to travel to the home for a reinspection. More to the point is that lack of documentation may be symptomatic of a larger problem the home is experiencing. If so, that is where the State should focus its attention, working with the home to identify and remedy the problem. The presence or absence of paperwork will likely be incidental to the underlying concern that should command the surveyor's attention: whether or not the home is meeting the intent of the regulation.

Even a missing document cannot easily be verified to exist over the telephone, the AAHA feels that suggestion should be withdrawn.

4. TIME-LIMITED AGREEMENTS

In 1981, Congress enacted section 2153 of Public Law 97-35, removing the 12-month limit on agreements with skilled nursing facilities. The proposed rules would eliminate the present requirement that agreements with skilled nursing and intermediate care facilities be limited to a period not to exceed 12 months.

AAHA supported the statutory change and endorses its implementation. Many homes have established records of consistent compliance with all conditions and do not need the frequent oversight associated with a 12-month agreement.

5. CANCELLATION CLAUSE PROVISIONS

The rules would eliminate a requirement that a skilled nursing or intermediate care provider agreement, accepted on the basis of a plan for correction of deficiencies, be automatically canceled unless the deficiencies have been corrected by a predetermined date. Under the proposal, life-threatening deficiencies continue to be subject to immediate termination procedures.

With the latter assurance—that termination provisions are not precluded from use by States when warranted—AAHA supports this change. We encourage HCFA to use the authority available under Public Law 96-499 to effect "intermediate sanctions," a series of graduated penalties, ultimately leading to decertification of a facility consistently found out of compliance with the regulation. This would permit States to tailor sanctions to fit the nature of deficiencies.

6. FLEXIBLE SURVEY CYCLE

The regulations would eliminate a requirement that all facilities be subject to annual surveys with the exception of intermediate care facilities for the mentally retarded. Instead, facilities would be surveyed as often as necessary to assure compliance, at least every 2 years for long-term care facilities.

AAHA homes are strongly supportive of flexibility in the survey process. Many homes have exemplary records and do not need to be surveyed every year. Others will have an incentive under this system to comply with the regulations if rewarded with a longer interval between inspections. The current system treats compliant homes and marginal homes equally, providing no incentive to either.

The public also will be able to use the survey interval as a basis for comparison, further motivating facilities to upgrade care in order to be competitive. Potential savings in time and money spent on surveying homes provides the opportunity for States to do more consultation with facilities requiring assistance in order to reach an acceptable level of compliance.

HCFA has assured that facilities with a history of poor compliance will be surveyed more often than annually. We suggest States be given specific criteria for determining the variable survey cycle, in order to give further assurance that budget and workload constraints will not weigh too heavily in the State's determination. Strict criteria also will forestall any claims of bias.

It should be noted that the facility's obligation to meet the conditions of participation is in no way diminished by this proposal. In addition, there are many other agencies and authorities at all levels of government that will continue nursing home oversight.

It bears repeating that, in our view, the most reasonable and effective recourse in the current period of economic downturn and scarce resources is targeting those resources where they are needed most. This proposed regulation attempts to do so.

7. DEEMED STATUS FOR SNF'S, ICF'S (EXCLUDING ICF'S FOR THE MENTALLY RETARDED) AND HHA'S ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH)

Under current regulations, hospitals accredited by the JCAH may be deemed to meet the conditions of participation for medicare and medicaid. HCFA proposes to extend this provision so that survey agencies may accept JCAH accreditation for SNF's, ICF's, and hospital-based home health agencies without an additional State agency survey. As a condition of deemed status, the facility would be required to post its current JCAH report of the survey findings in a prominent place.

AAHA has endorsed this proposal and, in doing so, pledges to continue our efforts to improve the quality of the JCAH program by actively working to upgrade standards, improve the quality of surveys, enhance the professionalism of surveyors and participate, if requested, in training of survey staff.

In addition to government's role, our members believe health care professionals can and should voluntarily shoulder the responsibility for monitoring and improving the quality of care provided in health care facilities. A nongovernmental approach, providers feel, offers the opportunity to exercise their professionalism and be helpful to fellow providers and the elderly they serve. AAHA members report good experiences with recent JCAH surveys, describing them as thorough and professional, more consultative then punitive.

As an active participant in JCAH, AAHA has evaluated the council's long-term care program and found it to be equal or superior to Federal standards. We are aware of concerns that have been expressed about JCAH's capacity to assure increased survey responsibilities, but we do not see this as a major problem, as long as the expansion is gradual, well planned and organized, as JCAH has assured it will be.

AAHA does support disclosure of JCAH findings, and we recommend that as a condition of deemed status, all facilities will be required to submit copies of the survey report to the appropriate government agency in addition to posting the reports in a prominent place in the facility. Disclosure of the survey findings is warranted by the fact that JCAH will be accrediting facilities in which government has

a major investment through medicare and medicaid funding. We encourage HCFA to seek Freedom of Information Act clarification of obligations in this regard.

VALIDATION SURVEYS

AAHA supports the concept of validation surveys for SNF's, ICF's, and hospital-based home health agencies approved on the basis of JCAH accreditation. We see this as an important step toward establishing quality assurance. We would go beyond the Department's proposal, however, and suggest that HCFA establish parameters of performance by State survey teams and periodically validate their findings, as well.

Care should be taken to insure that marginally acceptable facilities are represented in the validation surveys. Otherwise, an accredited facility which JCAH considers to be borderline could be overlooked, unless a specific complaint were lodged against it. To select these marginal facilities, it will be necessary to review JCAH findings, thus our recommendation that long-term care facilities authorize the release of JCAH survey findings and plans of correction to the appropriate government agency. Homes unwilling to make survey results public can forego deemed status and become subject to the State survey procedure.

SURVEYOR CREDENTIALS

In 1980, HCFA was considering regulations setting forth surveyor qualifications at the entry level. In hearings around the country that year, almost universal support was expressed for a surveyor credentialing system. AAHA strongly believes there should be some consistency in the skills and knowledge required of surveyors. If every surveyor were to interpret standards from a common knowledge base, we believe the survey process would be greatly enhanced. Knowledgeable, competent surveyors are more likely to be welcomed by administrators as fellow professionals who can identify problems and help solve them. We encourage the Department to address surveyor qualifications once again in this regulation.

CONCLUSION

For many months, we have heard arguments back and forth about whether these rule changes should be adopted. AAHA believes there is merit in combining State flexibility, targeted surveillance and a nongovernmental approach to enforcement in long-term care facilities. But we also understand and appreciate the concerns of those who do not share our position. For that reason, we suggest that a reasonable way to resolve the current debate would be to proceed with the proposed rules and incorporate a specific sunset provision. At the end of a reasonable trial period—we suggest 3 years—there would be an objective evaluation of the program, by the General Accounting Office or other appropriate authority, and an extension or not, based on the study results. This seems to us a reasonable compromise for all parties, and we will make this suggestion in formal comments to be filed with HCFA.

The American Association of Homes for the Aging would like to thank the committee for its attention to our concerns and to assure you of our continued willingness to provide assistance in working to make the certification and surveying process more effective and efficient. The task ahead of us is extremely important, as these revisions are an important step toward significantly streamlining and improving enforcement procedures. We appreciate having this opportunity to share our comments with you today.

STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

Good morning. My name is Gailan Nichols. I am a vice president of the American Health Care Association and the administrator at the Acacias Nursing Home, a 50-bed long-term care facility in Ojai, Calif., operated by the American Association of Retired Persons/National Retired Teachers Association. I am pleased to present the views of the American Health Care Association (AHCA), a membership organization of 8,000 nursing homes and other long-term health care facilities, providing services to 750,000 old and chronically ill people.

I wish to express support for revisions proposed in the way all health care providers are surveyed and certified to participate in medicare and medicaid. There is a popular misconception that the proposed revisions relate only to nursing homes. While not addressing all the problems associated with the current inspection and enforcement system, they do offer needed flexibility in the survey process without endangering quality of care. We believe that these proposals will:

(1) Add efficiency to the survey process.
(2) Give State agencies the flexibility to use their diminishing financial resources more appropriately.
(3) Improve the enforcement of Federal health care standards by freeing survey offices to focus time where most needed.
(4) Relieve nursing homes and other providers of administrative and paperwork burdens.

It is important for you to know what these proposals will not do.

(1) They will not affect State licensure requirements or States' responsibilities for licensing all health care providers or States' rights to conduct all the surveys they find are needed.
(2) They will not alter a single patient care requirement.
(3) They will not permit quality of care in nursing homes to suffer.
(4) They do not remove the Federal Government's responsibility for assuring that medicare and medicaid providers meet high standards.

It has been over 2 years since AHCA testified on survey and certification issues. At that time, we presented our views to the Department of Health, Education, and Welfare in response to Secretary Patricia Harris' 12 "Public Meeting Issue Papers" developed as part of the Carter administration's regulatory reform effort "Operation Common Sense." We supported the proposals at that time and believe that a continuation of that effort is needed.

We have seen major changes in the enforcement of nursing home standards. These have occurred for three reasons:

First, budget realities; in 1980, Congress decided not to renew the provision in the Social Security Act that paid State medicaid agencies 100 percent of their costs in surveying. The percentage was dropped to 75 and may soon drop to 50. At the same time that States take on a greater share of financial responsibility for quality assurance, they are also experiencing fiscal cutbacks from their State legislatures. Simply put, State survey agencies have had to become more cost effective. These State survey agencies had to achieve the same final outcome—assuring that only qualified facilities were licensed to operate and certified to provide medicare and medicaid services. To become more efficient, State agencies had to become more flexible. Facilities that had good, stable track records were put on an alternate survey schedule. They were told the agency would not be back for 2 or even 3 years. Resurveys were scheduled in many States only when the survey offices believed that correction of deficiencies needed to be observed first hand.

The second motivating factor to cause changes in the survey process has been the advancement in the methods of conducting surveys: the systematic study of how the process could and should be improved.

I would urge these committees to review the innovative approaches being tried and are now being evaluated in New York, Massachusetts, and Wisconsin. These States, with waivers from the Department of Health and Human Services and in consultation with providers, advocacy groups, and universities are changing the shape of nursing home surveys. These programs are identifying the key elements that check on the delivery of quality care and are dispensing with the insignificant minutia in the survey process. While results of these pilot projects are still being examined, I can report to you, the early evaluation of long-term care providers: The new survey systems are gaining favor with facility staff because these new surveys take less time, are much less paperwork oriented, and focus more on the service we provide—quality long-term health care.

The final reason for changes is the maturing of our profession. While the concept of self-inspection seemed unrealistic a few years back, it is a reality today. Provider self-regulation is now a necessity, not just an extra vigilance. Unfavorable headlines are detrimental for business, so providers are implementing various ways of monitoring their own activity. As a result of these self-inspections, State surveys no longer hold surprises for most of our facilities—administrators and staff know how they are doing because they have measured their own progress.

There is increasing provider attention and sophistication in quality assurance. Computerized patient assessment programs and systems for internal quality reviews are becoming common.

The American Health Care Association requires each of its State affiliates to conduct a peer assistance program. The programs are a systematic way to assist facility administrators and staff to meet professional and government standards in the delivery of long-term health care services. Features of peer assistance differ among States but may include the identification of quality standards, information exchange of quality control methods, peer consultation and complaint resolution, and recognition of exemplary facilities and staff. AHCA also is strengthening the ability of indi-

vidual facilities to monitor quality and currently is developing a self-appraisal guide for facilities to evaluate each of their departments and service areas.

In virtually every nursing home, the effectiveness of care is regularly monitored through ongoing evaluation of patient care plans. Regulations mandating a patient care management system may have suffered an untimely death last March, when it was decided not to revise the skilled nursing home standards. However, the spirit of the patient care management system, comprehensive patient care planning, is being actively carried out in most nursing homes.

Comprehensive oversight of all facilities, needed a decade ago, is now seen as excessive in view of limited resources and improvements in facilities. The emerging picture of quality assurances today includes Federal flexibility, State innovation, and provider initiatives. Providers with good track records know self-regulation is to their best interest and their responsibility must increase if the government is going to do less.

With this background, I will now address our views on the HHS proposed survey and certification regulations. I will discuss five key elements of the proposal that affect long-term care and provide you a summary of our views.

(1) Eliminating an extra staffing report of who worked when during 4 weeks of each year. I've yet to meet a Federal or State official who has read one of those reports. You will see that the proposal requires that these reports could again be required if a facility was suspected of having staffing problems. You should realize that other reports of staffing are available in facilities and are examined during inspections. Payroll and other staffing records would still be maintained.

(2) Permitting less than annual surveys. Facilities with good records of compliance could be surveyed as infrequently as every 2 years. Facilities having problems would be visited more often than once a year.

This proposal makes sense because of those budget realities I spoke of earlier that require cost-effective use of survey offices. The Congress recognizes this fact by eliminating time limited 12-month agreements with skilled nursing facilities (SNF's), as part of the 1981 Omnibus Reconciliation Act. This proposal merely carries out the intent of Congress. I submit to you that it is being done quietly in numerous States and we have not suffered adverse consequences.

Critics of the proposal have voiced concern that in 2 years even the best facility can suffer a lapse in quality. While this is true, we contend that although a formal inspection may not be scheduled, hundreds of people will be visiting these facilities during the interim. These visitors include family members, volunteers, ombudsmen, local authorities, students, church groups, attending physicians, and consultants. Nursing homes are part of their communities and our doors are kept open. If there is a problem in quality it is and will be readily identified and reported.

In view of the concerns raised, however, we are suggesting to the Department that facilities be required to report changes in ownership, administration, and director of nursing. We believe that reporting any of these changes will provide an additional safeguard for maintaining high quality.

(3) Eliminating the mandatory 90-day resurvey. This is one of the most controversial proposals and frankly, we cannot understand why. Surveyors are welcomed back to my facility at any time, but sometimes their vistis do not seem necessary. If a written policy is found unsatisfactory at the time of survey, shouldn't I just mail in the policy and save the surveyors a trip? Other examples when an on-site visit might not be needed concern deficiencies corrected at the time of the survey; replacing light bulbs; locking medication in refrigerators.

To improve this provision we have suggested to the Department that they specify—either in rules or survey instruction to States—circumstances in which the resurvey to check whether deficiencies have been corrected could be made later than 90 days, and when an onsite visit might not be needed.

(4) Eliminating the automatic cancellation clause. This is merely a technical change in the regulation. We support this part of the proposal because it eliminates some of the offices' paperwork and administrative burden.

(5) Permitting deemed status for medicare facilities accredited by the Joint Commission on Accreditation of Hospitals (JCAH).

We support this JCAH proposal, although we believe the deemed status provision should apply to facilities participating dually in medicare and medicaid, not just to medicare-only facilities. While we submit that this proposal could save funds, this savings is not our only reason for supporting the utilization of JCAH. Additionally, you should be aware that:

JCAH has been surveying nursing homes since 1966. We believe in the process of voluntary, private accreditation. JCAH is a credible, valid, and professional process with 16 years of nursing home experience.

JCAH would survey the "best" facilities, permitting State survey agencies to expend their efforts with those facilities most in need of State office efforts. Since JCAH has stricter requirements than HCFA maintains, such as 24-hour registered nurse coverage, only those facilities that maintain higher than federally mandated staffing level would consider applying for accreditation.

Deemed status is an accepted process for hospitals; we believe that hospitals and nursing homes should be treated equally in this regard.

Let me say forcefully, that none of these proposals will affect the level of quality care in nursing homes. Not only do these proposals avoid changing any nursing home requirements, but they will help States to realize the goal of enforcing those requirements more readily.

As you must realize, quality care is good business. Today more than ever, long-term care providers must compete with each other, especially for private pay patients. Over 40 percent of nursing home revenues come from out-of-pocket payments by residents or their families. The most vigilant inspector we have is the family member who is paying for nursing home care. If family members are unhappy, they tell me, the State survey office, and their friends. All nursing home care providers must be constantly evaluating their product—patient care.

I wish to make clear that these regulations are not a panacea for all problems that have and continue to characterize the nursing home inspection system. We will still have duplicative surveys. We will still have many inspectors who are ill prepared to carry out their responsibilities. We will still have a system overreliant on paperwork and lacking—in most States—the ability to measure quality care. However, the regulations will help to streamline the certification process.

Now Mr. Chairman, I would like to address some of the points that you and several other committee members raised in a letter to Secretary Schweiker on the proposed regulation.

First, you expressed concern about JCAH: That it is not an enforcement agency and that it does not disclose its survey findings. We have suggested to the Department that any facility wishing to apply for deemed status (using the JCAH survey in lieu of a medicare survey) should be required to submit its JCAH survey results to the State survey agency. Should this requirement be added, the survey findings would be available to the general public and the State could follow up with any needed enforcement activity.

Second, you asked how State agencies might determine which facilities could go a longer period of time between surveys. Recent addition to the HCFA State Operations Manual suggest how States might make such determinations. We agree that additional guidance may be needed and that instructions to States should make clear—as does this proposal—that facilities having problems must be strictly monitored.

Third, you raised concerns about deleting the mandatory 90-day resurvey requirement. As I mentioned earlier, we have suggested to the Department that guidance to States may be needed on the circumstances under which onsite resurveys or resurveys at 90 days may not be needed. Further, we believe that State offices must be given credit for sensible judgment. Enforcement of licensure and medicaid standards is State responsibility. We do not believe that State offices will renege on this responsibility and fail to resurvey when a resurvey is needed.

The HHS proposals are important. They fulfill the promise of the best of regulatory reform—eliminating paperwork and administrative burden. They will help to assure that health care dollars are spent for health services, not wasted on unnecessary administrative procedures.

Finally, I absolutely disagree with those who oppose these regulations on the grounds that the quality of nursing home care will suffer. These rules relate to inspections alone. They do not alter the standards nursing homes must meet or the need for strict enforcement of those standards. Quality care cannot and will not be compromised.

I urge you to join us in supporting the Department's proposal. For your information, I am submitting our detailed comments to the Department.

The American Health Care Association is pleased with the attention these proposals are receiving. We agree that the proposals should have been published for public comment and that hearings such as this have been planned to fully discuss the issues involved. We look forward to working with the Congress and the Department in the development of appropriate and effective inspection procedures.

Senator HEINZ. I guess I would like to ask you this question on the proposal of the administration to extend the required visitation cycle to a 2-year rather than a 1-year period.

If you accept the argument that 20 percent of the nursing homes are very good, 20 percent are not very good—indeed, they are pretty mediocre to lousy—and the rest are in the middle, how does one justify, for the ones in the middle, 60 percent of all the nursing homes where obviously some improvements remain to be made—how does one justify, in principle, going from a not less than annual checkup to a 2-year checkup? What is the basic justification for that group of nursing homes?

Mr. MACDONALD. Well, I will offer that to the rest of the panel members. In terms of our specific recommendations, we are urging the consideration of the flexible scheduling from 6 to 12 to 18 to 24 months, to allow for the State agency to make the determination based on a facility's past record.

Senator HEINZ. You are, in effect, advocating a more careful grading of facilities, assuming that that is possible.

Mr. MACDONALD. Absolutely.

Senator HEINZ. Therefore, it is fair to say that if the administration really intends that most nursing homes be inspected every 2 years rather than every 1, as it is now—not less than every 12 months—you would have some problems, I assume, with that. Is that right?

Mr. MACDONALD. Well, we feel that the recommendation is a little bit broad in that area, and that is why we have made the recommendation——

Senator HEINZ. Larry, do you and Gailan feel the same way?

Mr. LANE. I would add, Senator, that there was some discussion earlier of the Wisconsin experience. And in some other States that have gone through some demonstrations, it clearly shows that there is a great capacity in changing our enforcement effort to target it where we have the greatest amount of problems.

There clearly are some perceptual differences as to whether the industry has grown from the early 1970's. I would contend very strongly that it has, and I think in our formal statement we say that.

I would point out, though, that because we are aware of this public criticism, in the statement on behalf of the homes for the aging, we suggest that we put in a sunset provision and demonstrate this flexibility in the subpart S rules for a 3-year period and make a commitment to evaluate it. And we believe it will stand on its own merit.

The Wisconsin experience does show that. The work done in New York by the Rensselaer Polytechnical Institute, in their study that brought about the change in the enforcement effort in the State of New York, clearly indicated that too much time was being spent in a bureaucratic process that did not have a really clear focus and a definable objective.

What we said 2 years ago, in the public hearings that Len Schaefer held on these rules when they were in place, and in the statement that we make today in our presentation to this panel, is that we do believe there has been growth. We do believe that there is need for some flexibility, especially flexibility when there are inadequate resources.

And when States like New York and California can come forward and not also point out that they have increased their licen-

sure fees greatly as a direct passthrough, taking dollars from entitlement programs that are patient-care oriented and passing that through in their administrative costs, there is some gamesmanship going on.

So, the survey dollar is coming out of funds that either go into a bureaucratic process that enforces or out of direct patient care dollars. Somewhere in there, we have to move, and we do believe that the studies that have been done and the experiments and the demonstrations that have been done on flexibility and targeting at least indicate that there is growth.

We believe that, if nothing else, we should try it; put in a 3-year sunset provision here to demonstrate it and put in a commitment to evaluate it. And we think it will stand; that there is an opportunity for targeting rather than going to every facility once a year, looking at them with the same coloration of distrust, and leaving to a profession a very negative image rather than one that respects its growth.

Senator HEINZ. Gailan.

Mr. NICHOLS. Finally, Mr. Chairman, I have to agree with the comments that have been made already. But, basically, as an active, practicing nursing home administrator and as a nurse, with my educational background in the social sciences, the one motivation that will improve the facilities which can be improved is incentive.

The facilities that are in the 20 percent that you spoke of—it gives them something to maintain. The people in that 60 percent bracket that you are concerned about—it gives them something to work for; an opportunity to lessen the degree of bureaucratic survey or interference in their day-to-day operations that we all are seeking.

Currently, with the bureaucratic levels that do exist, my professional nurses and my trained nurses' aides, all of whom are certified by the State of California, can work in any other health care element. They can work in adult day health; they can work in clinics; they can work in doctors' offices; they can work in acute hospitals, as I did. And nowhere do they have to put up with the bureaucratic duplication and redundancy that exists in long-term care. And we need to keep those people in long-term care, and this is one way of doing it—incentive.

Senator HEINZ. The committee, on June 15, wrote to Secretary Schweiker. We made three specific recommendations regarding changes in the regulations. Have you seen our letter, signed by virtually all the members of the Aging Committee, as I recollect?

Mr. MACDONALD. Yes.

Senator HEINZ. I have got to go and chair another hearing in about 3 minutes, so I would appreciate it if you did not do it now, but we make some specific recommendations to HHS. To the extent that you disagree with our recommendations and have some other alternatives, I would appreciate your letting the committee know what you think makes better policy, and why yours is better than what we have proposed to the administration.

Mr. MACDONALD. We would be happy to.

Senator HEINZ. Thank you very much.

Mr. Affeldt, just a couple of things. You indicated, if I recollect your testimony correctly, that you did not feel there were tremendously big differences between hospitals and nursing homes. Is that right?

Dr. AFFELDT. No, that is not correct. I indicated the history of the hospitals—what they came from and what they went through—and I implied that that may be the same situation with the nursing homes. I therefore felt that they should be given the opportunity to repeat that.

Senator HEINZ. All right. I did not want to have the record unclear on that point. So, you understand that there are significant differences; that the largest proportion of hospitals are nonprofit and there is a very substantial portion of the nursing home industry that is for profit.

Dr. AFFELDT. Yes.

Senator HEINZ. And that creates certain kinds of incentives, and therefore certain kinds of standard enforcement issues and problems.

You make a very persuasive case and you are a very effective spokesman for the JCAH, but I must ask you a few questions. Senator Cohen, I think it was, suggested that it would not be a bad idea to have you send a copy of your survey results to the State agency. Could you do that?

Dr. AFFELDT. It was mentioned in the past, and I would like to emphasize it, that one of the key features of the JCAH is its confidentiality policy. That goes back to its voluntary nature in which a facility makes a choice as to whether they wish to apply to the JCAH for a survey. Based on that action on their part, we return the report to them. They are the ones to release it, not the JCAH. We encourage them to release that report.

Senator HEINZ. But you could not do that, even though you probably have a Xerox machine and many of the nursing homes I have visited do not?

Dr. AFFELDT. It would simply destroy that basis of the voluntary confidentiality, which is extremely important to the viability of the JCAH.

Senator HEINZ. And there is no way around that?

Dr. AFFELDT. Yes, there is a way around it, and I think it has already been proposed; namely, that the States can request that. They can receive it in just the same way by requesting it. The difference is whether you request JCAH to submit it or the State requests the facilities to submit it.

Senator HEINZ. And what does the facility do? It goes to the nearest Xerox machine and sends a copy?

Dr. AFFELDT. Yes, they certainly could do that. If they wanted to, we could send the duplicate to them and they could release it.

Senator HEINZ. And if they do not send that in because it did not look too good, what should the State do?

Dr. AFFELDT. Then the State would not recognize deemed status; the State would go in. That is the option of the State.

Mr. NICHOLS. Senator Heinz, if I might interrupt, the American Health Care Association, in our written statement that I have prepared, indicates that we are willing to accept the notion that the facilities, if they wished to have deemed status, would, in fact, not

only post those survey reports in our facilities but turn them over to the State agencies voluntarily.

Senator HEINZ. Thank you. I am glad to hear that.

Now, on page 7 of your testimony, I understand that you are required to post a public notice in advance of an impending survey. I wish everybody who had some kind of question they wanted to ask me would let me know 3 days, 3 weeks, or 3 months in advance that they were going to ask me a tough question, and especially newspaper reporters. [Laughter.]

Somehow they do not get around to doing that, and it is much more exciting this way. [Laughter.]

Does not that kind of advance notice prejudice the outcome?

Dr. AFFELDT. This is a basic or very important point of philosophy, I believe, that requires amplification. Remember, we are not an enforcement agency. We are not trying to catch the facility doing something wrong or doing something bad. Our purpose is helping them to improve.

Therefore, we feel that it is important to notify them when we are coming for several reasons: One, so that they can improve and get ready, and that is a benefit in itself for that objective. We also want the key staff there so that we can find out from them what they are doing. We also want the public to know that we are coming. If we go unannounced, the public does not know we are coming and therefore cannot meet with us.

We think there are many advantages to that. Now, we do provide unannounced visits when there are complaints, but we do believe that the announced approach is better than the unannounced approach.

Senator HEINZ. Did you serve in the Armed Forces?

Dr. AFFELDT. Yes, I did.

Senator HEINZ. Enlisted or officer?

Dr. AFFELDT. Officer.

Senator HEINZ. Did you ever conduct an inspection?

Dr. AFFELDT. Yes.

Senator HEINZ. Did you ever notice any difference between the announced inspections and the unannounced inspections?

Dr. AFFELDT. Yes.

Senator HEINZ. Fairly substantial, were they not?

Dr. AFFELDT. Exactly, and you will recall that I said our intent is not to catch, but to help improve.

Senator HEINZ. I was an enlisted man; maybe you inspected me. [Laughter.]

The general view of the enlisted men was, "Gee, we wish those officers would go away and leave us alone so we can go about our business the way it was before we had to clean up for their announced inspection." Now, that may not represent every enlisted man's point of view, but it was fairly common where I served.

We were more likely to be on our toes when we knew there was a substantial likelihood of an unannounced inspection. So, let me ask you, how many unannounced site surveys have you conducted in each of the last 2 years?

Dr. AFFELDT. I do not personally know. I will turn to Mr. Hall to see if he has information on that.

He says we are doing two this month, and last year he does not know.

Senator HEINZ. Well, based on available information, that is a grand total of two. [Laughter.]

There may be more information to fill out the record.

Dr. AFFELDT. Would you like us to supply that information?

Senator HEINZ. Yes, I think we ought to have that information.

Dr. AFFELDT. We will provide that.

[Subsequent to the hearing, Dr. Affeldt supplied the following information:]

Over the past 24 months, the JCAH long-term care accreditation program has received approximately 24 complaints about facilities we accredit. As a result of these complaints, we have conducted eight unannounced out of cycle onsite investigations. Some of these complaints are from facility management and pertain to the quality of our survey and surveyor performance. All complaints pertaining to the quality of patient care were investigated through the unannounced visit, correspondence, a regulatory scheduled visit and/or a combination of all of the foregoing.

Senator HEINZ. Let me ask you this. Another way of triggering an unannounced inspection is through complaints. As I understand it, you accredit 7,300 facilities.

Dr. AFFELDT. Approximately. That is all types of facilities.

Senator HEINZ. How many complaints do you receive annually from people that are either patients at, passing through, or working at, one of these facilities?

Dr. AFFELDT. Well, again, I do not think I would have a number. I am aware of a number of complaints coming in because they——

Senator HEINZ. You could go back and check and find out whether people complain to you very much?

Dr. AFFELDT. Yes, I think we could. We would have to check our correspondence logs, but I think we could.

Mr. MACDONALD. Mr. Chairman, in terms of these unannounced visits, I think that is one of the issues that needs to be sorted out here a little bit.

In terms of what is going to be the requirement and the function of the State licensure, you heard earlier the comment and the suggestion that State licensure be considered for deemed status. That is one of the recommendations that I think all three of our groups have also offered as an alternative in our prepared statements.

But one of the things that we find in terms of the unannounced visits is that some of the records and paperwork, if there is appropriate followup and consideration for their immediate impact on patient care, they can be handled in a different way than when that State surveyor comes into the facility for purposes of enforcement.

I think that one of the delineations here that Dr. Affeldt is making is the enforcement process, the State licensure process, and the third part of the wheel, so to speak, is the factor of consultation. And one of the missing ingredients in the past for the industry has been this consultation.

The State approaches it either purely from the police enforcement process or they approach it from the licensure perspective. And one of the areas that has been the responsibility of the industry—and I think to a great extent we have responded fairly effectively—has been to try and provide some of that consultation. But

that is one of the reasons that the industry has viewed the JCAH and the deemed status as being ultimately beneficial not just to the facility but to the quality of patient care.

Just in terms of your comparison earlier between hospitals and nursing homes, I would draw your attention to some of the Department of Health and Human Service's MMACS information and the comparison in deficiencies between hospitals and nursing homes in some of the key patient care areas. In terms of the nursing home record today—I think most of us at this table are very proud of the fact that the industry has a lower rate of deficiencies in certain key areas than hospitals do.

We certainly, as an industry, do not want to take any steps backward in terms of where we have come and where we are today.

Senator HEINZ. I appreciate that. There is one thing that we have not talked about today, and while our hearing is extremely important, in a way I am inclined to believe nursing home regulation often misses the entire point. It has been necessary for us to have a set of clearly defined, sometimes bureaucratic standards, information, reporting, and those kinds of things.

I would be the first to say that the industry has come a long way since the time of the Honesdale, Pa., fire and other terrible situations we have had in our State, and Senator Percy and others have had in theirs.

But, so far, the really quantum improvement in nursing home regulation, which is to focus on patient outcomes and finding a system that is patient-centered and outcome-centered, has somehow eluded us.

Now, we did ask the Carter administration when they were around to try and come up with something. They were working on what they called the PACE system.

Mr. MACDONALD. The PACE system; that is correct.

Senator HEINZ. And I know this is somewhat of a digression, but we do not get such a group of experts up here every day. Do you not think it would be a good idea for us to try to continue to move toward a PACE type of system?

Mr. MACDONALD. Absolutely. Just very quickly, from our perspective, we have four of our companies right now that are doing it on a voluntary basis. They have instituted this type of assessment program in their own facilities. It is not a requirement, as you have noted.

But as I stated earlier in the opening comment, we feel that we have got to move toward a patient-oriented system, and that is the bottom line.

Mr. LANE. I would add to that, Senator. As the one organization that deviated from the rest of the industry on the issue of the conditions of participation earlier this year, one of the very strong points that we worked on with you and your staff was the emphasis on a patient-outcome-oriented system and the need for us to move this field toward an approach that links its reimbursement and incentive criteria to the service delivery point.

Going back to your analogy, I also was an enlisted man, and I would point out that having starched shirts and short haircuts did not make the Army necessarily a better fighting unit. You begin to evaluate based upon what the outcome is that you are looking for.

We strongly believe in a movement in that direction—and this is, again, some of the flexibility that is provided in this subpart S, and if it is seized by the States in the way that some of the individuals have mentioned here in this hearing, it will be helpful. It will move us to a point whereby surveillance is not all that we are after, or merely having good haircuts and starched pants to evaluate an Army.

It will be a system that will say care delivered is important, and it is that product that will be evaluated.

Dr. AFFELDT. Mr. Chairman, our standards already require a mechanism similar to that.

Mr. NICHOLS. Many facilities are already using the problem-oriented medical record, Mr. Chairman. We, in AHCA, fully support that move that you speak of. We have in the past; we will in the future. Many of the States also have requirements for including the various disciplines within the facility as participants in implementation of those patient-care plans, whether they be dietary, whether they be nursing, whether they be activity coordination, or whatever. Steps in that direction I think will be fully supported by the industry.

Senator HEINZ. Well, I hope the administration is aware that there really is a lot of support for going toward a meaningful kind of quantum improvement in the whole regulation of the nursing homes, both long term and intermediate.

Last question: Do you believe that there really is much work going on in that area, at least in HHS?

Mr. MACDONALD. Yes; well, the last contact that we had on this issue was that they were looking at it and evaluating it in conjunction with prospective reimbursement, the whole issue of problem-oriented medical records, and the general recordkeeping requirements that are currently imposed on the facilities, as to how they can be related back to the patient.

Senator HEINZ. I will not get into the issue of why that should be tied or not to something you mentioned called prospective reimbursement. It seems as though they are separable issues to me.

If you have no further comments, I want to thank all of you for being here and for your testimony. I particularly appreciate your waiting until 1 p.m. You have been very patient and we thank you all.

Mr. MACDONALD. Thank you.

Dr. AFFELDT. Thank you.

[Whereupon, at 1 p.m., the committee was adjourned.]

APPENDIXES

Appendix 1

MATERIAL SUBMITTED FOR THE RECORD

ITEM 1. ILLINOIS DEPARTMENT OF PUBLIC HEALTH POSITION PAPER ON HEALTH CARE FINANCING ADMINISTRATION PROPOSED RULES ON SURVEY AND CERTIFICATION OF HEALTH CARE FACILITIES; SUBMITTED BY SENATOR CHARLES H. PERCY

We have one grave concern about the proposed regulations. The suggestion of "deemed status" for Joint Commission on Accreditation of Hospitals (JCAH) accreditied agencies, skilled nursing homes (SNF's) intermediate care facilities (ICF's), and home health agencies (HHA's), is like putting the fox in the chicken coop full of chickens and expecting the fox to lay eggs. Joint Commission on Accreditation on Hospitals is a not-for-profit organization of providers accountable only to its own board of directors. This change will, if adopted, pose a serious threat to the welfare of a highly vulnerable and dependent segment of the Nation's and this State's population—the elderly, the ill, and the disabled who require institutional care in nursing home facilities.

Illinois, in 1980, had a population of 11,418,461 of which 1,261,160 were age 65 years and over. Extended care facilities, essentially skilled nursing homes and intermediate care facilities, provided 596,048 days of medicare covered care to the aged and 19,006 days of medicare covered care to the disabled. In terms of dollars, extended care facilities accounted for $45,762,000 of medicare covered charges with $25,966,000 being reimbursed to the aged and $1,613,000 of medicare covered charges with $923,000 being reimbursed to the disabled. However, the overwhelming majority of public funding of nursing home care is under the medicaid program. Illinois, in 1980 had 1,048,621 medicaid recipients of which skilled nursing homes and intermediate care facilities accounted for 79,111 recipients. In terms of dollars, skilled nursing homes and intermediate care facilities accounted for $326,601,082 of the total $1,191,914,747 medicaid expenditures in Illinois.

Nursing home care accounted for almost 10 percent of the personal health care expenditures in 1980, and over one-half of the costs of nursing home care was paid from public funds. What we appear to have is a serious case of the "tail wagging the dog" in this set of regulations. Medicare, the smaller of the two programs in question with regard to nursing home care, is a Federal program. Whereas, the medicaid program is a Federal/State program with final responsibility for participation of vendors and recipients resting with the State. For example, a skilled nursing home certified for medicare shall be deemed to meet the requirements for participation in medicaid, although the State medicaid agency is not required to enter into provider agreements with every facility that is federally qualified. In addition, Illinois and most States have legislatively mandated a single State agency, in Illinois' case, the Department of Public Health, as the governmental agency responsible not only for survey and certification aspects of medicare and medicaid, but also the licensure of all nursing home facilities in the State.

Medicare accounted for 212 nursing home facilities out of a total of 815 nursing home facilities in 1979. This presents 7,131 beds out of a potential of 96,159 in 1979 or approximately 7 percent of the States' licensed bed count. Therefore, if there is to be "deeming" authority for an entity in the State of Illinois, it should not be a private, nonregulatory organization of service providers but rather the State of Illinois designated and legislatively mandated survey, certification and nursing home licensing agency, the Illinois Department of Public Health.

We feel that providing "deeming" authority to States is essential to the future of the medicare and medicaid survey, certification and licensing processes across the Nation. We assume that only States with standards of licensing equal to or higher

than the medicare standards would be eligible. This is the case in Illinois. Based on discussions with other State agencies, this type of provision would apply to most States with legislatively mandated nursing home licensure programs, such as the "Nursing Home Care Reform Act of 1979" (P.A. 81-223, as amended.)

We support and commend HCFA for some of the other specific proposals set forth in these regulations. We wholeheartedly concur with the view taken towards making the regulations more flexible and easier to administer, while retaining the enforcement capabilities necessary to ensure the health and safety of medicare and medicaid beneficiaries. To some degree, we wonder why this decision took so long in coming and why it does not appear to have filtered down to the mid-management of the organization.

In particular, we support:

(1) The "consolidation of medicare and medicaid survey and certification provisions" into a single part of 42 CFR chapter IV.

(2) The elimination of the "mandatory 90-day resurveys" while retaining a flexible followup requirement for the survey agency except in the case of life-threatening deficiencies where procedures are initiated immediately to terminate the facilities participation.

We support the concept of the following specific proposals and suggest the following clarifications:

(1) The total elimination of the automatic "cancellation clause provisions" goes too far in terms of deregulation. We would suggest that a middle-of-the-road approach be pursued as this regulation relates to quality of care issues important to the overall health and safety of medicare and medicaid beneficiaries. We propose that a HHS work group, in coordination and consultation with State survey agencies, be established to define specifically which correctable nonlife-threatening deficiencies should be retained to enhance the quality of life and care of medicare and medicaid beneficiaries. The work group should provide a report and regulatory proposals to the Secretary no later than December 31, 1982.

(2) The elimination of the requirement that all facilities be subject to annual surveys with the exception of ICF's for the mentally retarded (ICF/MR) does not go far enough in terms of deregulation. Surveys for all providers should be at the discretion of the State survey agency. It is our contention that although many of the patients in these facilities may lack the necessary experience or capability to bring quality of care problems to the attention of outside authorities, this is also the case for patients in other facilities. This should not be the guiding excuse for creating this exception since numerous watchdog groups exist, expecially in Illinois and in other States, which keep this department aware of changing conditions in the nursing home industry. We have established mechanisms for the immediate followup of complaints in the regulations, which we feel more than adequately address this particular problem. We support the concept of flexible survey schedules, and see no reason, in our experience, for the creation of this exception.

In conclusion, although we support most of the recommended changes in the regulation in concept, we cannot support the adoption of the regulation in its current condition. This is due exclusively to the incorporation of the "deemed status" for JCAH, SNF, ICF, and HHA affiliates.

ITEM 2. POSITION STATEMENT OF RUTH DEAR, GRAY PANTHERS, CHICAGO, ILL.; SUBMITTED BY SENATOR CHARLES H. PERCY

The Chicago Gray Panthers offer the following comments in reference to HSQ-502-P, the proposed rules on medicare and medicaid: Survey and certification of health care facilities.

It is our contention that the rules proposed in HSQ-502-P will not streamline or simplify procedures for medicare/medicaid approval. Rather, it will seriously jeopardize the safety and welfare of nursing home residents.

It is our understanding that a private, health provider dominated organization, the Joint Commission on Accreditation (JCAH) would accredit facilities as they've done in the past. Accredited facilities will then be deemed eligible to receive medicare and medicaid reimbursement. Facilities that do not chose to seek JCAH approval or are unable to achieve it would continue to be inspected by government agencies. Licensing will remain a function of the State.

What is simple or streamlined about this? States will not know whether facilities are being handled by JCAH or by HCFA. Providers will undoubtedly use this confusion to their advantage, playing several agencies off against each other. The task of

coordination among HCFA, JCAH, and State health departments will be an enormous if not an impossible one.

Who will monitor JCAH's activities to insure that their "accredited" facilities would indeed meet HCFA requirements? JCAH files are not open or available to public scrutiny, making public access to information about nursing homes even more difficult to obtain. Facilities currently pay JCAH for their reviews. Will HCFA now incur this cost or will payment still be made by the individual homes and if so, what makes HCFA believe JCAH will "bite the hands that feed them" and do a truly critical and responsible job of accreditation?

We know JCAH is a credible organization with a farily good track record, but they are consultants not regulators and no private entity should be allowed to do what is rightfully government's role in protecting the rights and welfare of nursing home residents and monitoring their care.

The creation of an indirect and highly flexible survey cycle serves only the needs of the nursing home industry. The idea that plans of correction can be verified or monitored by a mere phone call is ludicrous. Plans of correction will simply go uninitiated unless resurveys and frequent inspections are done on at least a 90-day basis.

In summary, it appears to the Chicago Gray Panthers that the overall intent of the proposed regulations is to severely weaken all enforcement processes. The Chicago Gray Panthers hear what's being said by the government. We can afford MX missiles, but we can't afford to enforce quality care in our Nation's nursing homes. The frail, elderly, and handicapped oppose these regulations and we raise our objections with them. Ten years of experience in advocacy and nursing home issues tells us all that the industry must be responsibly regulated by frequent inspections and surveys and by the prompt use of sanctions.

Gray Panthers urge our legislators and public officials to preserve and fortify the current standards of certification, so that our Nation's 2 million nursing home residents are assured a dignified existence.

ITEM 3. LETTER FROM EDWARD C. STEC, EXECUTIVE DIRECTOR, ILLINOIS CITIZENS FOR BETTER CARE, CHICAGO, ILL., TO SENATOR CHARLES H. PERCY, DATED JULY 9, 1982

DEAR SENATOR PERCY: Illinois Citizens for Better Care applauds you and the Senate Special Committee on Aging for the planned hearing on nursing home surveys.

Our organization, a privately funded, not-for-profit membership advocacy group, is very concerned about the recent actions by the Department of Health and Human Services in the regulation of the nursing home industry.

We have observed a deterioration in leadership and trend to misguided deregulation of a troubled industry.

ICBC will formally respond to the Department on the proposed regulations contained in the May 27, 1982 issue of the Federal Register, entitled "Medicare and Medicaid; Survey and Certification of Health Facilities." Your office and the committee will be furnished with copies.

In the meantime, we wish to advise you that ICBC strongly disagrees with the following concepts contained in the proposal: (a) Use of private accrediting bodies; (b) frequency of surveys; and (c) elimination of the time limited agreement and cancellation clause.

In addition, we seriously question a number of assumptions contained in the proposal. For example: (a) Cost effectiveness of use of private accreditation; (b) compatibility of standards used by the private organization; and (c) ability of the government and State agencies to determine "good" versus "poor" facility.

We also believe that the proposed regulations contain misleading and conflicting statements.

Until the detailed response to the Secretary is completed and distributed, we wish to formally go on record about the concerns shown above.

In addition, we are available to testify, and are also willing to direct you to other expert sources.

Sincerely,

EDWARD C. STEC.

ITEM 4

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1248

JUL 0 7 1982

Carolyne K. Davis, Administrator
Health Care Financing Administration
Department of Health and Human Services
P. O. Box 17073
Baltimore, MD 21235

Dear Ms. Davis:

REFERENCE HSQ-502-P

This is in response to your Department's proposed change in Federal regulations as contained in the Federal Register, Volumn 47, No. 103, Thrusday, May 27, 1982 to change and/or amend 42 CFR, Part 405, 431, 442, 489 and 490, Medicare and Medicaid; Survey and Certification of Health Care Facilities.

Of particular interest is the proposal to grant deemed status to skilled nursing facilities, intermediate care facilities and hospital-based home health agencies who are accredited by the Joint Commission on Accreditation of Hospitals. This proposal is unacceptable for the following reasons:

1. The accreditation process is, and would remain, voluntary. The philosophy of JCAH is that providers of health care should voluntarily assess the quality of the care they render. In addition, JCAH does not operate or conceive themselves as being a regulatory enforcement agency.

2. Accreditation surveys are announced. This ensures that each facility is afforded a maximum of preparation time and that facility operations will be evaluated only in circumstances which are the most favorable for each facility. Consequently, the situation presented for the JCAH survey may bear little or no resemblance to normal operation.

   In California state statutes require that all licensing visits to long-term health care facilities be unannounced. As a result, the probabilities of surveying the normal, day-to-day operations of the facility are greatly enhanced. This situation also currently exists for the federal recertification survey, as dual licensing/certification surveys are now performed.

3. The Licensing and Certification Division, which is the State Survey agency, has eleven district and sub offices located throughout the state which currently license and certify 1200 long-term health care facilities. These district and sub offices are located and staffed in such a manner to facilitate reaction to patient and community concerns and complaints. There also is a working arrangement and/or communication with patient advocacy and community action groups in order to identify and resolve issues.

   JCAH is neither equipped, located nor staffed in a manner conducive to conducting on-site complaint investigations or having involvement with patient advocate and community action groups. This type of relationship and routine complaint investigation would be cost-prohibitive for JACH.

4. There will be a duplication, overlap and fragmentation responsibilities should SNFs and ICFs be permitted to obtain deemed status from JCAH. These facilities will wtill have to be licensed by the state as mandated by state law and be in compliance with state licensing regulations. Consequently, each year state surveyors would continue to visit facilities for licensing and complaint visits while JCAH surveyors would be conducting accreditation surveys every two years in these same facilities.

   Another consideration is the fact that state surveyors are trained, experienced, qualified and familiar with surveying long-term health care facilities. JCAH surveyors, on the other hand, have little or no experience in long-term health care facilities as their major emphasis has been surveying general acute care hospitals. It is also doubtful that JCAH has an adequate number of qualified and experienced surveyors to carry out the long-term health care function in this state and will have to employ additional personnel. In California alone, there are 1200 long-term health care facilities and 549 general acute care hospitals of which 60 have hospital-based HHAs.

5. Currently, California shares the cost of the federal certification programs because of our mandate to conduct state licensing inspections. This share is approximately 66 2/3 federal and 33 1/3 state. It is assumed, that this proposal would exempt the federal government from compensating the state agency for surveying in those SNFs and ICFs that have obtained deemed status with JCAH and therefore reduce federal costs as JCAH would not directly be reimbursed for its accrediting activities. This is not true since these facilities would have to reimburse JCAH for the accreditation survey and these costs would be reimburseable to the SNF or ICF through the Medicare or Medicaid programs as an allowable cost of doing business. The federal government would still be indirectly paying for the JCAH accreditation surveys. In addition, these facilities are still mandated by state law, to pay a license fee on an annual basis.

Based upon these concerns, it is felt that the federal proposal to permit deemed status by JCAH in SNFs and ICFs would lead to an inevitable deterioration in the level of patient care that is now being provided by a majority of long-term health care facilities in this state. It also would be costly to the federal and state governments which really means an increased cost to the public and consumer with no further guarantee that individual patient care needs will be met. It is therefore recommended, that this proposal not be adopted.

Sincerely,
Original signed by
CLIFTON A. COLE

Beverlee A. Myers
Director

ITEM 5

March 29, 1982

A REGION III POSITION PAPER

Regarding

OPPOSITION to the Health Care Financing Administration (HCFA) proposal which would grant deemed status to nursing home accreditation programs for Federal certification purposes,

and

SUPPORT of the concept of granting deemed status to State Licensure Programs for certification purposes with continuation of Federal-State cost sharing arrangements.

The Directors of Licensure and Certification of the states comprising Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia) have endeavored to develop this paper in hopes that it will serve as a vehicle by which we can express major concerns regarding the Health Care Financing Administration's proposal to grant deemed status to nursing home accrediting bodies, as well as that agency's perceived refusal at this point to consider the deeming of State Licensure Programs for nursing home certification in the context of continued cost sharing relationships with the states. Adoption of such a proposal would represent, at the outset, a radical departure in current nursing home monitoring and Federal Certification processes for those facilities electing to participate in the Medicare Title XVIII program. According to Health Care Financing Administration (HCFA) officials, implementation would be followed by an effort to persuade each state's Medicaid agency to extend deemed status to facilities participating in the Medicaid Title XIX program. Therefore, notwithstanding the language of the proposal as it will appear in the upcoming Notice of Proposed Rule Making, the issue revolves around the advisability of assuming that nursing homes accredited by the Joint Commission on Accreditation of Hospitals (JCAH) meet standards set at the federal level (Conditions of Participation) for participation in the Title XVIII/XIX reimbursement programs.

State Survey Agencies

The responsibility for monitoring and evaluating each nursing home's compliance with eligibility standards pursuant to participation in the Title XVIII/XIX Medicare/Medicaid reimbursement programs is currently vested in each state's health standard setting agency (State Survey Agency) as mandated by Chapter 42 of the Code of Federal Regulations. Since the vast majority of State Survey Agencies are also required by state law to monitor and evaluate health care facilities relative to state licensure standards, the combination of licensure with the certification process is an extremely common arrangement. The consolidation of those processes has allowed states to strengthen licensure standards and State Survey Agencies to improve their monitoring, enforcement and consultative capabilities because of the influx of federal funds. At the same time, the Secretary of Human and Health Services, by virtue of 1864 Agreements with the states, has been able to discharge his responsibilities relative to assurances that program beneficiaries are receiving adequate care as required by the Social Security Act. This has all been accomplished in a relatively brief period of time, and within the context of the increased responsiveness of public agencies to concerns of the general public brought about by the advent of patient advocacy groups and resultant increases in the levels of public education, awareness and expectations.

The Joint Commission for Accreditation of Hospitals

JCAH is a national independent accrediting agency headquartered in Chicago, Illinois. An outgrowth of the Hospital Standardization Program established in 1918, the organization became a private non-profit corporation via a consolidation of associations in 1951 in order to promote and encourage voluntary attainment of high standards of institutional medical care. In 1965, JCAH accredited hospitals were automatically "deemed" by Congress to be in compliance with Medicare program eligibility requirements, though in 1972, provision was made for validation surveys of such hospitals by the Secretary of HEW through State Survey Agencies.

Presently, the Commission offers accreditation in a number of categories of service, including acute care hospitals and long term care facilities. Basic to the accreditation process is the belief that health care providers should voluntarily assess the quality of the services they render. Consequently, many educational and consultative tools are available through the organization and as a result of the accreditation process.

Since we have been aware of HCFA's intent to advance the concept of JCAH deemed status in nursing homes for almost a year, we have had ample opportunities to examine advisability of such action in terms of its expected effects. Our conclusions are that the changes contemplated would result in duplication, cost ineffectiveness, and would have a decidedly adverse effect on patient care.

While we develop the rationale which has led us to these conclusions, we would also like to take this opportunity to describe a counter-proposal that we find to be both logical and relatively free of the complex effects which would be occasioned by the implementation of the current HCFA proposal. We

are referring to the concept of deeming State Licensure programs for nursing home certification in those instances in which a determination is made that a state's licensure standards or its mechanisms of enforcement are equivalent or superior in stringency to appropriate federal standards. By virtue of such an arrangement, a facility would be regarded as certifiable if it is in compliance with state licensing requirements.

In our judgement, the HCFA proposal for deeming of JCAH accreditation surveys for nursing home certification is contraindicated for reasons discussed below. Since many of these same points are supportive arguments for deeming of State Licensure programs, ensuing discussion pertinent to each point will be developed simultaneously.

JCAH deeming would result in:

1. decreased quality of patient care;
2. increased duplication and overlap of responsibilities;
3. increased costs to HCFA;
4. increased costs to State Agencies;
5. increased costs to State economies;
6. increased costs to the public.

State Licensure Program deeming would result in:

1. increased quality of patient care;
2. decreased duplication and overlap of resonsibilities;
3. decreased costs to HCFA;
4. decreased costs to State Agencies;
5. decreased costs to State economies;
6. decreased costs to the public.

1. Quality of patient care services delivered in nursing homes

We are convinced that implementation of JCAH deeming would be followed by an inevitable deterioration in the quality of patient care services rendered. We are equally firm in our belief that the deeming of State Licensure Programs would have a positive impact on the quality of patient care delivered.

a) The accreditation process is, and would remain, voluntary. A basic JCAH operational tenet is that providers of health care should voluntarily assess the quality of the care they render. Since participation in the program is voluntary, the approach is necessarily one of peer review. While such an operational mode may be beneficial for educational and consultative programs, it does not lend itself to evaluation, monitoring, and adverse action. The JCAH has no intention of functioning in a regulatory mode. Nor can scrutiny be purely objective when modified by the need for program participants to generate funds to meet operational costs.

No such modifying circumstance exists relative to State Licensure Programs. While participation in Title XVIII/XIX Programs or JCAH is voluntary, state licensure is not. All service providers must comply with existing state requirements in order to operate. If non-compliance is determined, the State Agency has the option of invoking civil and/or administrative penalties. One

such penalty which has proven to be extremely effective by virtue of present licensure/ certification arrangements has been the leverage afforded by the option to recommend decertification. The possibility of a cut-off of reimbursement has provided impetus for facilities to effect necessary corrective measures in many instances. For this reason, and for those discussed below (see #2), we see continuation of the present prerequisite linkage between certification and state licensure as being essential.

b) Subject facilities are given advance notice of anticipated dates of JCAH visits. The use of announced inspections ensures that each facility is afforded a maximum of preparation time and that facility operations will be evaluated only in circumstances which are the most favorable for (and most conducive for a finding of compliance in) each facility. As a result, the situation presented for JCAH scrutiny may bear little or no resemblence to normal operations.

The opposite situation prevails relevant to oversight by states. Most State Licensure programs are not required to give advance notice of inspection visits. As a result, the probabilities of evaluating normal, day-to-day operations are increased. Those possibilities are further enhanced by the accessibility of State Survey Agencies to the facilities occasioned by on-site follow-up visits and consultation and training contacts.

c) JCAH findings are not subject to Public Disclosure considerations. Regulation 422.426(b)(2) and Regulation 431.115(e)(1) of the Code of Federal Regulations, Chapter 42, specifically excludes JCAH survey reports in describing documents subject to disclosure.

Certification findings by State Agencies are subject to public disclosure considerations. This includes reports generated as a result of inspections, follow-up visits, and complaint investigations.

d) JCAH is neither equipped nor located in a manner conducive to on-site complaint investigations. It would obviously be cost-prohibitive for JCAH to conduct on-site complaint investigations as a matter of routine, and it would be inconsistent with the services provided by that organization. As a result, they do not routinely investigate. We understand that less than twenty on-site investigations were conducted nationally in 1981 in the hospital setting. While this does not indicate responsiveness to concerns of patients or concerned citizens, we are certain that non-responsiveness is not intended since complaint investigation is not a viable alternative for JCAH in most instances, and is therefore not a mode in which they see themselves routinely functioning. Complaint investigation serves little purpose in a context which precludes regulatory oversight.

State Survey Agencies, however, are located and equipped in such a manner as to facilitate reaction to patient and community concerns and complaints. Virtually all states have the added dimension of working arrangements and/or communication with patient advocacy and community action groups in order to define and resolve issues.

e) JCAH has a two year accreditation period for nursing homes. We have learned through experience that the quality of services can deteriorate much more rapidly in the nursing home than in the acute care setting. This tendency

may be attributed to a variety of reasons which range from the lack of administrative expertise as compared to the acute care setting, generally lower pay scales in long term care, the proprietary ethic, the lack of an organized and active medical staff, and the frail elderly characteristics of the patient population therein. Whatever the reason, quality of care appears to be in direct proportion to the frequency of oversight in a significantly large segment of long term care service providers. Oversight once every two years on an announced basis will not be sufficient to overcome the deleterious effects of insufficient care.

Regardless of any HCFA commitment to lengthen certification periods and decrease frequency of inspections, most states still require at least annual licensure inspections. This requirement has been born of long and various experiences by the states, leading the vast majority to a conclusion shared even by many representatives of the long term care industry itself. That conclusion is that nursing homes should be visited in a regulatory mode on at least an annual basis.

f) Nursing homes losing their accreditation would probably revert back to the State Survey Agency. Although we are not yet aware of the specific mechanism for this transfer under the HCFA proposal, it is clear from State Survey Agency experiences in validating JCAH accredited hospitals that such transfers many times occur upon State Agency validation of an accredited facility, that the transfer is effected amidst accusations of responsibility for non-compliance, and that the State Survey Agency is responsible for assisting the facility to return to compliance status. It is our view that those adverse conditions would be accentuated in the long term care setting if JCAH deeming occurs.

Under an arrangement by which State Licensure programs are deemed, any questions as to interpretation or enforcement of state requirements would be discussed by the State Agency with HCFA staff. Such two-party negotiations would have the advantages of including participants familiar with the socio-economic conditions prevalent in the facility location, and issues and decisions would be subject to discussion by any concerned citizen through public disclosure. In addition, the public could be assured of an objective decision since the licensing and certification agency has no proprietary interest in whether or not a facility is licensed or certified.

2. Duplication and overlap of responsibilities

As discussed in #4 below, State Agencies will retain licensure responsibilities whether or not JCAH is deemed. The logic involved in JCAH deeming, therefore, appears to be inconsistent with consideration of state licensure mandates. Further evidence of inconsistency would be demonstrated if the proposed federal nursing home regulations were to make no mention of compliance with state licensure requirements as a prerequisite to certification. Omission of this requirement would be an open invitation for facilities to secure both certification and JCAH accreditation without bothering to obtain a state license to operate. Considered in the context of JCAH deeming, it would also prevent an effective enforcement tool from being utilized by State Agencies in their efforts to develop and maintain consistent and reasonable licensure programs. Finally, it would clearly circumvent the intent of every state legislature in the country.

The increase in duplication caused by JCAH deeming resulting from variations in standard interpretation and enforcement would be extremely unfair to the provider community, opportunities for providers to facilitate antagonistic relationships between JCAH versus State Agency surveyors would abound, and confusion would reign.

Furthermore, the deeming of JCAH does not appear to be consistent with the "New Federalism" described by President Reagan in his State of The Union address of January 26, 1982, since a national accrediting agency would be substituted for State Agencies resulting in removal of the decision-making process from the "grass roots" level. The deeming of State Licensing programs, on the other hand, appears to fit perfectly the mold of the "New Federalism". Certificiation would be a normal outcome of state licensure procedures. Thus the decision making would remain in the hands of those most familiar with the facility and conditions prevalent in the state. Moreover, the processes leading to those decisions would be available to public scrutiny.

The deeming of State Licensure programs would allow State Agencies to continue in their roles as the state authority for certification issues, and the concept of certification through licensure would simplify the process immensely. The relationships that State Survey Agencies have cultivated with providers over the years could proceed uninterrupted, and would improve as a result of a simplification of the process. It has been our observation that the provider values highly the qualities of accessibility and consistency in application of standards that we have been able to provide.

3. Costs to HCFA

Currently the states share the cost of the Federal certification programs because of their mandate to conduct state licensure inspections. The sharing percentages range from approximately 35% to 65% of the total, depending on each state's licensure activity.

One of the motivating factors precipitating the proposal to deem JCAH has been the perception that such deeming would exempt HCFA from compensating State Agencies for services leading to certification of accredited nursing homes, and would therefore represent a savings since HCFA would not directly reimburse JCAH for its accrediting activities. This viewpoint does not take into consideration that accreditation costs would be reimburseable to the nursing home through the Medicare or Medicaid programs as an allowable cost of doing business. Although we realize that some of the figures below may be open to question, the following is our best estimate of anticipated accreditation expenditures in a JCAH deemed status situation. JCAH currently charges $625 per surveyor per day for long term care facilities plus a $250 application fee (we are assuming that these figures include all expenses and processing costs). Assuming six (6) surveyor days for a 120 bed facility, at least $4,000 would be reimbursed to the nursing home from the Title XVIII/XIX Programs. Based on the rate of reimbursement of actual fiscal year 1981 SNF expenditures to Region III states, the average annual cost of oversight per facility was approximately $3,300. Since HCFA is interested in letting JCAH continue inspecting only once every two years, however, we are certain that State Agencies would be afforded the same "every other year" considerations. The annual costs to HCFA, utilizing State Agencies then becomes $1,650. Of that amount, we conservatively estimate that approximately 40 per cent was due to

follow-up visits (conducted to ascertain correction of cited deficiencies), consultation visits, and on-site complaint investigations. The analogous figure for a State Agency survey is then estimated to be $990, which represents a savings of 50 percent as compared to the cost of a JCAH accreditation survey.

We do not agree with the philosophy of inspections on an every-other-year basis, and we recognize that the Commission also has the capability of issuing one year accreditations. For illustrative purposes, therefore, we can compare the same costs on a yearly basis ($4,000 versus 60 percent of $3,300 or $1,980) with the same results (State Agencies still save HCFA approximately $2,000 per survey).

While it is impossible to estimate the cost required to build into JCAH the flexibility for follow-ups and on-site complaint investigations, one can surmise that the $4,000 figure would at least double. The comparison between $8,000 (JCAH) and $3,300 (State Agency) at the same approximate level of flexibility leaves us confused as to how HCFA intends to save money by such an arrangement. It does not appear to us to be a bargain to anyone except the JCAH.

JCAH has predicted approximately 5,000 accredited nursing homes nationally if they are given deemed status. Based on the $2,000 average cost per year per facility, we anticipate an annual price tag of $10 million in accreditation fees for long term care facilities. Who will pay the $10 million? It will ultimately come primarily from the Title XVIII/XIX Programs. It is important to note that there are approximately 20,000 nursing homes nationwide. Therefore, even with a $10 million outlay to JCAH, HCFA would still be providing oversight funding to the states for the other 15,000 homes.

Interestingly, fiscal year 1980 Title XVIII funds contributed to all states to support SNF survey and certification activities was approximately $8.4 million. The projected figure for fiscal year 1981 is $7.5 million, or a decrease of more than 10% (much of this decrease can be attributed to a 50 percent decrease in available federal funds).

The deeming of State Licensure programs would decrease HCFA costs in the following ways:

a) The deemed State Licensure programs would use one survey instrument (the state licensure survey report form rather than the four to six instruments currently utilized by many states);

b) Time-consuming ancilliary federal form submission could be deleted, and interpretation of issues would be pursued at the state level only;

c) By capitalizing on each state's "frequency of inspection" requirements, the federal government could continue to ensure facility compliance with federal standards based on review of state licensure inspection reports which it could continue to support on a cost sharing basis;

d) Since the federal government could continue to ensure facility compliance as required by the Social Security Act, future costly legal actions such as the Colorado Suit could be avoided (see #4 below).

4. Costs to State Agencies

State Agencies will retain the responsibility for nursing home licensure whether or not JCAH receives deemed status. Severing the cost-sharing relationship which currently exists between the State Licensure and Federal Certification programs would result in each state having to bear the entire inspection costs of licensing accredited facilities. These costs would be drawn exclusively from state funds and would be roughly equivalent to the loss of federal funds. Therefore, both HHS and the states would lose current cost sharing benefits as a result of unnecessary duplication.

On the other hand, continuation of federal funding participation as a result of State Licensure deeming would allow the continuation of the evolutionary changes in State Survey Agencies which has been so important during recent years to the emergence of those agencies as a dominant force in the improvement of health care delivery. Preservation of the integrity of the process would also be reflected by the non-duplicative thrust of such a move. The opportunity for increasing duplicative functions will have been short-circuited by deeming State Licensure Programs. Interruption of the Federal funding participation process would result in further loss of highly skilled positions which could only be compensated for by extensive retraining and many years of experience.

By utilizing one survey instrument for licensure and certification purposes (as discussed in #3 above), on-site as well as survey processing time required per survey would decrease significantly.

HCFA officials have let it be known that if State Licensure programs are deemed, those states receiving deemed status could expect to lose that portion of federal funds constituting support of State Agency nursing home certification activities. We perceive this position as an attempt to compromise by intimidation any state's decision to apply for deemed status of its licensure program. The logic is inescapable. A state may choose not to apply for such deeming if doing so would jeopardize federal funding, particularly if only a small segment of program participants in that state would be anticipating accreditation. With such a high potential for retaliatory action by HCFA, the possibility of implementation of HCFA's JCAH deeming proposal would be greatly enhanced.

Aside from what we would regard as a punitive nature of such an action taken against states applying for deemed status of their licensure programs, we are concerned with the legality of eliminating federal funding support of deemed status licensure programs. Section 1864 of the Social Security Act as Amended requires the Secretary to make agreements with each able and willing State whereby the appropriate State Agency would be utilized for purposes of determining whether appropriate Conditions of Participation are met. This Section further requires that the Secretary shall pay any such state on the basis of reasonable costs incurred for performing such functions.

It is apparent to us, therefore, that any effort to discourage State Licensure program deeming by eliminating payment of costs attributable to nursing home certification activities would be a clear violation of Congressional intent as set forth in the Act.

5. Costs to state economies

Since accreditation costs are reimbursable, the net effect of a nursing home accreditation would be the outflow of federal and state money to JCAH headquarters (as is currently occurring with accredited hospitals). Given the present economic conditions prevalent in most states, we doubt that an exodus of funds would be perceived by the public as being helpful to economies in their states. If, in some states, accreditation fees prove not to be a reimbursable cost, the nursing home will be forced to increase charges to private pay patients to meet the deficit. Either way, the undesirable effect will be an unnecessary outflow of money from each state economy.

Since costs pursuant to state licensure are reimburseable and there are no certification fees, under a state licensure deeming arrangement, federal certification funds would be involved as reimbursement to facilities only for licensing fees (which is nominal in most states) and as cost-sharing for State Survey Agencies as described in #4. These funds, however, would remain in the states and would represent an injection into the economies of those states.

6. Costs to the public (and consumers)

The deeming of JCAH in nursing homes would increase duplication and overlap of responsibilities. Since State Survey Agencies would be required to comply with their licensure mandate, the public would be supporting two survey agencies where only one is necessary. Furthermore, since JCAH deeming involves a discontinuation of federal participation in cost sharing, operating costs of the State Survey Agencies would have to be entirely supported by state funds. The end result would obviously be an enormous increase to the public in general, and to consumers of services in particular.

The deeming of State Licensure programs and continuation of federal cost sharing would allow the utilization of state standards only, more efficient resource allocation, and obviate the need for an accreditation fee.

In the event that HCFA would deem State Licensing programs, but decline to assume its share of the certification inspection costs, the states would be forced either to assess certification fees necessary to cover that activity (such fees would be reimbursed to the nursing home as allowable costs by Title XVIII/XIX funds through the Single State Agency or fiscal intermediary) or to increase licensing fees in order to cover their operating costs.

Whatever the mechanism of payment, however, it is very clear that the taxpayer ultimately bears the cost. It is just as apparent that the taxpayer should not be asked to support superfluous accreditation costs when a mechanism exists whereby state licensure and certification can be easily consolidated.

Summary

Indeed, this is a complex and multi-faceted issue. From whichever facet we examine the situation, however, we arrive at the same conclusion. The advisability of assuming accredited nursing home compliance with certification requirements is poor, and contraindications of such a policy are overwhelming.

We all share concerns regarding the need for improving services rendered in long term care and we recognize the dilemma that we all face in attempting to effect such improvements in the face of substantive funding cuts. We believe, however, that any decision to replace the State Survey Agency as the facilitator of certification would be particularly ill-advised in light of the existance of an alternative option, the advantages of which we have described above. We are convinced that deeming State Licensure programs will decrease costs for all concerned, decrease duplication, and will result in greatly improved patient care. Therefore, we respectfully request careful review of the matter and support of the concept of deeming State Licensure programs for long term care facility certification in conjunction with a continuation of Federal funding participation supporting those activities.

James E. Harvey, Director
Health Facilities Licensure
and Certification
Delaware Department of Health and
Social Services

Jennifer Rizzeon, Director
Office of Quality Assurance
Pennsylvania Department of Health

Frances Bowie, Chief
Office of Licensing & Certification
Washington, D.C.

Mary W. Francis, Director
Division of Medical & Nursing
Facilities Services
Commonwealth of Virginia
Health Department

Harold Gordon, Chief
Division of Licensing and
Certification
Maryland State Department of
Health & Mental Hygiene

John J. Jarrell, Director
Health Facilities Evaluation Program
West Virginia Department of Health

ITEM 6

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-2070

XXXXXXXXXXX
XXXXXXXXXXX
XXXXXXXXXXX
XXXXXXXXXXX
XXXXXXXXXXX

Dear XXXXXXXX:

This is in response to your request for information regarding the California Department of Health Services' (DHS) contract with the Joint Commission on Accreditation of Hospitals (JACH) and the California Medical Association (CMA), for the inspection of general acute care hospitals as a combined survey effort for the purpose of data gathering and the sharing of information.

Enclosed is a copy of Section 1282 of the Health and Safety Code which is the law authorizing the Department to enter into this contractual arrangement, a copy of the cooperative agreement between the survey participants, and a copy of the task assignment responsibilities of each.

The concept of a combined survey (Consolidated Accreditation Licensure Survey - CALS) is unique, as each of the survey participants has a specific area of survey responsibilities, for which each surveyor evaluates the facility's compliances with the JCAH standards and the State regulations (Title 22, Division 5, California Administrative Code); in addition, the CMA evaluates the facility's compliance with their guidelines. The intent of the combined survey effort was to eliminate the potential for duplication and to reduce the time spent in facilities.

The survey schedule is prepared by the CMA in accordance with previous accreditation ratings. If a facility receives a two-year accreditation, this corresponds to California statute which requires an inspection no less than every two years. However, annual licensure fees are required.

The recent decision by the JCAH, Board of Commissioners, to move to a three-year accreditation period beginning January 1, 1982, presents an issue of concern to the Department, in view of the California requirement.

The task assignment responsibilities are determined by the JCAH; some areas are surveyed by more than one surveyor, but for the acquisition of different information.

A schedule has been established regarding the length of time spent "on-site" for hospital surveys, which is based upon the licensed bed capacity of each facility, as follows:

Licensed Beds	Days on Site
1 - 100	1 Day
101 - 349	2 Days
350 & over	3 Days

The very large medical facilities with over 750 licensed beds, having over fifteen supplemental or special permit services (i.e., rehabilitation, cardiovascular surgery, burn unit, intensive care, coronary care, end-stage renal dialysis, etc.), are considered on an individual basis for an additional day of survey.

The composition of the CALS team consists of the following:

JCAH	1 administrator 1 physician 1 medical technologist (College of American Pathologist)
CMA	2 physicians (participating on the final survey date)
DHS	1 registered nurse 1 health facilities representative

Team members assemble in the facility for a pre-survey conference and a presummation conference, the former is to share information regarding known facility problems (historical or existing) and the latter is to share the survey findings which impinge on the accreditation rating and to discuss any potential threat to the life, safety or physical or mental well-being of a patient. Only JCAH non-compliances are discussed at the summation conference.

The State prepares their statement of deficiencies, upon receipt of the survey report forms from all of the participants, after such reports have been reviewed by the CMA. The statement is then provided to the administration of the facility, by the State evaluators, during a special visit made for the purpose of discussion and consultation. A plan of correction is submitted to the Department by the facility and follow-up visits are conducted to determine compliance.

Reports of the investigative findings are forwarded to various agencies and become a public document; this is also true of the regular survey findings. However, public access to documents is limited to documents reflecting the State licensing regulations.

The survey results of the CMA and the JCAH, with respect to their guidelines/standards, are not disclosed to the State. Such information is according to the CMA and JCAH, confidential due to the "voluntary" nature of their survey. This is a major criticism regarding the tri-partite survey.

The CALS survey process has been in effect since 1976, and it has become increasingly apparent that critical information regarding facility deficiencies, particularly in the areas of goverance and medical staff, which are major problems, have not been reported to the Department of Health Services.

This fact has been demonstrated by the Department's investigative findings in response to complaints of several general acute care hospitals, necessitating closure and/or stringent monitoring activity. Evidence substantiates the fact that, frequently, the problem areas were known by the CMA/JCAH evaluators during the previous CALS survey and (1) were discussed during the medical staff conference, which the Department evaluators are not privileged to attend, or (2) were included as part of the JCAH "recommendations", which are not provided to the Department. The Department of Health Services shares its information without full reciprocation.

The JCAH views themselves in the role of consultant, not in the role of enforcers; while the CMA physicians appear to be reluctant to report adverse findings regarding their peers.

In view of these facts, the Department is now taking a "hard look" at the CALS process to determine if the best interest of the health care system is being met.

If I can be of further assistance, please do not hesitate to contact me at (916) 445-2070.

Sincerely,

Mildred G. Simmons, R.N.
Deputy Director
Licensing and Certification Division

Enclosures

ITEM 7

State of California — Department of Health Services

Memorandum

To : Mildred G. Simmons, R.N.
Deputy Director
Licensing and Certification Division

Date : July 12, 1982

Subject: L & C Division and JCAH Survey Cost Comparison

From : Tom Richards, Chief
Operations Support Section

The cost for an initial survey by JCAH is $1,500 and for a recertification survey is $875. The cost of a full survey by Licensing and Certification is $1,040;* if an abbreviated survey is appropriate, it can be performed for a cost of $624.* These figures represent the comparative costs to the federal government.

These cost estimates are based upon survey time spent in an average 100 bed facility. JCAH normally completes an initial survey in two days (16 work hours) by one surveyor, and normally completes a recertification survey in one day (8 work hours) by one surveyor. Licensing and Certification completes a full survey, including travel and report writing, in five days by two surveyors(80 work hours). An abbreviated survey can be performed in three days by two surveyors (48 work hours).

Hourly cost comparison information follows:

	Licensing & Certification
Total Budget for L & C (1982-83)	$14,349,000**
Skilled Nursing Facilities	72.39%
Total Amounts/SNFs	10,387,241
Hours/SNFs	÷ 320,700
Cost per hour/SNFs	$32
Federal Share/Hour at 40%	$13

JCAH Costs

Application Fee	$250
Cost per surveyor/day	625
Total	875
	÷ 8 hours
Cost/Hour	$109

*Based upon $13 per hour.
**L & C budgeted amount based on California State Budget, fiscal year 1982-83.

ITEM 8

NURSING HOME PATIENT ABUSE: Realities & Remedies

TO
Hugh L. Carey, Governor
Robert Abrams, Attorney General
The Legislature of the State of New York
The People of the State of New York

FROM

Edward J. Kuriansky
Deputy Attorney General
for Medicaid Fraud Control

Prepared by:
Beatrice A. Close
Matthew S. Greenberg
Beth R. Morgenstern
Special Assistant Attorneys General

L. Sabina Klaimitz
Research Analyst

December 1981

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INTRODUCTION

The Office of the Deputy Attorney General for Medicaid Fraud Control has been investigating patient abuse in residential health care facilities for over five years. As a result, this Office has become increasingly aware of recurring systemic problems affecting patient care and of the obstacles to deterring and punishing those who abuse the elderly infirm. We believe, therefore, that it is appropriate at this time to systematically analyze, assess and report the problems and findings noted in the more than 1100 cases investigated to date and to make recommendations based on these findings.

This report will highlight some of the persistent patient care problems that we have found. Examples of poor care and malicious behavior will be described. Much of the conduct that we have uncovered demonstrates the need for New York State to enact legislation imposing criminal liability for acts of patient abuse which are currently unprosecutable. Furthermore, our findings illustrate the urgent need for improved staff training and for a certification program that would ensure the

accountability of nonlicensed aides and orderlies. This report also includes recommendations relating to heat emergencies, fire safety, suicide prevention, medical care, and the use of guardrails and restraints.

Although five years of investigation have presented this Office with a broad picture of patient care problems in the nursing home industry, it must be stressed that this report is not intended as a blanket condemnation of the care and treatment provided in residential health care facilities. Nor do we intend to criticize the efforts of the vast majority of people who work in these facilities. In fact, our investigations indicate that the sick and elderly are diligently cared for by most of these employees. Unfortunately, their excellent work and contribution to society frequently go unreported. We believe that the adoption of the recommendations set forth in this report will greatly assist these dedicated individuals in their efforts to provide the highest quality care to the nursing home patients of New York State.

BACKGROUND

In 1975, Governor Hugh L. Carey directed the formation of the Office of the Special Prosecutor for Nursing Homes, Health and Social Services. Former Attorney General Louis J. Lefkowitz appointed Charles J. Hynes as the first Deputy Attorney General and Special Prosecutor to conduct investigations into all aspects of the nursing home industry with the powers set forth in Executive Law Sections 63(3) and 63(8). The Office's mandate included, as a paramount objective, the investigation of allegations of abuse of nursing home patients. When the Deputy Attorney General's Office was designated in 1978, pursuant to newly enacted federal legislation, as the Medicaid Fraud Control Unit for New York State, it became responsible for investigating allegations of abuse and neglect of patients in all residential health care facilities receiving payments under the state Medicaid plan (42 U.S.C. §1396b(q)(4)). On December 8, 1980, Attorney General Robert Abrams appointed Edward J. Kuriansky as the new Deputy Attorney General for Medicaid Fraud Control, succeeding Mr. Hynes, who had resigned to become New York City Fire Commissioner.

The patient abuse program in the Deputy Attorney General's Office focuses directly on the vital issues of patient care and treatment. The principal function of the Unit is to investigate and, when appropriate, to prosecute cases of assault, gross neglect, reckless endangerment and unsafe conditions which threaten the health of patients. In addition, the Unit refers appropriate cases to the Department of Health and the Department of Education for administrative action. Currently, in New York City, two attorneys and six investigators, two of whom are registered nurses, are assigned to the Patient Abuse Unit. In each of the other six regional offices of the Deputy Attorney General, located in Albany, Buffalo, Long Island, Rochester, Syracuse and Westchester-Rockland, at least one attorney and one investigator have primary responsibility for the investigation of allegations of abuse, neglect and mistreatment of patients and residents.

In addition to investigating allegations of abuse of individual patients, the Unit conducts special inquiries into general conditions affecting all patients. Two of these special inquiries concerned summer heat emergencies and resulted in reports recommending reforms in regulating the residential health care system.

Other activities of the Patient Abuse Unit include maintaining active liaison with state agencies and community groups interested in improving conditions in nursing homes, and participating in training ombudsmen and facility employees.

Based upon information obtained during the course of the Office's investigations, the Deputy Attorney General has urged various administrative and legislative changes to improve the delivery of patient care, including reform of nursing home regulations on both the state and federal levels. All of these activities will be more fully described in this report.

INDIVIDUAL INVESTIGATIONS

A review of patient abuse cases investigated from 1975 through 1980 indicates that the Patient Abuse Unit has dealt primarily with allegations within the following categories of abuse:

-- Deaths of patients under suspicious circumstances or circumstances indicating deficient care;

-- Assaults, including sexual abuse;

-- Rough treatment;

-- Unexplained physical injuries;

-- Facility conditions or staff neglect which endanger the health and safety of patients;

-- Deteriorated patient condition attributable to reckless treatment.

The Patient Abuse Unit has received complaints from various sources including victims, friends or relatives of victims, public officials, and facility employees. Since the enactment of the Patient Abuse Reporting Law (Public Health Law §2803-d) in 1977, the majority of cases investigated by the Unit have

been referred by the New York State Department of Health. [See pp. 10-14, infra]. The number of complaints investigated by the Patient Abuse Unit has increased from 143 in 1976 (the first full year of investigations) to over 300 in 1980. Two-thirds of the complaints involved patients in proprietary facilities. One-quarter of the complaints concerned patients in voluntary facilities. The remaining 8% of the cases concerned patients in public homes. [Appendix I, Table 1]

The largest category of complaints investigated by the Patient Abuse Unit concerned allegations of neglect. These allegations, which comprised 26% of the total number of complaints, concerned inadequate medical or custodial care (including inattentiveness, careless medication practices, and failure to treat decubitus ulcers) or other situations creating risks (such as leaving a weak, nonambulatory patient unattended on a toilet, bathing a patient with scalding water, or moving a patient in an unsafe manner).

Assault allegations represented 24% of all complaints investigated. These allegations concerned conduct such as slapping, kicking, pinching or hitting a patient; sexual abuse; or a physical invasion of a patient by a foreign object under the control of a staff person (including cases where feces had been placed in a patient's mouth and where a rubber glove had been tied around a patient's penis).

Eleven percent of complaints investigated involved unexplained physical injuries including bruises, lacerations, fractures, swellings or other similar injuries of unknown cause.

The fourth most prevalent type of complaint, accounting for 9% of the Unit's caseload, was rough treatment. These complaints alleged unnecessarily forceful treatment during the course of care, such as jerking the patient during transfer from wheelchair to bed or physical behavior which did not rise to the level of an assault, such as squirting water on a patient. [Appendix I, Tables 2 and 3]

With the implementation of the Patient Abuse Reporting Law in 1978, the number of complaints and referrals received by the Patient Abuse Unit increased dramatically. The Unit's paramount law enforcement responsibility, together with limited staff resources, necessitated a shift in emphasis in the type of complaints investigated to those cases having a potential for criminal prosecution. Thus, the Unit began referring cases of missing or wandering patients (which comprised 13% of its work in 1977) to the appropriate local police department. Verbal abuse allegations, which were 6% of the 1978 caseload, are currently referred to the Department of Health inasmuch as verbal abuse alone does not constitute a crime under the Penal Law. Similarly, complaints alleging failure to comply with nursing home regulations such as improper placement, poor food, dirty linens, or inadequate familial communication are now, barring exceptional circumstances, referred to the Department of Health. [Appendix I, Tables 2 and 3]

In 37% of all cases investigated, a specific person or target was alleged to have caused an injury or to have jeopardized the health and safety of a patient. The persons most

often accused of this abusive conduct were nurses' aides and orderlies. In complaints of assault where a target was identified, 62% were nurses' aides and 26% were orderlies. In cases of unexplained physical injuries where investigations eventually revealed a target, 79% of the targets were nurses' aides and 16% were orderlies. Where specific persons were alleged to have treated patients roughly, 66% were nurses' aides and 19% were orderlies. [Appendix I, Tables 4-6]

The Patient Abuse Unit closes the vast majority of cases investigated without taking prosecutive action. Investigations often reveal that there is insufficient evidence to meet the legal standard of proving beyond a reasonable doubt that a crime has been committed. In some cases, sufficient evidence cannot be adduced to charge a specific person with a specific crime. In others, the evidence may not spell out an injury as that term is defined by the Penal Law. Even where an abuser has been identified and an injury has been sustained, the criminal intent of the abuser cannot always be conclusively demonstrated.

Through December 1980, the Unit had prosecuted seven cases of assault and one case of endangering the welfare of an incompetent. Three defendants were convicted; three were acquitted after trial; and two cases were dismissed by the court.

Delays in the judicial process were a significant contributing factor in the acquittals and dismissals, as time took a harsh toll on the elderly and sick victim/witnesses in these

prosecutions. In one case, a licensed practical nurse allegedly whipped a seventy-seven year old nursing home resident across the back with a towel. At a lineup held at the nursing home shortly after the incident, the victim identified his assailant. However, when the trial was eventually held almost two years later, the judge dismissed the case because the victim was unable to correctly identify his assailant. The three cases resulting in acquittals involved similar problems. The trials were held approximately a year after the incidents. In each case, the victim was the only witness to the incident and was unable to correctly identify the attacker at trial. In addition, because of the length of time before trial, the quality of the victim's narrative had deteriorated. Details, such as time of day and clothing worn by the assailant, became less certain and the testimony of the victim was easily discredited.

In each of the cases where a conviction was obtained, there were other witnesses, generally facility employees, who observed the incidents. In two cases, the defendants pleaded guilty. In the third case, the trial was held within six months of the assault.

One hundred and fifty-two complaints investigated by the Deputy Attorney General were subsequently referred to other agencies [Appendix I, Table 7]. Administrative violations were referred to the New York State Department of Health for appropriate action. Where unprofessional conduct was suspected, the Deputy Attorney General referred cases to the New York State

Department of Education. Examples of cases referred to the Department of Education include:

-- Two licensed practical nurses were responsible for a patient's care; one during the evening shift, the other during the night shift. Although the patient had a history of heart trouble and had just returned to the home that very day from a hospital following treatment for a heart attack, neither nurse gave ordered medication to the patient because the medication had not been delivered. When the patient complained of chest pains, the night nurse did not contact the physician because she believed that the evening nurse had done so. The patient died at the nursing home the day following her return from the hospital.

-- A registered nurse failed to follow a physician's orders to apply a warm compress to a patient's ecchymotic area. Instead, she applied a "Kwik Heat" pack. She failed to consult the facility's manual which outlined the proper use of "Kwik Heat" and failed to observe the patient for possible adverse reactions. On the following morning the patient was discovered to have second degree burns on the treated area.

-- A licensed practical nurse was responsible for administering medication to forty patients. Between 8:15 a.m. and 8:55 a.m. she gave medication to thirty-four patients. However, she recorded only twenty-eight distributions and failed to administer medications at all to the remaining six patients for whom she was responsible. She allegedly stated that she did not administer the medications because they were "unimportant."

From 1978 through 1980, the Deputy Attorney General referred nine registered nurses and eleven licensed practical nurses to the Department of Education for a review of professional conduct. To date, the Department of Education has taken some disciplinary action in five of these cases and closed eight others without further action. Seven cases remain under active investigation.

The Impact of the Patient Abuse Reporting Statute

The Patient Abuse Reporting Statute (Public Health Law §2803-d) requires that incidents of physical abuse, neglect and mistreatment of patients in New York State long term care facilities be reported to the Department of Health. The law, in effect since September 1977, was designed to reveal instances of patient abuse which might otherwise have gone unreported or undetected. Amendments to the law became effective in September 1980.

There are several explanations for the frequent failure of patients to report abuse. A fundamental reason is the nature of the nursing home patient/employee relationship; namely, the nursing home patient depends totally on staff to respond to his or her basic needs. Patients and their families deeply fear retaliation and may endure abuse rather than risk the consequences, real or imagined, of reporting alleged mistreatment. The physical and mental condition of patients also contributes to the low rate of reporting. Many patients, afflicted with varying degrees of senility, are unaware that they have been abused. In one investigation, for example, an orderly stuck a patient's head with diaper pins. Fortunately, another employee reported the abuse, because the patient had been totally unaware of what had happened to him. Other patients do not report abuse because they are blind or deaf and unable to identify an abuser. In addition, the mechanics of reporting often prove too taxing for the patient. Few patients have telephones

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in their rooms; public telephones are located in hallways, affording only minimal privacy. A complaint by letter can be even more difficult for a patient who can no longer write or who fears interception of the letter.

Prior to the enactment of the statute, reporting by facility staff was also infrequent. In the two years and three months preceding the Patient Abuse Reporting Law, employees of nursing home facilities reported twenty-two cases to the Deputy Attorney General. Employee witnesses feared retaliation by accused co-workers. Many also believed that no corrective action would be taken, rendering their efforts futile.

Recognizing these problems, the Legislature imposed a legal duty on certain staff to report cases of suspected abuse. Although the reluctance to report may still exist, staff now face censure, suspension or revocation of their licenses for failure to report. Under the 1980 amendments to the reporting law, a staff member can also be fined up to $1,000 for not reporting.

Under the law passed in 1977, only licensed professionals in skilled nursing and health related facilities were required to report incidents of patient abuse. The 1980 amendments expanded the categories of persons who must report to include all residential health care facility personnel and the facility operator, as well as licensed personnel, whether or not they are employed by the facility. Thus, physicians, registered nurses, licensed practical nurses, certified social workers, administrators, as well as nurses' aides, orderlies,

housekeepers and clerks are now required to report suspected patient abuse.

Public Health Law Section 2803-d requires that a report be made whenever there is "reasonable cause to believe" that physical abuse, neglect or mistreatment has occurred. According to the regulations, "reasonable cause to believe" exists if, upon a review of the surrounding circumstances, a prudent person would form the opinion that an abuse has occurred.

The law presumes the good faith of a person filing a report and thus holds such a person immune from civil or criminal liability. In addition, under the 1980 amendments, a person who makes a complaint in good faith cannot be discharged from employment or otherwise harassed or discriminated against because of the report.

A Memorandum of Understanding provides for referrals by the Department of Health to the Deputy Attorney General's Office of all Section 2803-d complaints. Upon receipt of a complaint, the Department's Patient Advocate must immediately advise the Deputy Attorney General's Office, which in turn accepts all those referrals where it appears that a crime may have been committed.

Each allegation referred to the Deputy Attorney General's Office is also investigated by the Patient Advocate. This practice does not result in duplication of effort, however, because each agency has a distinct function to perform. The Department of Health is a regulatory agency which monitors and

enforces administrative regulations. It may pursue civil remedies against persons or facilities which fail to comply with required standards. However, the Department of Health has no criminal jurisdiction. In contrast, the Deputy Attorney General is charged under Executive Law Section 63(3) with the responsibility of investigating and prosecuting crimes committed in skilled nursing and health related facilities. Furthermore, the Deputy Attorney General is also responsible for conducting an overall inquiry under Executive Law Section 63(8) into the health, safety and welfare of patients at these facilities and reporting relevant findings to the Governor.

The Memorandum of Understanding also provides that if a particular complaint suggests the commission of a serious crime such as homicide or rape, the Department of Health will defer its investigation, if requested to do so by the Deputy Attorney General's Office, in order to prevent the inadvertent overlooking or loss of relevant evidence. Understandably, the Patient Advocate's health care professional may not necessarily be familiar with the type of, or proper method of obtaining, evidence essential to an effective criminal prosecution.

The increase in the number of cases reported since the advent of the Patient Abuse Reporting Law demonstrates the significance of the statute. In the two years and three months prior to its implementation, the Deputy Attorney General's Office investigated 293 complaints of patient abuse. Of those complaints, 126 were received from family and friends of patients, and ten were from the victims themselves. Facility

staff reported only twenty-two complaints. The remainder of the complaints were received from public officials, the Department of Health, the media and community groups. When the Memorandum of Understanding became operational in April 1978, the number of complaints rose sharply and the source of these complaints changed dramatically. [Appendix I, Tables 8 and 9] From April 1978 through December 1980, this Office investigated 811 complaints. The number of cases reported directly by friends and relatives fell off significantly while the Department of Health became the single greatest source of patient care complaints.

Public Health Law Section 2803-d has unquestionably helped expose incidents of abuse in skilled nursing and health related facilities. Reporting has increased substantially since its enactment. The network of those who report cases has expanded to include those who work with the institutionalized elderly on a daily basis. Moreover, the law has heightened the awareness of staff to the problem of abuse and increased their sensitivity to the needs of the elderly infirm. This has been accomplished through their participation in the investigation process and the training given to staff concerning the new law. Perhaps most importantly, these patient abuse investigations have permitted further identification and understanding of some of the causative factors and problems underlying nursing home abuse.

SPECIAL PROJECTS

Queens County Grand Jury Report

In June 1979, a Queens County Grand Jury, empaneled at the request of the Deputy Attorney General, reported on its exhaustive inquiry into the deaths of two patients and the emergency hospitalization of seventeen other patients of a Queens County nursing home during the heat wave of July 18-23, 1978.

According to the Grand Jury, patients of the facility were exposed to temperatures inside the building approaching 100° due to a breakdown of the air conditioning system, and the home's administrative, nursing and medical staff took no meaningful affirmative measures to protect patients from the dangers attributable to such extreme heat. The report cited the absence of trained staff, inadequate emergency guidelines, a failure of leadership and, in some instances, an inexplicable insensitivity to human suffering.

The Grand Jury recommended actions to prevent the occurrence of similar incidents in the future. It proposed that

additional staff be provided to assist in a heat emergency and that all staff be trained in heat emergency procedures. The Grand Jury urged that staff be required to sponge bathe patients, to force fluids, to remove unnecessary patient clothing and bedding, to ascertain potentially contraindicated medications, and to obtain new orders from attending physicians. It also advocated requiring notification of any such heat emergency to the Department of Health, attending physicians, affiliated hospitals, local emergency service agencies and next of kin.

The Grand Jury further recommended that the State Hospital Code be amended to require each facility to maintain either (1) a functioning backup, emergency air conditioning and heating system, or (2) a current written service contract for the repair and maintenance of the facility's air conditioning and heating systems.

In addition, the Grand Jury recommended the training and licensing of nurses' aides and orderlies, who were found to provide the most frequent "hands-on" care to the elderly patients.

Commenting on the Grand Jury's report shortly after its issuance, the Regional Director, Bureau of Health Standards and Quality, U.S. Department of Health, Education and Welfare, stated: "[T]he report has enormous professional and ethical implications for all, including regulatory agencies, who have responsibility for the health and safety of the extremely vulnerable and dependent patient population residing in long

term care facilities." He urged all administrators of long term care facilities to obtain the report, which he labeled "required reading for all key staff, including physicians," and to evaluate their facilities' capability for coping with such heat emergencies in light of the report's recommendations.

Workmen's Circle Report

A second report concerning the care, treatment and safety of patients during a heat wave was issued by the Deputy Attorney General in September 1980 pursuant to Executive Law Section 63(8). An in-depth study of the deaths of fifteen patients of the Workmen's Circle Home and Infirmary for the Aged in the Bronx concluded that there was insufficient evidence to prove criminal conduct during the heat wave of July 1980, but cited staff behavior which complicated patients' care and jeopardized their safety. In addition, the report noted that none of the recommendations made by the Queens County Grand Jury in June 1979 had yet been adopted by the State Hospital Review and Planning Council, the body within the Department of Health with authority to promulgate regulations governing residential health care facilities.

The Workmen's Circle Report reiterated many of the recommendations of the Queens County Grand Jury and urged reforms designed to prevent potential health disasters during future heat waves. The report recommended that a heat emergency should be specifically defined by temperature; that in the event of such a heat emergency, facility staff should be

required to notify the Department of Health, neighboring hospitals, attending physicians and patients' families; and that there should be adequate staff trained in implementing heat emergency health measures. The report set forth guidelines for ensuring proper temperature inside facilities. It proposed the formation of a Heat Emergency Task Force to monitor, inspect and certify compliance with existing guidelines and to require the transfer of patients to cooler facilities if necessary. The report also recommended an increase in basic diagnostic equipment necessary for performing routine chemistries, urinalyses and blood counts at all nursing homes.

It should be noted that the Department of Health issued a memorandum to all facilities on June 18, 1981 which reviewed state requirements and "generally accepted patient care practices" during a heat wave. It recommended many of the precautions and procedures outlined in the 1979 Queens County Grand Jury and 1980 Workmen's Circle Reports. However, these recommendations do not have the same force or effect, nor would they ensure the same degree of compliance, as would departmental regulations. Moreover, absent specific and binding regulations, it would be extremely difficult to sanction those facilities which fail to implement the recommendations contained in the memorandum. The heat disasters of 1978 and 1980 establish the need for specific, enforceable heat emergency regulations. The Deputy Attorney General urges that they be

promulgated before another long hot summer - with its potential for human tragedy - is once again upon us.

Inspection Program

Prior to September 1981, the Department of Health was required to conduct two inspections of every nursing home in the state each year, at least one of which had to be unannounced. Between 1975 and 1980, staff of the Deputy Attorney General's Office joined the Department in twenty-three rounds of unannounced inspections. Attempts were made to visit at least seven nursing homes throughout the state in each round, but a home's administration sometimes exercised its right to refuse to admit a team from the Deputy Attorney General's Office. When admitted, a team consisting of one attorney and one investigator accompanied the Department's surveyors to ensure that the homes were safe and clean, and that patients and residents were receiving appropriate care. The team focused on fire safety, food service, night coverage, medication practices, and staffing. Such unannounced inspections afforded a meaningful opportunity to make direct observations of conditions of patients and overall cleanliness, served a substantial deterrent purpose, and underscored this Office's continuing concern for patient care.

The benefits of the unannounced inspection process have been somewhat negated, however, by virtue of the fact that these yearly surveys are conducted at approximately the same time each year and therefore are not altogether unexpected by

the facilities. Thus, the predictability of these technically unannounced inspections limits their effectiveness in determining whether facilities are in compliance with state and federal regulations throughout the entire year.

In September 1981, the Legislature reduced the number of required inspections by the Department of Health from two to one per year. This change was necessitated by a reduction in federal reimbursement available for state inspection programs. The new statute does mandate, however, that the remaining inspection be unannounced, comprehensive and, if necessary, followed-up by further inspections to ensure compliance with applicable standards. In addition to this legislative change, the Department of Health, late in 1981, instituted a new survey program under which facilities review their own documents and procedures, and certify required information on report forms provided by the Department of Health prior to an on-site visit. This practice of requiring completion of the survey forms in advance alerts a facility that an inspection will soon be conducted. Thus, the new survey process continues to defeat one of the primary purposes of conducting unannounced, and presumably unpredictable, inspections, and runs contrary to another of the Queens County Grand Jury's recommendations, namely, that the "Department shall take all necessary precautions to insure the confidentiality of the inspection schedule."

Educational, Training and Community Liaison Programs

Members of the Patient Abuse Unit have participated in training sessions for various ombudsman programs. The New York State Office for the Aging conducts an intensive initial training session in order to provide ombudsman volunteers with the information and skills needed to carry out their functions. These sessions have been phased in throughout the state. As new volunteers are recruited, the training is repeated. Attorneys from the Deputy Attorney General's Office have taken part in training sessions conducted in New York City, Syracuse, Rochester, Kingston, Albany, Purchase, White Plains, Utica and Hauppauge. The attorneys discuss the types of complaints within the jurisdiction of the Deputy Attorney General's Office, how an investigation is conducted, and ways in which the ombudsmen and Patient Abuse Unit can work together to achieve their common objective of improved patient care in nursing homes.

In addition to working with the ombudsman programs, the Patient Abuse Unit has maintained active liaison during the past five years with numerous community groups committed to bettering the quality of long term care. Because members of these community organizations actually visit the facilities and patients on a regular basis, they have a unique view of daily conditions and problems. This perspective enables them to act as effective, indeed indispensable, advocates for patients' concerns, including those beyond the scope of criminal statutes and administrative regulation. The Deputy Attorney General

considers the input and contribution of these organizations invaluable in the struggle for quality care for our elderly citizens.

Attorneys from the Patient Abuse Unit have also addressed meetings of the American Arbitration Association and the New York City Chapter of the National Association of Social Workers. Training sessions have been conducted for representatives of the Patient Advocate's Office of the Department of Health and, perhaps most encouragingly, for employees of several New York City nursing homes.

In addition to the educational and training activities within New York State, the Patient Abuse Unit has been consulted by many other states engaged in the drafting of patient abuse reporting legislation as well as the creation and organization of patient abuse investigative units. The Deputy Attorney General's Office has also been invited to address two National Medicaid Fraud Control Unit training conferences, and has exchanged information with representatives of over twenty states regarding patient abuse investigatory tactics and techniques. Although the states vary widely in their approaches to ensuring proper patient care, these exchanges have proven to be a source of new insights into methods of eliminating abuse of the elderly infirm.

State Regulations

Because the quality of care provided to patients in long term care facilities is to a great degree determined by

standards set by state law and regulations, the Deputy Attorney General has consistently sought improvements in these laws and regulations in order to ensure the highest quality care.

The New York State Department of Health monitors residential health care facilities based on regulations promulgated by the State Hospital Review and Planning Council. Currently, two sets of regulations, or codes, are mandated by Public Health Law Section 2803(2)(c). The particular code followed is at the option of the facility. One set of regulations, known as the "Mini Code" (10 NYCRR §400 et seq.), contains the minimum standards necessary to qualify for federal reimbursement under the Medicare and Medicaid programs. The other set of regulations, known as the "Maxi Code" (10 NYCRR §700 et seq.), contains higher standards. As the system was originally conceived, a facility that adhered to the standards of the "Maxi Code" would receive a higher Medicaid reimbursement rate. However, since 1977, when there was an alteration in the state reimbursement formula, there has been no financial incentive to comply with the "Maxi Code" inasmuch as nursing homes receive the same reimbursement regardless of which code they follow. Thus, the only code that has been enforced since 1977 has been the "Mini Code."

In any event, both codes are markedly deficient in defining standards of adequate care and protection of patients of residential health care facilities, and many of the regulations in both codes are virtually unenforceable. The language is often vague and thus subject to varying interpretation. Words such

as "satisfactory," "sufficient," "appropriate" and "adequate" abound. For example, both Section 416.1(f)(1) and Section 731.1(f)(1) state that "the medical staff of a public or voluntary nursing home shall be sufficient to meet the needs of the patients" (emphasis added). Section 416.8(a) states "[t]he operator shall have satisfactory arrangements for: (1) identifying the patients' personal and social problems and needs which interfere with the use of medical care services or with recovery or rehabilitation" (emphasis added). In both codes, most regulations are prefaced with the words "the operator shall." Although the operator has the ultimate responsibility for compliance, the codes rarely require him to delegate these responsibilities to specific staff persons who can then be held accountable for failure to comply.

In 1977, a new code, known as the "New 700," was drafted by the Department of Health with input supplied by operators, consumer groups, the Deputy Attorney General and other governmental agencies. The new code revisions focus on four areas: patients' rights; medical services and the use of restraints; staffing; and enforcement and accountability.

In the area of patients' rights, the New 700 requires that facilities establish and publicize in-house grievance procedures and inform patients of complaint mechanisms. The Code protects and extends visitation rights. It prohibits discrimination in admission or retention of patients on the

bases of age, handicap, or source of payment.[1]

The New 700 requires that patients and their families be informed of the name, address and telephone number of attending physicians. It also establishes procedures for the use of both physical and chemical restraints, and specifically addresses such concerns as proper length and frequency of use.

The new code requires additional staffing for nursing, social work and leisure time activities. It extends the requirements of licensed nursing coverage in health related facilities from day shifts to all shifts, every day. It requires one full-time social worker for every 100 beds available for patients and an activities program seven days a week at all facilities.

The New 700 contains specific, enforceable language and ensures that administrators and other employees are accountable for compliance.

For over three years a coalition known as the Ad Hoc Coalition for a Single Standard Code has sought implementation of the New 700. This Coalition is comprised of over forty agencies and organizations throughout the state, including consumer

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1 On December 2, 1981, a New York County Grand Jury, empaneled at the request of the Deputy Attorney General, issued a report concerning the admission practices of certain voluntary nursing homes in New York State. The report revealed a pattern of solicitation of charitable contributions from prospective patients--many eligible for Medicaid--and their relatives at the time of their application for admission, and recommended certain legislative and administrative measures to curb this abuse.

groups, a professional association, a labor union, and public officials [Appendix II]. The Deputy Attorney General has served as an active consultant to the Coalition.

The Coalition has urged the Department of Health to implement the New 700. The Department has thus far declined to do so citing insufficient funds to reimburse facilities for Medicaid expenditures which would be incurred in meeting the new standards. The Coalition, with the support of the Deputy Attorney General, has therefore requested--unsuccessfully to date--that the Department implement at least those regulations in the New 700 which would not require additional reimbursement.

In addition, the Coalition has sought legislation amending the Public Health Law to require a higher quality single standard code. In 1980, the State Senate passed a bill which would have required a single standard code. However, a similar bill died in committee in the State Assembly because it failed to make clear that the future single standard code would be one which would actually improve the quality of care for residents and contained no guarantee that adequate funds would be available to pay the price for a higher quality code.

In 1981, Assembly Bill No. 8017 was introduced. This bill would mandate a single standard code for all residential health care facilities which is no less stringent than the current "Maxi Code," thus ensuring that whatever code is promulgated will contain higher standards than the currently operative "Mini Code." The Deputy Attorney General, writing in support of this proposal, observed that this "single Code would both

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facilitate compliance by the subject facilities and enhance the enforcement capability of the Office of Health Systems Management. Moreover, the institutionalized elderly in New York State surely deserve the protection and improved standard of care mandated by this bill."

This bill is still pending in the Legislature.

Federal Regulations

Federal regulations, known as Conditions of Participation, establish the minimum standards that states must adopt and that residential health care facilities must meet in order to be eligible for federal reimbursement under the Medicare and Medicaid programs. In New York these standards are currently contained in the "Mini Code" (10 NYCRR §400 et seq.), and they serve as a basis for federal and state agency survey and certification compliance review.

In 1980, the United States Department of Health and Human Services proposed a general revision of the Conditions of Participation. The drafters of the proposed regulations stated that their goals were to simplify and clarify the regulations, to focus on patient care, to promote cost containment while maintaining quality care, and to achieve more effective compliance. The proposed regulations offered notable improvements to the existing code and represented a necessary and promising step toward ensuring proper patient care. The Deputy Attorney General submitted detailed written comments regarding many of the proposals. In addition, a Patient Abuse Unit attorney

testified before a hearing of the Health Care Financing Administration, the division of the Department of Health and Human Services responsible for setting nursing home standards, and highlighted five areas warranting special attention:

First, the Deputy Attorney General strongly approved of the Condition making participation in the Medicare and Medicaid programs by residential health care facilities dependent upon the preservation of patients' rights. In so doing, the proposed regulations strengthened the enforcement mechanism for securing these rights, making them a verifiable part of the survey process.

Second, the Deputy Attorney General addressed the need for air conditioning in residential health care facilities. While the proposed Conditions of Participation require moderate temperatures to be maintained, this simply cannot be accomplished without the use of air conditioning from time to time. The cost of failing to maintain proper temperature is too great in human terms to justify the financial savings of not having air conditioning for patients, many of whom never go out-of-doors. The Deputy Attorney General recommended a phase-in period to minimize the financial burden on the Medicare and Medicaid programs. In addition to this recommendation, the Deputy Attorney General advocated mandating specific steps to be taken in the event of a heat emergency, as previously recommended in the Queens County Grand Jury and Workmen's Circle Reports.

Third, the Deputy Attorney General proposed that facilities be required to hire certified nurses' aides and orderlies as a Condition of Participation.

Fourth, the Deputy Attorney General recommended stringent restrictions on the use of patient restraints.

Finally, the Deputy Attorney General criticized the absence of any standards for terminating a provider from the Medicare and Medicaid programs. Presumably, not every violation of the Conditions of Participation is of sufficient gravity to warrant termination. However, the proposals left unclear which violations of the Conditions would lead to termination and which might be considered appropriate for less drastic remedial measures, thus raising the possibility of arbitrary application of these sanctions.

On January 19, 1981, the proposed federal changes were approved by the outgoing Secretary of Health and Human Services. On January 21, 1981, however, this approval was withdrawn pursuant to President Reagan's order mandating review of all federal regulations. The Health Care Financing Administration is currently conducting a review of all nursing home regulations with a view to reducing costs. As of December 1981, the Administration had not yet formally published its recommendations for regulatory change. It should be emphasized, however, that while cost containment and elimination of unnecessary regulations are unquestionably laudable goals, the findings of the Deputy Attorney General's patient abuse investigation over the past five years demonstrate unequivocally the

critical importance not only of preserving, but of strengthening, those regulations that directly impact on patient care and patients' rights. Any reduction of federal standards (and, particularly, of federal reimbursement) in these essential areas would only serve as a dangerously tempting precedent for financially strapped state governments and as an ominous signal to our vulnerable elderly of a possible return to the scandal-scarred, unenlightened days of the recent past.

PROPOSALS

Amendments to Public Health and Penal Laws

A. Obstacles to Prosecuting Patient Abuse Under Existing Statutes

The Patient Abuse Reporting Statute (Public Health Law §2803-d) was enacted to ensure that instances of patient abuse would be reported. Three years' experience with the law demonstrates that in fact there is a serious problem of nursing home patient abuse.[2] The Reporting Statute was a necessary first step. However, the inherent difficulties in prosecuting abuse cases vividly illustrate the need for criminal statutes aimed specifically at the abuse and mistreatment of the elderly and infirm.

The problems are illustrated in the following composite narrative which typifies cases that the Deputy Attorney General's Patient Abuse Unit has investigated:

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2 In 1980, the Department of Health sustained 45% of its 1,536 cases. New York State Department of Health, Fourth Annual Report to the Governor and the Legislature, Public Health Law §2803-d, March 15, 1981, p. 10.

> Mrs. Jones, an eighty-five year old wheelchair bound patient at the Rest Well Nursing Home, complained to a registered nurse (RN) at 9:00 a.m. that she was hit while getting dressed. Mrs. Jones believed that a nurses' aide hit her but was unsure if it was Mrs. Green or Mrs. Brown. She said that her roommate, Mrs. Smith, had seen the incident but that Mrs. Smith did not want to talk about it. Both Mrs. Green and Mrs. Brown denied that they hit the patient. Upon examination, the RN discovered no lacerations but did observe a reddened area with a slight swelling on the patient's right leg, just below the knee. Mrs. Jones complained that her leg hurt, but no pain medication was prescribed. X-rays revealed no internal injuries. Mrs. Jones's son urged his mother not to cooperate with the investigation.

Patients like Mrs. Jones are often no longer mentally alert and thus cannot meaningfully assist in an investigation. Such patients and their families frequently fear retaliation by staff members and often refuse to cooperate. Generally there are no other witnesses to an alleged incident. It is also emotionally upsetting for elderly and sick victims to talk about such matters. Finally, even if it can be documented that an incident has occurred and even if the victim is willing and able to testify and a suspect has been properly identified, the facts of a typical patient abuse case often do not fit within the narrow provisions of the existing New York State Penal Law.

The Penal Law requires that there be a physical injury in order to prosecute an assault. A physical injury is defined as an "impairment of physical condition or substantial pain" (Penal Law §10.00(9)). Under current judicial interpretation, a court might well not consider Mrs. Jones's injury to be an impairment of physical condition or substantial pain. This view is based on a 1980 New York State Court of Appeals

decision. While recognizing that pain is subjective, the Court of Appeals held in the case of Matter of Philip A., 49 N.Y.2d 198 (1980), that there is an objective level below which there can be no physical injury as a matter of law. The Court stated that "petty slaps, shoves, kicks, and the like, out of hostility, meanness, and similar motives" are not within the definition of a physical injury.

Lower court cases decided after Philip A. suggest that additional information about the circumstances surrounding the incident and the injury (particularly the victim's own perception of the injury) may permit such cases to go to a jury.[3] However, these decisions indicate that the victim must be able to effectively express the extent of the pain or impairment. To these courts, "substantial pain" has become articulated pain. In many of the cases that the Patient Abuse Unit has investigated, the elderly victims were, not surprisingly, unable or unwilling to express themselves.

The abuse most often reported to the Deputy Attorney General's Office technically falls within the Penal Law definition of harassment.

> A person is guilty of harassment, when, with intent to harass, annoy or alarm another person:
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> 1) He strikes, shoves, kicks or otherwise subjects him to physical contact, or attempts or threatens to do the same; . . .[4]

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3 See People v. Almonte, N.Y.L.J., February 25, 1980, p. 15, col. 2 (Sup.Ct., N.Y.Co.); People v. Moore, N.Y.L.J., April 14, 1980, p. 12, col. 5 (Sup.Ct., Queens Co.); People v. Gordon, N.Y.L.J., March 13, 1981, p. 5, col. 1 (App. Term 1st Dept.), leave to appeal denied, 53 N.Y.2d 842 (1981).

4 Penal Law §240.25.

Unlike assault, physical injury is not an element of harassment. However, harassment is not a crime, but merely a violation. The possible sanctions imposed for conviction of a violation range only from unconditional discharge to a maximum of fifteen days in jail. Moreover, an harassment conviction does not even result in a criminal record and is thus altogether unavailing as a means of tracking convicted patient abusers. Therefore, for most patients, the significant physical and emotional disruption associated with leaving a nursing home to appear in court militates against prosecuting such a minor harassment charge.

Cases involving neglect of patients rather than affirmative acts of physical abuse are also difficult to prosecute. Statutes which generally apply to neglect situations, such as endangering the welfare of an incompetent, reckless endangerment, and criminally negligent homicide, are seldom applicable in patient abuse matters. To date, the Deputy Attorney General's Office has been able to prosecute only one case of endangering the welfare of an incompetent person. This is due to the fact that the majority of patients in nursing homes, although physically frail and infirm, are not necessarily incompetent by reason of "mental disease or defect" as specified in the statute, and thus they are not protected by it.

Reckless endangerment is applicable to reckless conduct which creates a substantial risk of physical injury or a grave risk of death. To constitute recklessness, the actor must be

aware of and consciously disregard such risk and the conduct must be a gross deviation from the standard of care that a reasonable person would observe in the situation. Moreover, if the conduct involves an omission or failure to act (as is often the case in neglect situations), rather than an affirmative reckless act, a person may not be found guilty of reckless endangerment unless the law imposes a duty on him to perform the act which he failed to perform. Since current laws and regulations rarely assign responsibility to specific staff members, the elements of the crime of reckless endangerment can seldom be made out.

The crime of criminally negligent homicide presents equally insurmountable difficulties in prosecuting patient abuse matters. To prove this particular crime, the People must establish beyond a reasonable doubt that the defendant's criminally negligent conduct caused the victim's death. In cases involving sick and often debilitated elderly persons, it is usually impossible to establish conclusively that death was caused by negligence rather than by some other, natural cause. Even if causation can be proved, the People must also show that the defendant failed to perceive a substantial and unjustifiable risk that death would occur and that the failure to perceive it constituted a gross deviation from the standard of care that a reasonable person would observe in the situation. As with reckless endangerment, the evidence rarely satisfies this standard. In fact, the Deputy Attorney General's Office has never been able to bring a case of criminally negligent homicide.

As the foregoing review of current statutory provisions reveals, the New York State criminal law is simply inadequate in addressing the unique problem of abuse of nursing home patients.

B. Legislation Enacted in Other States

A number of our sister states have already devised criminal statutes to deal with the specialized problems of prosecuting patient abuse cases.

The Arkansas Legislature enacted a penal statute in 1977 governing "adult abuse."[5] The Legislature stated its intent as follows:

> The General Assembly recognizes that rehabilitative and ameliorative services are needed to provide for the detection and correction of the abuse, maltreatment, or exploitation of adults who are unable to protect themselves. Such abuse, maltreatment, or exploitation includes any willful or negligent acts which result in neglect, malnutrition, sexual abuse, unreasonable physical injury, material endangerment to mental health, unjust or improper use of an adult for one's own advantage, and failure to provide necessary treatment, attention, sustenance, clothing, shelter, or medical services.[6]

The statute provides for three gradations of the crime of abusing an adult. The most serious offense provides that "whoever, willfully or by culpable negligence, deprives an adult of, or allows an adult to be deprived of necessary food, clothing, shelter, or medical treatment, or who knowingly or by culpable

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5 Ark. Stat. Ann. §59-1301 et seq.

6 Ark. Stat. Ann. §59-1302.

negligence permits the physical or mental health of the adult to be materially endangered, and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to such adult," shall be guilty of a felony.[7] The two other gradations of abuse constitute misdemeanors.[8]

The Arkansas provisions apply to "developmentally disabled adults"[9] and to those adults suffering from the "infirmities of aging."[10] Abuse and maltreatment are defined under the statute to include conduct resulting in malnutrition, physical assault or battery, physical or psychological injury inflicted by other than accidental means, and failure to provide necessary treatment, rehabilitation, care, sustenance, clothing,

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7 Ark. Stat. Ann. §59-1303(1).

8 "Whoever willfully or by culpable neglect, deprives an adult of, or who allows an adult to be deprived of necessary food, clothing, shelter, or medical treatment, or who knowingly or by culpable negligence permits the physical or mental health of an adult to be materially endangered, shall be guilty of a Class B misdemeanor. . . ." Ark. Stat. Ann. §59-1303(2).

"Whoever negligently deprives an adult, or allows an adult to be deprived of, necessary food or shelter or medical treatment, is guilty of a Class C misdemeanor. . . ." Ark. Stat. Ann. §59-1303(3).

9 "Developmentally disabled adult" is defined as "an adult having a disability attributable to mental retardation, cerebral palsy, epilepsy, or other neurological condition related to mental retardation or requiring treatment similar to that required for mentally retarded individuals, which has continued or can be expected to continue indefinitely, and substantially prevents the individual from adequately providing for his own care and protection." Ark. Stat. Ann. §59-1301(1).

10 "Infirmities of aging" is defined as "chronic brain damage caused by advancing age or other physical deterioration to the extent that the person is substantially impaired in his ability to adequately provide for his own care and protection." Ark. Stat. Ann. §59-1301(2).

shelter, supervision or medical services.[11]

South Carolina has also enacted a statute to prohibit the abuse, neglect and exploitation of certain classes of dependent persons:

> It shall be unlawful for any person to abuse, neglect or exploit any senile, mentally ill, developmentally disabled or mentally retarded person or any person who is incapable of caring for or managing his own affairs. This shall not apply to altercations or acts of assault between persons protected by this section.[12]

There have already been several convictions for abuse and neglect of patients in nursing homes under this two-year-old statute, which provides penalties of up to $5,000 and five years in prison.

The Minnesota Legislature has adopted a similar statute directed specifically at patient and resident mistreatment:

> Whoever, being in charge of or employed in any facility required to be licensed under the provisions of sections 144.50 to 144.58, or section 144A.02, intentionally abuses, ill-treats, or culpably neglects any patient or resident therein to his physical detriment may be sentenced to imprisonment for not more than one year or to payment of a fine of not more than $1,000, or both.[13]

To date, there have been two convictions under this statute: one involving employees of a hospital for severely retarded adults, and the other involving an orderly at a nursing home. In both instances, the Attorney General encountered the traditional difficulties associated with prosecuting patient abuse cases. The actual victims of abuse could not testify because

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11 Ark. Stat. Ann. §59-1301(4).

12 S.C. Code §43-29-40.

13 Minn. Stat. §609.231.

of advanced senility. The events in issue were dated because employees who had seen the acts of abuse had been initially reluctant to come forward. In addition, although the accused employees admitted having hit and kicked the residents, they claimed that the residents required firm treatment because they had been unruly or difficult. Furthermore, the defendants asserted that they had not been trained to handle residents who became obstreperous and argued that the amount of force used in the situation did not amount to abuse. Moreover, the language of the statute leaves the meaning of the term "abuse" ambiguous, thereby presenting yet another obstacle to the prosecution. Nevertheless, the Attorney General was able to obtain guilty pleas under this statute in each instance.

Arizona has devised a markedly different statutory scheme which attempts to define, objectively and specifically, certain types of prohibited conduct. Although the statute only applies to the abusive treatment of mentally retarded persons, the approach might well be adapted to protect residents of health and adult care facilities as well:

> A. Improper, abusive treatment or neglect of a mentally retarded person is prohibited. For the purposes of this section:
>
> 1. "Abusive treatment" means:
>
> (a) Physical abuse by inflicting pain or injury to a client. This includes hitting, kicking, pinching, slapping, pulling hair or any sexual abuses.
>
> (b) Emotional abuse which includes ridiculing or demeaning a client, making derogatory remarks to a client or cursing directed toward a client.
>
> (c) Programmatic abuse which is the use of an aversive stimuli

technique that has not been approved as a part of such person's individual program plan and which is not contained in the rules and regulations adopted pursuant to sub-section B of §36-561. This includes isolation or restraint of a client.

2. "Neglect" means:
(a) Intentional lack of attention to physical needs of clients such as toileting, bathing, meals and safety.
(b) Intentional failure to report client health problems or changes in health condition to immediate supervisor or nurse.
(c) Sleeping on duty or abandoning work station.
(d) Intentional failure to carry out a prescribed treatment plan for a client.

B. A person who violates any provision of this section is guilty of a class 2 misdemeanor.[14]

In July 1980, the Massachusetts Legislature enacted a patient abuse reporting law similar to the one in effect in New York. However, unlike New York, Massachusetts has taken the necessary next step and also made it a criminal offense to abuse, mistreat or neglect[15] a long term care patient. The

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14 Ariz. Rev. Stat. §35-569.

15 Mass. Gen. Laws c.111 §72F defines abuse, mistreatment and neglect as follows:
"Abuse" is defined as "physical contact which harms or is likely to harm the patient or resident."
"Mistreatment" is defined as "use of medications, isolation, or use of physical or chemical restraints which harms or is likely to harm the patient or resident."
"Neglect" is defined as "the failure to provide treatment and services necessary to maintain the health and safety of the patient or resident, provided, however, no person shall be considered to be neglected for the sole reason that he relies or is being furnished treatment in accordance with the tenets and teachings of a well-recognized church or denomination by a duly accredited practitioner thereof."

statute provides:

> Any person who knowingly and wilfully abuses, mistreats, or neglects a patient or resident of a long-term care facility required to be licensed under section seventy-one of chapter one hundred and eleven, shall be punished by imprisonment in a jail or house of correction for not more than two years or by a fine of not more than five thousand dollars, or by both such fine and imprisonment.[16]

In the short time since its enactment the Massachusetts Attorney General has already initiated six prosecutions under this section.

C. Deputy Attorney General's Proposal

Several New York cases investigated by the Patient Abuse Unit might well have been successfully prosecuted if a Massachusetts-type statute, which does not require physical injury or substantial pain as an element of the crime, had been in effect. For example, in 1978 a patient was allegedly punched in the stomach by a nurses' aide. There were no bruises, and the patient refused to talk about the incident. However, a licensed practical nurse (LPN) at the facility had observed the incident, and could have supplied the testimony necessary to prosecute the aide. In another incident, a nurses' aide allegedly hit a patient in the face twice with a towel after observing a bowel movement in the patient's bed. Again, there were no injuries, but the incident was observed by another nurses' aide. In still another case, a ninety-four year old patient was allegedly hit by an aide with a sheet, struck in

16 Mass. Gen. Laws c.265 §38.

the forearm and kicked in the shins. Although the patient sustained a bruise on her left shin and several marks or bruises on her arm, she was incompetent to testify. Once again, however, another aide had witnessed the incident and could have provided the necessary testimony under a statute like Massachusetts's which does not require the victim to articulate substantial pain.

After reviewing the law and the experiences of other states and analyzing the special problems encountered in the cases investigated by the Patient Abuse Unit in recent years, the Deputy Attorney General has drafted two proposed amendments, one to the Public Health Law and one to the Penal Law, which would make certain abusive or neglectful conduct a criminal offense. The suggested amendment to Public Health Law Section 2803-d would, as in Massachusetts, add a criminal penalty to the existing law requiring the reporting of patient abuse. Under this amendment, the Deputy Attorney General proposes that a person who commits an intentional act of patient abuse or mistreatment, including those so defined by the Commissioner,[17] shall be guilty of a misdemeanor. In addition, it

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17 10 NYCRR §81.1(a) defines "abuse" as "inappropriate physical contact with a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility, which harms or is likely to harm the patient or resident. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving, bumping, and sexual molestation."

10 NYCRR §81.1(b) defines "mistreatment" as "inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on or of a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility."

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is proposed that Penal Law Section 260.25 (currently, Endangering the Welfare of an Incompetent Person) be amended by enlarging the protected class to include not only incompetent persons but residents of nursing homes and similar facilities as well. Such an amendment would greatly facilitate the prosecution of neglectful conduct directed at those individuals unable to care for themselves.

These amendments are proposed in recognition of the fact that patient abuse is a unique problem which has all too frequently eluded traditional methods of prosecution. Abusive conduct that is ordinarily not criminal must be treated differently when it is visited upon the sick and elderly by the very persons on whom they depend for all or most of their daily needs. Since almost the turn of the century, this state has shown an historic concern for the health and well-being of its helpless citizens. Criminal statutes have long existed to protect the physical, mental and moral welfare of both children and the mentally disabled.[18] It is now time to extend the same solicitude to our elderly infirm who are equally unable to care for themselves and equally vulnerable to abuse.

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18 See, for example, Penal Law §§260.10, 260.25

The Deputy Attorney General's Proposed
Criminal Statutes Relating to Patient Abuse

AN ACT to amend the penal law and the public health law in relation to abuse, mistreatment and neglect of patients in long term care facilities

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 260.25 of the penal law is hereby amended to read as follows:

§260.25 Endangering the welfare of an incompetent or infirm person.

A person is guilty of endangering the welfare of an incompetent or infirm person when he knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person who is unable to care for himself because of mental disease or defect, physical disability, or because his care has been entrusted to a nursing home, health related facility, adult care facility, or a like institution.

Section 2. Subdivision 7 of section 2803-d of the public health law is hereby amended to read as follows:

7. In addition to any other penalties prescribed by law, (i) any person who commits an act of physical abuse, neglect or mistreatment, or who fails to report such an act as provided in this section, shall be deemed to have violated this section and shall be liable for a penalty pursuant to section twelve of this chapter after an opportunity to be heard pursuant to this section; and (ii) any person who intentionally commits an act of physical abuse or mistreatment, including an act so defined by the commissioner, shall be guilty of a misdemeanor.

EXPLANATION-Matter in italics (underscored) is new.

Certification and Training of Nurses' Aides and Orderlies

As much as eighty to ninety percent of the direct hands-on care provided to residents of long term care facilities is given by nurses' aides and orderlies.[19] These noncertified personnel feed, bathe, dress and move patients. As a result, the quality of life in long term care facilities is in large measure determined by the competence and attitudes of the aides and orderlies. Notwithstanding their critical responsibilities, there are currently no meaningful requirements that these employees be trained in basic geriatric care.

The investigations conducted by the Deputy Attorney General indicate that aides and orderlies are involved in most incidents of abuse of patients. Aides or orderlies were accused in 88% of the assault cases, in 85% of the rough treatment cases and in 95% of the unexplained injury cases with identified targets.[20] In addition, aides and orderlies were frequently accused of negligence, many of the complaints alleging that they were unresponsive and inattentive to patients' needs. A common complaint has been inadequate incontinent care resulting in exacerbation of decubitus ulcers.

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19 Subcommittee on Long-Term Care of the Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy; Suppporting Paper No. 4, Nurses in nursing homes: the heavy burden (the reliance on untrained and unlicensed personnel), S. Rep. No. 355, 94th Cong., 1st Sess. 392 (1975).

20 In 77% of assault complaints and in 83% of rough treatment complaints there was an accused abuser. However, in only 13% of the unexplained injury complaints could a specific target be identified. [Appendix I, Table 4]

Caring for the elderly and infirm presents unique problems. The patients in nursing homes may be incontinent, nonambulatory or unable to control the movements of their limbs; some are totally dependent on facility staff for their care. In addition, patients are often senile, depressed and/or hostile. These special patient care difficulties, prevalent in a nursing home setting, strongly suggest the need for training, state certification and ongoing in-service education of aides and orderlies.

New York State should require nurses' aides and orderlies to complete a prescribed course of training in the care of the elderly and infirm. The state should certify those who successfully complete such a program and should mandate that licensed facilities be permitted to hire only these certified employees.

Several states have enacted certification statutes.[21] For example, Kansas currently requires a ninety-hour certification course for nurses' aides [Appendix III]. A follow-up Task Force in that state recommended that this course be completed within one year of initial employment. It also proposed a forty-hour basic skills training program within seven days of employment [see Appendix IV for proposed curriculum], pre-employment training sessions and continuing in-service education.[22]

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21 K.S.A. §39-936; Cal. Health & Safety Code §§1337-1338.3; Mich. Comp. Laws §333.21795; Minn. Stat. §144A.61.

22 Report of the Task Force on Comprehensive Recruitment and Employment Training For Adult Care Home Aides, as directed by the Kansas Senate Concurrent Resolution 1637, December 1980.

Management and labor in the New York nursing home industry have recognized in-service training as a means of improving the quality of job performance. Some in-service training is regularly conducted. However, the regulations of the Department of Health are not specific with respect to either the amount or substance of in-service training.[23] The Department of Health should adopt minimum and explicit standards for in-service training of aides and orderlies.

In many of the cases investigated by the Patient Abuse Unit, abusive aides and orderlies were subsequently suspended by the facilities; in some cases, they were even dismissed. Nevertheless, this Office has documented cases where aides or orderlies who had been dismissed for abusive conduct at one facility were thereafter hired by another home only to have similar patient abuse complaints lodged against them. For example, one orderly suspected of causing bruises to patients at a nursing home in the Albany region had been previously employed at three other homes in the area, one of which dismissed him twice for threats to the nursing staff and for suspected patient abuse. The individual omitted his past employment record on his application to this latest home and, because he had once worked there briefly, he was hired again after only a limited review of his application. Despite the fact that suspicions circulated about his treatment of patients at the home, that the staff thought him verbally abusive and short-tempered, and that the facility confirmed that he had

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23 See, 10 NYCRR §414.15(a).

lied about his previous employment, the individual remained employed. Decertification would not only provide a mechanism for removing aides and orderlies who are unsuited for direct patient care, but would establish a procedure for tracking and preventing the re-employment of such abusive employees at the same or other facilities.

Accordingly, the Deputy Attorney General believes that the adoption of a coordinated and detailed program of training and certification is essential to ensure (1) that nurses' aides and orderlies have sufficient grounding in the basic skills of caring for the ill and aging, and (2) that there is an effective means of removing and tracking those abusive aides and orderlies ill-suited for the delivery of direct patient care.

Suicide

The Patient Abuse Unit investigates all reports of patient suicides. These investigations do not duplicate police efforts, which concentrate primarily on determining the cause of death. Instead, if a death has been ruled a suicide by the medical examiner, the Deputy Attorney General will attempt to determine whether facility staff were aware of the patient's suicidal tendencies, and, if so, what actions were taken to prevent the suicide. In some cases investigated by the Patient Abuse Unit, patients expressed suicidal ideation prior to the actual occurrence. The Deputy Attorney General therefore

recommends a regulation requiring facility staff to promptly report suicidal ideation, gestures and attempts to the administrator of the facility, who, upon receiving such information, should be required to arrange a psychiatric consultation for the distressed patient.

The Deputy Attorney General has also observed that classic indicators have invariably preceded nursing home suicides. These indicators include permanent impairment of physical condition, separation from or loss of a spouse, initial inability to adjust to an unfamiliar setting, and an abrupt disappointment in familial relations. These indicators have often been ignored or disregarded. The Deputy Attorney General believes that facility staff should be trained to recognize these suicidal indicators and be required to carefully monitor residents when such early warning signs are present.

Fire Safety

To date, New York State has been fortunate in not experiencing a major fire disaster, resulting in multiple deaths or injuries, in any of its long term care facilities. However, the deaths by fire of at least four New York City nursing facility residents within the last two years suggest a need for additional fire safety measures.

-- In November 1979, at 12:30 p.m., while apparently trying to light or smoke a cigarette in a bathroom in a Queens nursing home, a patient set his clothes on fire. A secretary at the facility smelled smoke and looked in the direction of the patient's

toilet. The secretary then ran to the bathroom door with a nurses' aide. When the aide pulled open the door, smoke billowed out thereby activating a smoke alarm in the facility. By the time the fire was extinguished the patient had suffered second and third degree burns over 30% of his body. He died as a result of these burns.

-- In January 1980, while attempting to light a cigarette in a bathroom at 11:30 p.m. in a Bronx nursing home, a patient set fire to her nightgown. While making rounds, a nurses' aide smelled something burning but could not determine where the smell was coming from. When the aide approached the patient's room she heard a crackling sound. It was only after the toilet door was opened that a fire alarm was activated. The burns caused the patient's death.

-- In December 1980, a patient at a nursing home in Manhattan was found ablaze in his room. Apparently, he had been smoking. He was taken to the Burn Unit of New York Hospital with third degree burns over 60% of his body. He died at the hospital. In addition, four employees at the facility suffered smoke inhalation when they tried to combat the fire. Two of the employees required treatment at Bellevue Hospital.

-- In January 1981, a Brooklyn health related facility patient was severely burned in his room. He was reported to be a smoker who required supervision. As a result of his burns, he was transferred to Kings County Hospital where he died.

In recent years, the Deputy Attorney General has frequently urged an increase in fire safety protection measures. Letters advocating installation of additional smoke detectors have been sent to nursing home associations and to the New York State Department of Health. In a letter to the Deputy Attorney General's Office in August 1980, the Deputy Director for Health Facilities Standards and Control for the Department of Health responded, "Installation of smoke detectors in all areas may

help in early detection of fire and thereby reduce the extent of injury or perhaps death, but this is not a certainty. . . . We will continue to exercise our surveillance responsibilities to the best of our ability, but we feel that requiring installation of additional smoke detectors would not necessarily be effective and would result in a significant cost."

Smoke detectors may indeed "reduce the extent of injury or perhaps death" of nursing home patients. In New York City, in fact, smoke detectors are presently required in every multiple dwelling apartment, and hotel room,[24] as well as in all patients' rooms in nursing homes built after 1968.[25] Our elderly nursing home residents are certainly entitled to the same degree of protection afforded every tourist vacationing in a Manhattan hotel. Accordingly, the Deputy Attorney General urges that smoke detectors be made mandatory in every patient's room in all New York State residential health care facilities.

In 1981, the New York State Legislature enacted a bill embodying the recommendations of the Special Fire Safety Task Force which was convened by the Governor in the aftermath of recent tragic fires in New York State and elsewhere. The new law requires, among other things, the development of a uniform state fire prevention and building code to take effect on

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24 Admin. Code of the City of N.Y. §C26-1705.0 (1981) (effective Jan. 1, 1982).

25 Id. §C26-1703.1 (1968).

January 1, 1984. It also provides for the establishment of a seventeen-member council to formulate the new uniform code.

The fire-related deaths investigated by this Office,[26] as well as the catastrophic and highly publicized fires which have occurred with alarming regularity in nursing homes throughout the country in recent months, graphically illustrate the need for strict fire protection measures for residential health care facilities. The sick and elderly of New York State who live in nursing homes, their families, and the employees of these facilities deserve the mental comfort and physical protection that additional fire safety measures would bring. New York should lead the way, as it so often has in health care matters, in addressing this vital area of concern to our elderly institutionalized citizens. Accordingly, the Deputy Attorney General urges the council to give particular consideration to the special hazards confronting infirm and often nonambulatory patients when formulating statewide fire safety standards applicable to nursing homes.

Restraints

The Patient Abuse Unit has investigated twenty-eight cases involving the misuse of restraints in residential health care facilities. Descriptions of two such cases which resulted in patients' deaths follow:

-- In April 1979, a female patient in a Rensselaer nursing home was restrained

26 New York City Fire Department statistics indicate that in 1980 alone there were 521 hospital and nursing home fires in New York City resulting in 6 deaths.

in a wheelchair with a posey vest. She died of strangulation when she slid down in the chair to a point where her neck was caught on the vest.

-- In August 1979, a female patient in a Schenectady facility had a bedsheet tied around her waist. Left unattended in a wheelchair, she slid down in the chair and the sheet caught her throat. She was unable to call for assistance, and when finally discovered in this position, she was comatose. She died fifteen days later.

Following these deaths the Deputy Attorney General wrote to the Department of Health to urge that the use of bedsheets be prohibited as restraints for patients sitting in chairs, and further recommended that multiple restraints should be used where chest or waist restraints are ordered for seated patients. The latter would require application of a second strap passing between the patients' legs and secured to the seat of the chair. Current regulations concerning restraints are unduly vague, and do not include essential patient protections.[27]

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27 10 NYCRR §416.11 provides:

Patient restraint. The operator shall establish written policies and procedures acceptable to the commissioner, for the use of restraints to prevent injury to the patient or others, which shall, as a minimum:

(a) Prohibit the use of locked restraints.

(b) Require that a device used to restrain a patient shall be utilized only when authorized in writing by a physician for a specified and limited period of time, except when necessitated by an emergency, approved by the medical director, director of nursing service or in the absence of such individual, a designated licensed nurse or administrator and applied by a licensed nurse who shall set forth, in writing, as a part of the patient record, the circumstances requiring the use of such emergency restraint.

(c) Require that, in addition to the requirements of section 416.10 of this Part, there be consultation with the physician within 24 hours of the emergency administration of a chemical restraint and that such restraint be administered by a licensed nurse.

The Department of Health circulated proposals governing the use of restraints in residential health care facilities in July 1980. On August 1, 1980, the Deputy Attorney General recommended the following amendments to the restraints proposals: (1) that a physician's written order for restraints specify not only the length of time but also the frequency and time of day that the restraints are to be applied; (2) that restraint orders be reviewed monthly rather than annually; (3) that the proposals require a change of position, motion or exercise when restraints are applied; (4) that restrained patients be monitored on a regular and scheduled basis; and (5) that restraints not be used as a substitute for patient care, as punishment, or for the mere convenience of the staff.

The Department of Health's proposed revisions have not to date been formally adopted. Therefore, the Deputy Attorney General urges that new regulations governing the use of restraints and incorporating the aforementioned protections be promptly promulgated.

Guardrails

The Deputy Attorney General has investigated 137 cases of unexplained bruises found on patients. Most of these bruises have appeared on the patients' extremities and were discovered when the patients were in bed. Facility staff members generally discount assault as a cause of these injuries. Instead, the most frequent explanation given for such bruises is self-infliction. Aides report histories of patients flailing

about; medical personnel note fragile skin susceptible to easy bruising.

Most of the bruised patients sleep in beds with metal guardrails which frequently lack any protective padding. The Deputy Attorney General recommends that a regulation be promulgated making specific personnel responsible for padding beds of patients who are known to flail their arms and legs against guardrails and thereby cause injury to themselves.

Medical Care

The Deputy Attorney General has also had occasion to inquire into and report on the quality of care provided by physicians at residential health care facilities. For example, the Workmen's Circle Report observed:

> During the heat wave medical practice at the facility was, at times, confused and erratic. One physician, who had practiced medicine for 30 years, was on duty on July 20th from 8:00 a.m. to 4:00 p.m. He stated that the facility was extremely hot and "unbearable." He was "miserable walking in the corridors." This physician did not come to work on July 21st because of predictions that the temperature would be over 100° and he could not tolerate the heat. A second physician who has been attending at the facility for ten years is not licensed to practice medicine in the State of New York. He practices at the facility pursuant to an arrangement whereby the Medical Director of the facility must countersign each of his orders. This physician allegedly told a third physician who was working for the first time at the facility during the night shift of July 21st-July 22nd that only patients with temperatures of 105° should be transferred from the facility to a hospital. 105° is one degree higher than the actual transfer temperature established by the Medical Director in a directive posted at nursing stations. The third physician stated that his tour of duty was "extremely busy." He was unaware that one patient's condition had become critical at

> 11:00 p.m. on July 21st. He pronounced the patient dead at 2:50 a.m. on July 22nd. When asked whether the heat had any effect on the patient's demise, the physician responded that he did not know; his field was obstetrics and gynecology.

The Deputy Attorney General has investigated other cases where the quality of emergency medical care, while not criminal, was subject to question. In one case, a patient was discovered unconscious in her bathroom at 6:45 a.m. with a pair of sewing scissors embedded in her throat. The scissors were removed and the patient was revived. The physician who assumed responsibility for the patient's care at 8:00 a.m. did not see her until fifty minutes later. At that time he listened to the patient's lungs for the first and only time. He failed to compare the lung sounds over a period of time to detect possible changes in her condition. At 10:15 a.m. the patient died as a result of an internal hemorrhage. The medical examiner found 1500 cc. of blood in one of her lungs and concluded that the blood had accumulated in the lung because of the wound in her jugular and subclavian veins caused by the scissors.

Other cases investigated by the Deputy Attorney General have reflected delays in transferring patients to hospitals when they have suffered broken bones, renal failure or insulin shock. In such instances, physicians and administrators have generally blamed one another and the Emergency Medical Service.

Furthermore, medical emergencies are not always obvious, and a lack of basic diagnostic equipment in some facilities often forces physicians to make difficult medical choices.

When a physician sends specimens to outside laboratories for analysis, he must either wait the hours or days necessary for the return of a lab report before treating a patient, begin treating the patient prior to receiving the report, or transfer the patient to an acute care facility for more immediate, but perhaps unnecessary and expensive, analysis. Thus, the Deputy Attorney General proposes, as was earlier recommended in the Workmen's Circle Report, that all skilled nursing facilities be required to maintain certain minimal diagnostic equipment on the premises capable of performing routine chemistries, urinalyses and blood counts.

The Unit's investigations of alleged neglect by physicians and nursing staff not only underscore the necessity for improved acute care but strongly indicate the need for better care plans to deal with patients' chronic health problems as well. The Deputy Attorney General therefore enthusiastically supports a report of the New York State Health Planning Commission which urges the State Education Department to review current professional training requirements and make whatever revisions are necessary to assure that adequate emphasis is given, in both curriculum and licensing examinations, to subject areas such as the aging process, the effects of aging, and the problems of the elderly and chronically impaired.[28]

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28 Subcommittee on Staff Resources and Training, Long Term Care Policy Committee, New York State Health Planning Commission, Education and Training of Long Term Caregivers, pp.11, 17, (September 1981).

CONCLUSION

This report has documented the activity and findings of the patient abuse program in the Deputy Attorney General's Office over the past five years. This program, which is unique in character and scope among the thirty state Medicaid Fraud Control Units throughout the country, is designed primarily to investigate and, when appropriate, to prosecute cases of assault, reckless endangerment, gross neglect, and unsafe conditions which threaten the health and well-being of nursing home patients. Moreover, uncovering evidence of patient abuse often complements the Office's other predominant mission, namely, the prosecution of Medicaid fraud and other financial wrongdoing, because poor patient care and deplorable conditions are the not uncommon consequence of operators' greed. Perhaps more importantly, however, nursing home patients and their friends and relatives have frequently reported that the very presence of this highly trained and responsive prosecutorial Unit serves as a source of solace to those elderly New Yorkers it seeks to protect and as a stern deterrent to those who would

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abuse them. And finally, the program is deeply committed to discovering, and educating the public about, the underlying causes of patient abuse, and then to proposing appropriate preventive and remedial measures.

The recommendations contained in this report are the result of a thorough review of current laws and regulations and their effect on both prosecuting and preventing nursing home abuse. The proposed amendments to the public health law and penal law recognize the undeniable trauma of abuse and the demonstrated problems inherent in prosecuting crimes committed against the old and infirm. The overwhelming percentage of abuse and neglect cases involving nurses' aides and orderlies strongly indicates the need for stricter training and certification requirements for these employees who deliver the vast majority of direct patient care. The proposed regulations concerning heat emergencies, suicide, fire safety, restraints, guardrails and medical care result directly from a detailed analysis of the findings of actual investigations and the poignant lessons to be learned therefrom.

During the past five years the Deputy Attorney General's Office has examined over 1100 cases of nursing home patient abuse and neglect. With these investigations still continuing at the rate of 300 per year, it is clear that more can yet be done to ensure that the sick and elderly who reside in New York's residential health care facilities remain free from physical, mental and emotional abuse. And, as this report demonstrates, the laws and regulations of this state can, and

should, be strengthened to further guarantee these vulnerable individuals the care, treatment and protection they so richly deserve.

Some years ago, the French writer Simone de Beauvoir was prompted to observe, astutely and not without a certain degree of cynicism: "By the way in which a society behaves toward its old people, it uncovers the naked, and often carefully hidden truths about its real principles and aims." The generosity and swiftness of our response today to the fundamental needs of thousands of our dependent fellow citizens will surely be the measure by which future generations judge us.

APPENDICES & GLOSSARY

Appendix I

Table 1

Distribution of Cases by Type of Ownership

May 1975 - December 1980

	Total	%
Proprietary	780	67%
Voluntary	294	25%
Public	98	8%
Total	1172	100%

Table 2

Types of Complaints Investigated Each Year*

January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Assault	12	24	85	82	104	307
Unexplained Injuries	10	11	39	45	32	137
Rough Treatment	5	6	40	35	32	118
Negligence	51	65	67	85	62	330
Verbal Abuse	2	5	20	5	3	35
Isolation or Improper Restraints	4	3	7	8	6	28
Suicide or Patient Death	8	5	11	7	15	46
Unsafe Conditions	3	3	22	2	24	54
Missing or Wandering Patient	12	23	3	0	1	39
Patient to Patient or Visitor to Patient Abuse	3	4	2	9	18	36
Failure to Comply With Regulations	13	19	19	20	9	80
Individual Financial Irregularities	8	3	1	4	2	18
Other	12	13	11	9	7	52
Total	143	184	327	311	315	1280

*Each case could involve more than one type of complaint.

Table 3

Types of Complaints Investigated Each Year By Percentage*

January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Assault	8%	13%	26%	26%	33%	24%
Unexplained Injuries	7%	6%	12%	14%	10%	11%
Rough Treatment	3%	3%	12%	11%	10%	9%
Negligence	36%	35%	20%	27%	20%	26%
Verbal Abuse	1%	3%	6%	2%	1%	3%
Isolation or Improper Restraints	3%	2%	2%	3%	2%	2%
Suicide or Patient Death	6%	3%	3%	2%	5%	4%
Unsafe Conditions	2%	2%	7%	0	8%	4%
Missing or Wandering Patient	8%	13%	1%	0	0	3%
Patient to Patient or Visitor to Patient Abuse	2%	2%	0	3%	6%	3%
Failure to Comply With Regulations	9%	10%	6%	6%	3%	6%
Individual Financial Irregularities	6%	2%	0	1%	1%	1%
Other	8%	7%	3%	3%	2%	4%

*Each case could involve more than one type of complaint.

Table 4

Cases In Which a Target Was Identified*

May 1975 - December 1980

	Total Number of Identified Targets	Total Number of Cases	Percentage of Cases in Which a Target Was Identified
Physical Assault	247	320	77%
Unexplained Injuries	19	142	13%
Rough Treatment	99	120	83%
Negligence	71	361	20%
Verbal Abuse	31	38	82%
Isolation or Improper Restraints	8	28	29%
Suicide or Patient Death	1	65	2%
Unsafe Conditions	3	55	5%
Other	49	288	17%
Total	528	1417	37%

*Each case could involve more than one type of complaint.

Table 5

Target of Investigation*

May 1975 - December 1980

	Physical Assault	Unexplained Injuries	Rough Treatment	Negligence	Verbal Abuse
Orderly	63	3	19	4	3
Aide	153	15	65	22	22
Licensed Practical Nurse	24	1	10	12	3
Registered Nurse	7	0	4	10	2
Physician	0	0	1	22	0
Administrator	0	0	0	1	0
Total	247	19	99	71	30

*In cases where a target of investigation was identified.

Table 6

Targeted Personnel By Percentage*

May 1975 - December 1980

	Physical Assault	Unexplained Injuries	Rough Treatment	Negligence	Verbal Abuse
Orderly	26%	16%	19%	6%	10%
Aide	62%	79%	66%	31%	73%
Licensed Practical Nurse	10%	5%	10%	17%	10%
Registered Nurse	3%	0	4%	14%	7%
Physician	0	0	1%	31%	0
Administrator	0	0	0	1%	0

*In cases where a target of the investigation was identified.

Table 7

Disposition by Type of Complaint*

January 1976 - December 1980

	Indictment	Referral to Dept. of Health	Referral to Dept. of Education	Closed Without Referral	Other
Physical Assault	8	21	4	260	9
Unexplained Injuries	0	7	0	131	1
Rough Treatment	0	7	2	105	2
Negligence	0	38	10	306	2
Verbal abuse	0	1	0	32	2
Isolation or Improper Restraints	0	4	0	23	0
Suicide or Patient Death	0	4	0	54	2
Unsafe Conditions	0	5	0	29	19
Other	2	34	9	231	4
Total	10	121	25	1171	41

*Each case could involve more than one type of complaint.

Table 8

Source of Cases Reported Each Year
January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Victim	8	1	3	1	1	14
Friend	7	1	1	2	0	11
Relative	44	65	36	24	18	187
Patient Advocate/ Department Of Health	4	14	171	230	238	657
Staff	9	9	17	7	9	51
Public Official	18	24	7	9	4	62
Anonymous	7	7	5	2	10	31
Other	19	25	30	4	13	91
Total	116	146	270	279	293	1104

Table 9

Source of Cases By Percentage

January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Victim	7%	1%	1%	0	0	1%
Friend	6%	1%	0	1%	0	1%
Relative	38%	45%	13%	8%	8%	17%
Patient Advocate/ Department of Health	3%	10%	63%	83%	79%	60%
Staff	8%	6%	6%	3%	4%	5%
Public Official	16%	16%	3%	3%	1%	6%
Anonymous	6%	5%	2%	1%	4%	3%
Other	16%	17%	11%	1%	5%	8%

Appendix II

The Ad Hoc Coalition for a Single Standard Nursing Home Code

Member Organizations

The Alliance of Aged & Disabled

American Jewish Congress

Associated Y's of Greater New York

Central Bureau for the Jewish Aged

Citizen Leaders for Action

Coalition of Institutionalized Aged and Disabled

Community Action for Legal Services

Community Advocates

Community Council of Greater New York, New York City Nursing Home Patient Ombudsman Program

District 1199

Friends and Relatives of Institutionalized Aged (FRIA)

Gray Panthers, New York City Chapter

Institute on Law and Rights of Older Adults, Brookdale Center on Aging

Joint Consumer Council, Health Insurance Plan of New York

Junior League of Brooklyn

Legal Services for the Elderly Poor

Monroe County Nursing Home Patient Ombudsman Program

Nassau Action Coalition

National Association of Social Workers, New York City Chapter

National Council of Jewish Women, New York City Section

New York City Coalition for Community Health

New York City Coalition to Improve Nuring Home Care

New York City Foundation for Senior Citizens

New York Joint State Legislative Committee, National Retired Teachers Association/American Association of Retired Persons

New York Society for Ethical Culture

New York State Coalition for Improved Long Term Care (CILT)

New York State Coalition of the Concerned for Older Americans (COCOA)

New York State Conference for the Aging

New York State Nurses Association

New York State Office for the Aging

New York Statewide Senior Action Council

Nursing Home - Long Term Care Committee, United Hospital Fund

Office of Manhattan Borough President Andrew Stein

Relatives Association of the Daughters of Jacob Geriatric Center

Selfhelp Community Services

Senior Citizens Action Council of Monroe County

State Communities Aid Association

West Side Interagency Council on Aging

Women's City Club of New York City

Appendix III

Excerpted from Kansas Statutes Annotated

K.S.A. 39-936. Education and training of unlicensed personnel

A qualified person or persons shall be in attendance at all times upon residents receiving accommodation, board, care, training or treatment in adult care homes. The licensing agency may establish necessary standards and rules and regulations prescribing the number, qualifications, training, standards of conduct and integrity for such qualified person or persons attendant upon the residents. Unlicensed employees of an adult care home who provide direct, individual care to residents under the supervision of qualified personnel and who do not administer medications to residents shall not be required by the licensing agency to complete a course of education or training or to successfully complete an examination as a condition of employment or continued employment by an adult care home during their first ninety (90) days of employment. The licensing agency may require unlicensed employees of an adult care home who provide direct, individual care to residents and who do not administer medications to residents after ninety (90) days of employment to successfully complete an approved course of instruction and an examination relating to resident care and treatment as a condition to continued employment by an adult care home. A course of instruction may be prepared and administered by any adult care home or by any other qualified person. A course of instruction prepared and administered by any adult care home may be conducted on the premises of the adult care home which prepared and which will administer the course of instruction. The licensing agency shall not require unlicensed employees of an adult care home who provide direct, individual care to residents and who do not administer medications to residents to enroll in any particular approved course of instruction as a condition to the taking of an examination, but the licensing agency shall prepare guidelines for the preparation and administration of courses of instruction and shall approve or disapprove courses of instruction. Unlicensed employees of adult care homes who provide direct, individual care to residents and who do not administer medications to residents may enroll in any approved course of instruction and upon completion of the approved course of instruction shall be eligible to take an examination. The examination shall be prescribed by the licensing agency, shall be reasonably related to the duties performed by unlicensed employees of adult care homes who provide direct, individual care to residents and who do not administer medications to residents and shall be the same examination given by the licensing agency to all unlicensed employees of adult care homes who provide direct, individual care to residents and who do not administer medications.

Appendix IV

Recommended Forty-Hour Post-Employment Curriculum Outline*

I. Introduction to Being a Nursing Home Aide (6 hours)

A. Long Term Care Philosophy

B. Job Description

1. Appearance and Conduct (Behavior)
2. Chain of Command
3. Personnel Policies
4. Fire/Accident Prevention and Safety Prevention (Sanitation)

C. Federal and State Regulations

1. Licensure
2. Confidentiality

D. Legal Aspects

1. Residents' Rights

E. Normal Aging Process

II. Physical Needs of the Resident (14 hours)

A. Hygiene

1. Bathing (bed, tub, shower)
2. Personal Hygiene and Grooming
3. Oral Hygiene

B. Dietary Needs

1. Nutrition
2. Feeding
3. Fluids
4. Diets

C. Bowel and Bladder

1. Bathroom Assistance
2. Bedpan and Urinal Placement
3. Catheter Awareness

* Report of the Task Force on Comprehensive Recruitment and Employment Training For Adult Care Home Aides as directed by the Kansas State Senate, December 1, 1980.

II. Physical Needs of the Resident (Continued)

D. Proper Method to Align and Move Residents

1. Body Mechanics - lifting
2. Positioning - transferring
3. Restraints

E. Bedmaking

1. Mechanics
2. Bedrails
3. Linen Care

F. Observation of Physical and Behavioral Changes

1. Importance of Observation and Reporting

(a) physical
(b) behavioral

G. Vital Signs--observing but not taking

1. Temperature, pulse and respiration and blood pressure (Limited to certified and licensed employees)

H. Rehabilitation (Restorative)

1. Define
2. Services Available or Offered

III. Psychosocial Needs of the Resident (10 hours)

A. Adjustment to Institutional Life

1. Facility Routine
2. Basic Considerations

(a) What are the emotional needs of the nursing home resident?

self-esteem
affection
security
achievement
individuality
independence
hope

(b) How do you relate to residents with special needs?

98-970 O—82——14

ALL behavior has meaning:
the difficult
the non-complaining
the quiet, withdrawn
the verbal abusive/aggressive
the blind or deaf
the exhibitionist
the paranoid

B. Special Problems of the Elderly

1. Adapting to Change

(a) loss of identity
(b) loss of independence
(c) loss of mobility
(d) loss of contact with the everyday world
(e) loss of loved ones
(f) loss of possessions

C. Communications Disorders and Skills

1. Technique needed

(a) loss of vision
(b) loss of hearing
(c) confusion or disorientation

D. Understanding Death and Dying

1. What to do for a dying resident
2. What to do in case of death

E. Importance of Resident Participating in Decision-making and Self-determination

1. Resident Rights
2. Personal Choice
3. Resident Council, Clubs and Associations

Glossary

DECUBITUS ULCERS - sores caused by prolonged pressure on a patient confined to bed for a long period of time.

ECCHYMOTIC AREA - black and blue area.

HEALTH RELATED FACILITIES - residential health care facilities providing health services of a lesser degree than those provided by a hospital or skilled nursing facility.

KWIK HEAT PACK - a chemical pack which produces heat used for treatment.

MEDICAID - a social welfare program established under Title XIX of the Social Security Act which provides medical assistance to low income and certain other medically needy people.

MEDICARE - a social insurance program established under Title XVIII of the Social Security Act which provides hospitalization and other benefits to persons over 65 years of age and disabled persons who are receiving social security benefits. Entitlement to Medicare is not based on need.

NEW YORK STATE HEALTH PLANNING COMMISSION - a state agency with responsiblity for development of health policy for the state.

ORGANIC BRAIN SYNDROME - senility.

PATIENTS RIGHTS - constitutional and other legal rights guaranteed to nursing home residents. See Public Health Law §2803-c.

POSEY VEST - chest restraint for a patient confined to a wheelchair or a bed.

PROPRIETARY FACILITIES - facilities which are privately owned and operated for profit.

RENAL FAILURE - kidney failure

SKILLED NURSING FACILITIES - residential health care facilities providing the highest level of long term care.

STATE HOSPITAL REVIEW AND PLANNING COUNCIL - the New York State council which adopts regulations governing health care facilities, subject to the approval of the Commissioner of Health.

SUBCLAVIAN VEINS - part of the main vein under the shoulder and in the arm.

VOLUNTARY FACILITIES - non-profit facilities which are not privately owned and managed, such as those run by religious or charitable organizations.

ITEM 9

COST ANALYSIS

IOWA STATE HEALTH DEPARTMENT vs. JCAH

LONG-TERM CARE SURVEY

Iowa State Health Department Actual Costs for a Long-Term Care Survey:

Total Medicaid Billings, FY1981	$1,073,027.00
Total Certified ICF's in Iowa, November 1981	427
Annual Cost Per Facility	$ 2,513.00

This Cost Covers:

1 Annual Health Survey (2 people, 2 days)
1 Annual Health Mid-year Revisit (1 person, 1 day)
Average of 1 annual complaint investigation (1 person, 1 day)
1 annual State Fire Marshal survey (1 person, 1 day)
1 annual State Fire Marshal Revisit (1 person, ½ day)

Total Surveyor Days: 7½ days	
Total Cost Per Surveyor Day:	$ 335.06

JCAH Estimated Cost for a Long-Term Care Survey:

(2 people, 2 days)	$ 2,751.00
Total Surveyor Days: 4 days	
Total Cost Per Surveyor Day:	$ 687.75

JCAH Estimated Costs 205% of the Iowa Health Department Costs

ITEM 10

NCCNHR SURVEY OF STATE NURSING HOME SURVEYORS

-Preliminary Findings; July 1982

The following quotations are typical comments made by state surveyors when asked about the quality of surveys conducted by the Joint Commission on Accreditation of Hospitals (JCAH):

CALIFORNIA

* Accreditation by the JCAH is a purchased item. You pay for it, you get it. Their survey requirements are non-specific and nebulous.

* As a former director of nursing in several SNFs, I have nothing but negative comments regarding my JCAH inspections...There were never any communications regarding complaints, even though complaints were registered.

* Accreditation (by JCAH) does not adequately reflect the degree of compliance or non-compliance with regulations/conditions of participation.

* State agencies will retain their licensure responsibilities whether or not deemed status is granted. Consequently this would result in duplicate inspections as well as being less cost-effective.

MISSOURI

* JCAH is a private organization and accountable only to member facilities.

* Consultation between surveys will be limited due to distance of (JCAH) survey team.

NEBRASKA

* No monitoring by JCAH for correcting deficiencies; no unannounced surveys; SNFs and ICFs do not compare with hospitals in that they do not have daily physician contact and professional nurse coverage for supervision.

* I understand that JCAH provides an adequate survey; however, the facilities vary from excellent to poor as if the JCAH survey had no effect.

* How can a three-member team review a 60-bed hospital and an 84 bed long term care area in one six-hour day, and actually review the services as they are being provided?...These facilities hear what a wonderful job they are doing from the JCAH reviewers and we as certification surveyors follow behind listing all our problems with patient care, dietary, social services, etc.

NEW HAMPSHIRE

* I do not think JCAH does an in-depth survey of areas in a survey. It is a too-fast thing. This is based on my hospital experience.

NEW JERSEY

* (Of three JCAH accredited nursing homes), one maintains excellent standards...The other two...were recommended for decertification from titles 19/18 based on nursing care and staffing, dietary and infection control services at the same time they received JCAH accreditation. One of the two was also subject (to) licensing sanctions based on patient care. The other one was denied title 18 participation by HHS based on physical plant/ life safety code deficiencies.

* Surveys are conducted by appointment and based largely on documents submitted in advance by the facility. Their reports are not disclosable to the public.

* I feel it would be unfair to smaller facilities which could not afford the cost of a JCAH survey.

NEW MEXICO

* Six weeks following JCAH survey of a hospital, some of the deficiencies noted by this agency and not by JCAH were:

- 146 shifts did not have an RN assigned on one or more patient units;
- aides performing treatments, which is in direct violation of the New Mexico Nurse Practice Act;
- insufficient staffing throughout facility;
- 48 shifts for the emergency room did not have scheduled staff RN coverage.

I do not feel JCAH is qualified to conduct a survey if the above example is representative of their completeness of survey!

* We have enough evidence of (JCAH's) slipshod ways with hospitals in this state to indicate that they should not be anywhere else. Costs will not be decreased, but increased, for complaints will soar, will have to be investigated, and validation surveys and revisits performed by the state agency.

* I have never seen one (JCAH) surveyor on the patient floors or talking to one patient.

NORTH CAROLINA

* Some accredited nursing homes have stated that the JCAH dietary surveys are not what they should be.

PENNSYLVANIA

Nursing homes will become beautiful institutions and only warehouses to die! ... I can see the possiblility of "payoffs" between providers and JCAH.

SOUTH CAROLINA

* JCAH surveyors would not have the personal interest in the welfare of the resident, being based in another state. A body that certifies for pay may not have the best interest of the patients at heart ... It would be much more difficult (for the State agency) to follow up on (JCAH) findings.

SOUTH DAKOTA

* I feel (JCAH accreditation) is more prestige than actual function connected to their surveys. They do not spend enough time in a facility to evaluate quality of care.

UTAH

* JCAH is milktoast; administrators like JCAH because they are lax; more conceit than substance; no regulatory power; no complaint investigation.

* I have not heard that JCAH has ever closed a facility--lack of authority...little cooperation in sharing information...

I also feel that what I am doing is important to our society and I hope if the day comes when I am the patient in a facility that there is still an agency monitoring as thoroughly (as ours).

WEST VIRGINIA

* The JCAH survey is for prestige only. Their survey is liken to a walk through with eyes closed. They never check with the state licensing rules and regulations; even change some certification conditions of participation to suit their survey.

* Overall effect of the total package:

1. A cost saving to HCFA,
2. Increased costs to facilities to purchase JCAH surveys,
3. Reduction of the number of state surveyors,
4. Reduced level of care and staffing in nursing homes.

ITEM 11

National Citizens' Coalition for
NURSING HOME REFORM

1424 Sixteenth Street, N.W.
Suite 204
Washington, D.C. 20036
202/797-8227

Freida E. Gorrecht
President

Elma L. Griesel
Executive Director

July 12, 1982

Secretary Richard Schweiker
Department of Health and Human Services
Washington, D. C., 20201

Dear Secretary Schweiker:

Enclosed is a position statement endorsed by 44 national organizations and over 100 state and local organizations opposing proposed regulations which would revise the survey and certification process for health facilities participating in Medicare and Medicaid.

These organizations have reiterated the concern which led them to sign a similar statement in March prior to receiving assurances from you that you would not "imperil senior citizens in nursing homes, our most vulnerable population, by removing essential federal protections."

The endorsing organizations appeal to you to maintain your commitment to federal protections for nursing home residents.

Thank you for your consideration of these concerns.

Sincerely,

Elma L Griesel

Elma L. Griesel
Executive Director

ELG:mt

Enclosure

POSITION STATEMENT

RE: HCFA NPRM May 27, 1982 Medicare and Medicaid; Survey and Certification of Health Care Facilities

July 12, 1982

We, the undersigned, urge the Department of Health and Human Services to maintain its leadership and fulfill its responsibilities in working to assure a high quality of care and life for America's 1.3 million nursing home residents.

We maintain that the federal government should continue to operate an effective enforcement system that ensures, at least, minimum standards of care and decency by providing financial support and regulatory guidance to state agencies.

We were reassured by the commitment Secretary Schweiker made to the American public on March 22, 1982, when he stated, "I will not imperil senior citizens in nursing homes, our most vulnerable population, by removing essential federal protections. I will not turn back the clock."

It is our belief that the rule changes proposed by the Department of Health and Human Services on May 27 which would revise Subpart S - the survey and certification process - will, over time, imperil nursing home residents. We oppose the proposed regulations as a step backward and a removal of essential federal protections.

We agree that the survey and certification system needs improvement; therefore, we urge the Department to withdraw these proposed rules in favor of developing a new proposal which would focus the system on the actual quality of services received by residents. We stand ready to assist in the task of designing a system which effectively ensures high quality care and services.

Further, we urge the Department to seek essential funding to ensure that the federal and state systems have continued enforcement capability. State survey agencies have reported 30-40% cuts in program funds which have limited their ability to monitor nursing homes and other health care facilities. HHS regional oversight of state enforcement activities has also been significantly reduced by the budget cuts. Figures available through the Health Care Financing Administration indicate that $121 million is needed in FY 1983 to carry out a viable survey and certification program. While this represents far less than 1% of the funds expended for nursing home care by the government, it is money which helps assure that billions of health care dollars are well spent.

We call upon the Department to withdraw these regulatory and budgetary proposals which endanger essential protections for nursing home residents.

National Organizations Endorsing Statement

American Association of University Women
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Jewish Congress
American Public Health Association
Association for the Advancement of Psychology
Center for Community Change
Coalition of Labor Union Women
Commission on Social Action of Reform Judaism
Committee on Aging, Unitarian Universalist Association
Consumer Coalition for Health
Consumer Federation of America
Council of Jewish Federations
Episcopal Church Center
International Association of Fire Chiefs
National Alliance for the Mentally Ill
National Association of Activity Professionals
National Association of Area Agencies on Aging
National Association of Health Facility Licensure and Certification Directors
National Association of the Physically Handicapped
National Association of Retired Federal Employees
National Association of Social Workers
National Caucus and Center on Black Aged
National Citizens' Coalition for Nursing Home Reform
National Coalition of Resident Councils
National Community Action Agency Executive Directors Association
National Conference on Catholic Charities
National Conference on Social Welfare
National Council of Jewish Women
National Council of Senior Citizens
National Council on the Aging
National Farmers Union
National Gray Panthers
National Mental Health Association
National Women's Health Network
Older Women's League
Service Employees International Union
United Auto Workers
United Church of Christ
Urban Elderly Coalition
Women's Equity Action League

Office of Legislative Affairs, Women's Division, General Board of Global Ministries, United Methodist Church
Washington Office, United Presbyterian Church in the U.S.A.

Separate listing of state and local organizations and individuals on next page.

State and Local Organizations and Individuals Endorsing the Statement

In addition to the 96 state and local organizations which NCCNHR represents (and which are included in the attached list), the following organizations and individuals have endorsed this statement:

Bentley Gardens Resident Council, New Haven, Ct.
Harbor View Manor Resident Council, New Haven, Ct.
Federation of Jewish Philanthropies of New York
Task Force on Health and Human Services of the Episcopal Diocese of Connecticut
Commission on Aging, Ohio
Commission on Aging, District of Columbia
Office on Aging, District of Columbia
Long Term Care Council, National Association of Social Workers, Calif.
Senior Issues Action Committee, Nashville Communities Organized for Progress, Tenn.
Coalition for Improved Long Term Care of Arizona Valley of the Sun Gray Panthers
Gray Panthers of Metropolitan Washington, D.C.
Montana Seniors' Advocacy Assistance
Elderly Law Project, New Haven Legal Assistance, Ct.
Attorneys for Plaintiffs and Plaintiffs in Intervention in Smith v. O'Halloran
Long Term Care Ombudsman Committee, District II, Fla.
Nursing Home Ombudsman Program, State of North Carolina
Sarah Greene Burger, R.N.
Elma Wolf, L.C.S.W., A.C.S.W.

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

MEMBER ORGANIZATIONS - July, 1982

California
Berkeley Gray Panthers, Berkeley
Citizens for Better Nursing Home Care, Oakland
Citizens for Better Nursing Home Care, Soquel
Citizens Who Care, Davis
Concerned Citizens for Better Nursing Home Care, Monterey
Gray Panthers of Santa Clara County, San Jose
Nursing Home Ombudsman Program, San Francisco
Ombudsman, Inc., Riverside
Sacramento Area Long Term Care Ombudsman, Sacramento
Santa Barbara Citizens for Better Nursing Home Care, Santa Barbara
Senior Adults Legal Assistance, Palo Alto
Sonoma County Ombudsman, Sabastopol
United Neighbors in Action, Oakland

Colorado
Concerned Relatives and Friends of Residents of Nursing Homes, Ft. Collins
Family and Friends of Nursing Home Residents, Aurora
Nursing Home Review Committee Advisory Board, Pueblo

Connecticut
Connecticut Citizens Concerned with Convalescent Care, Cromwell

District of Columbia
Washington Home Residents Council, Washington, D.C.

Florida
Citizens Advocates Community Group, Pensacola
Nursing Home Hotline Patrol, St. Petersburg

Georgia
Long Term Care Facility Ombudsman, Douglasville
Long Term Care Ombudsman Program, Valdosta
Nursing Home Ombudsman Program of Metropolitan Atlanta, Atlanta
Nursing Home Ombudsman Project, Brunswick

Illinois
Committee for Community Involvement in Nursing Homes, Champaign
Illinois Citizens for Better Care, Chicago

Indiana
Byron Health Care Residents Council, Fort Wayne
Legal Services Organization of Indiana, Indianapolis
United Senior Action, Indianapolis
Volunteers Organized to Assist in the Institutionalized Care
of the Elderly and Sick, Evansville

Kentucky
Citizens Involvement Project, Louisville

Louisiana
Citizens for Quality Nursing Home Care, New Orleans
State Nursing Home Ombudsman Program, Baton Rouge

(continued)

Maine
Maine Committee on Aging

Maryland
Maryland Advocates for the Aging, Baltimore
Maryland Conference of Social Concern, Baltimore
Montgomery County Ombudsman Program, Wheaton
Nursing Home Ombudsman Program, Salisbury

Massachusetts
Age Center of Worcester Area, Worcester
Cambridge and Somerville Legal Services, Cambridge
Cape Cod Nursing Home Council, Hyannis
Central Massachusetts Legal Services, Worcester
Consumer Advocates for Better Care, Leominster
Cooperative Metropolitan Ministries, Newton
Greater Boston Elderly Legal Services, Boston
Nursing Home Advocacy and Assistance Project, Holyoke
Nursing Home Ombudsman Program, Fall River
Unitarian Universalist Committee on Aging, Boston

Michigan
Citizens for Better Care, Big Rapids
Citizens for Better Care, Detroit
Citizens for Better Care, Farmington
Citizens for Better Care, Flint
Citizens for Better Care, Grand Rapids
Citizens for Better Care, Lansing
Citizens for Better Care, Metropolitan Detroit
Citizens for Better Care, Traverse City

Minnesota
Friends and Relatives of Nursing Home Residents, Minneapolis
Minnesota Senior Federation, Long Term Care Committee, Edina
Nursing Home Residents' Advisory Council, Minneapolis
Nursing Home Residents' Advocates, Minneapolis
Senior Citizen Coalition, Duluth
South Minnesota Legal Services

Mississippi
Jackson Gray Panthers, Jackson

Missouri
Kansas City Gray Panthers, Kansas City
Nursing Home Ombudsman Program, St. Louis

Nebraska
Mayors Advisory Committee on the Handicapped

New York
Coalition of Institutionalized Aged and Disabled, Bronx
Friends and Relatives of Institutionalized Aged, New York
New York City Nursing Home Ombudsman Program, New York
New York State Coalition for Improved Long Term Care, Albany
Relatives Association, Daughters of Jacob Geriatric Center, Bronx
State Communities Aid Association, New York
Village Nursing Home, New York

(continued)

Ohio
Nursing Home Ombudsman Program, Cleveland
Nursing Home Ombudsman Program, Dayton
Pro Seniors, Inc., Cincinnati

Oregon
Northwest Portland Gray Panthers
Oregon Legal Services, Portland
Salem Gray Panthers, Salem

Pennsylvania
Coalition of Advocates for the Rights of the Infirm Elderly, Phila.
Interfaith Friends, Scranton
Interfaith Friends, Wilkes-Barre
National Gray Panthers, Phila.
Northwest Interfaith Movement, Phila.

Rhode Island
Citizens Alliance for Nursing Home Residents, Cumberland
RIsource, Providence

Tennessee
Social Action Group on Aging, Nashville

Texas
Texans for the Improvement of Nursing Homes

Virginia
Friends and Relatives of Nursing Home Residents, Annandale
Friends and Relatives of Nursing Home Residents, Richmond

West Virginia
Center for Long Term Care Advocacy, Charleston

Washington
Citizens for the Improvement of Nursing Homes, Spokane
King County Coalition of Nursing Home Resident Councils, Seattle

Wyoming
Advocates for Care of Elderly, Laramie
Concerned Citizens for Quality Care, Casper

Appendix 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

The American Hospital Association (AHA) appreciates the opportunity to present its views on the recently published proposed Federal regulations governing the survey and certification of health care facilities as providers under the medicare and medicaid programs (47 Federal Register 23404, May 27, 1982). AHA represents more than 6,300 hospitals and other health care institutions, as well as more than 35,000 personal members employed in the health care field. Our members provide a variety of services, including long-term care and home health care.

AHA shares the committee's commitment to protect the health, safety, and human rights of institutionalized persons in both acute care and long-term care settings. We are also committed to the cost-effective delivery of health care and believe that the Department of Health and Human Services' (HHS) regulatory reform initiative properly addressed these objectives. AHA supports the HHS proposal because it represents a conscientious effort to increase flexibility and reduce unnecessary regulatory burdens associated with the overall Federal certification process, while safeguarding patients' health and safety.

Background in Brief

On many occasions AHA has urged the Congress and HHS to eliminate, or at least avoid separate certification standards and surveys for each level or type of service covered under medicare and medicaid, particularly when multiple levels of care are provided by a single institution. The HHS proposal is a sensible reform because it provides an opportunity to treat institutions with multiple levels of care as integrated facilities. It would allow consolidated surveys, and it would reward facilities with exemplary compliance histories by concentrating enforcement activities on marginal or substandard facilities. We are concerned, however, that the proposal may be discarded because of opposition from those who have focused on selected types of facilities—without regard to the proposal's universal application—and from those who mistakenly equate different levels of care with distinctly different facilities.

The proposal's positive impact on hospitals and all of their services should not be overlooked. Based on our 1980 annual survey, of the 5,830 short-term community hospitals in the United States, 1,453 (87 percent of which are small—less than 100 bed—hospitals) are subject to medicare/medicaid hospital certification surveys and 244 of them also provide skilled nursing facility (SNF) care, intermediate care facility (ICF) care, and/or home health (HHA) services. Of the 4,377 hospitals that are accredited by the Joint Commission on Accreditation of Hospitals (JCAH), 958 provide one or more of these three nonacute levels of care.

AHA Comments and Recommendations

AHA supports the following portions of HHS proposal, although we do plan to recommend some modifications to the Department:

—Adoption of a flexible survey cycle of up to 3 years for hospitals with excellent compliance histories.

—Replacement of the mandatory 90-day onsite resurvey requirement for facilities correcting deficiencies, with a proposal that State agencies use the most appropriate method and schedule to monitor the correction of deficiencies.

—Extension of deemed status to SNF's, ICF's (except ICF's for the mentally retarded), and hospital-based HHA's which are accredited by the JCAH; and

—Replacement of the requirement that nonaccredited hospitals and other health care providers submit staffing reports on a quarterly basis to their State survey agencies, with a proposal that staffing reports be submitted on request.

As indicated by the committee's letter to the Secretary, the most controversial and misunderstood provisions in HHS proposal are flexible survey cycles, flexibility in monitoring correction of deficiencies, and deemed status for JCAH-accredited SNF's, ICF's, and hospital-based HHA's. AHA would like to address these concerns of the committee as follows:

FLEXIBLE SURVEY CYCLES AND CORRECTION OF DEFICIENCIES

HHS' proposed flexible survey cycles are designed to make more effective use of compliance enforcement resources. AHA believes that facilities with exemplary compliance records should be subjected to less frequent surveys, allowing State agencies to focus limited human and fiscal resources on facilities with marginal or substandard compliance histories. Providing this flexibility to the State survey agencies would alter neither their obligations nor their ability to oversee the quality of care provided by institutions. Furthermore, if the Department's proposal were modified to require consolidated surveys of hospital-based services on a single survey cycle, substantial progress could be achieved toward eliminating the current piecemeal approach to certification which treats each level of care as if it were a separate entity.

With respect to oversight of deficiency corrections, the only sensible approach would be to schedule followup surveys consistent with agreed upon correction plans. State agencies must be allowed to use judgment in overseeing correction of deficiencies, since the nature of deficiencies can vary widely—from lack of a written policy on some aspect of institutional operations to the need for major structural renovations.

DEEMED STATUS

AHA supports the deemed status proposal. Since the inception of the medicare program in 1965, medicare and medicaid have relied on JCAH's experience and excellent record in hospital accreditation. During the 16 years that accreditation has been accepted as deemed status for hospitals, mechanisms have been developed to insure and maintain compliance with Federal standards. These mechanisms include validation surveys of a random sample of accredited facilities, surveys of any accredited facility against which a complaint has been received, annual HHS reports to the Congress on the aggregate results of validation surveys, and other periodic evaluations such as the 1978–79 General Accounting Office study.[1] HHS 1980 report to the Congress reaffirmed that "the JCAH accreditation program is as effective as the HCFA certification programs." [2] The extension of deemed status to JCAH-accredited SNF's, ICF's, and hospital-based HHA's would make use of these same oversight mechanisms. Furthermore, it should be noted that medicare/medicaid certification surveys constitute only one of many types of government surveys of health care institutions.

We also support the proposed extension of deemed status because it could reduce the effect of the fragmented certification process for accredited hospitals that provide long-term and home care services. Any hospital seeking accreditation must subject all of its services (and, hence, all levels of care) to review. Because a large number of hospitals seek and receive accreditation, there is a correspondingly high level of accreditation for hospital-based long-term and home health care services. As medicare and medicaid currently provide deemed status only for acute care programs, accredited hospitals are subject to separate certifications surveys of their other levels of care (e.g., SNF, ICF, HHA, end-stage renal disease). These certification surveys duplicate the accreditation survey and subject the hospital to repetitive reviews of operational areas often common to all levels of care (e.g., administration, food service, physical plant, medical record system).

The beneficial effect of the proposal on such hospitals would be substantial. AHA's 1980 annual survey showed that 958 accredited community hospitals offer SNF, ICF, and/or HHA services and that:

[1] U.S. General Accounting Office, "The Medicare Hospital Certification System Needs Reform" (HRD-79-37, May 14, 1979).

[2] Department of Health and Human Services, Health Care Financing Administration, "Fiscal Year 1980 Annual Report—Medicare Validation Surveys on Hospitals Accredited by the Joint Commission on Accreditation of Hospitals," p. 20.

—75.9 percent of community hospitals with skilled nursing beds are accredited, representing 82.6 percent of community hospital-based skilled nursing beds.
—63.5 perent of community hospitals with intermediate care beds are accredited, representing 69.2 percent of community hospital-based intermediate care beds; and
—88.7 percent of community hospitals with home health care programs are accredited.

Implementation of Deemed Status

AHA has suggested that HHS should be prepared to operationally phase in the deemed status proposal. This suggestion was made in response to the committee's concern about the potential surge in demand for accreditation. JCAH currently accredits approximately 1,300 long-term care facilities (both SNF's and ICF's) and over 600 hospital-based HHA's. This figure represents only 11 percent of the more than 18,000 federally certified SNF's, ICF's, and HHA's.

We believe that the development of an administrative plan to phase in deemed status is a reasonable and prudent precaution in the event that a large number of facilities seek accreditation. In making this suggestion to HHS, we have maintained that hospital-based services should be included in the first phase of any such plan, recognizing: (1) The high level of accreditation already present; (2) that hospital-based services represent approximately 50 percent of current JCAH-accredited long-term care facilities and 100 percent of JCAH-accredited home care programs (the JCAH accredits only hospital-based HHA's); and (3) that hospitals with multiple levels of care are more acutely affected by the fragmentation of the certification process.

Conclusion

We urge that the Senate Special Committee on Aging consider the concerns we have outlined and add its endorsement to our recommendation that HHS proposals be issued in final form as soon as possible, incorporating the modifications we have recommended. We appreciate the opportunity to submit our views and to offer any assistance your committee may request.

ITEM 2. STATEMENT OF HAROLD GORDON, CHIEF, DIVISION OF LICENSING AND CERTIFICATION, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

I would like to testify in opposition to the concept presented by the Health Care Financing Administration (HCFA) on the Joint Commission on Accreditation of Hospitals (JCAH) deemed status proposal and the proposed reduced schedule of inspections in long-term care facilities.

It is my belief that the use of JCAH to certify long-term care facilities for the Federal Government program will result in an increase in cost to both the Federal Government and the individual States, as well as a deterioration of services in this Nation's nursing homes.

The JCAH certification process will require payment by the nursing homes to JCAH. These expenditures will be charged to the Federal Government as part of the nursing home's operational cost. The States are now legally mandated to conduct licensure inspections and will continue to do so, notwithstanding the Federal utilization of JCAH. Rather than decreasing the regulatory impact on nursing homes, this process will in fact create a duplicative inspection process. Currently, the States inspection of nursing homes consolidates the medicare, medicaid, and licensure requirements in a single visit.

The use of JCAH would duplicate that process and will present a significant potential for conflict in findings between the State agencies and JCAH which will be utilized by the nursing home industry to their advantage. Such a process could further lead to "competitive surveys" wherein the States and JCAH would be fearful of what the other agency would find and as a result might have an inclination to be more detailed and rigid in their observations and application of the regulations.

JCAH surveys are announced and will provide the facility with ample opportunity to prepare for their inspection. JCAH has no obligation to make their findings public and the failure to make their observations available will deprive the public of important information on which to base placement decisions.

JCAH operates on a 2-year schedule and does not have capabilities for complaint investigation or follow-up to assure compliance with noted deficiencies. It will,

therefore, be possible for nursing homes to continue operation with deficiencies for extended periods of time. The State agencies in all probability will be utilized for complaint investigations as well as validation surveys and it will therefore be incumbent upon the Federal Government to continue funding for these programs. Recent Federal validation surveys of the JCAH process in hospitals as well as the California experience should establish beyond any question that accreditation by that organization does not necessarily guarantee compliance with the Federal conditions of participation.

I would suggest that as an alternative, deemed status be granted on the basis of compliance with State licensure, provided that the State involved has and enforces laws and regulations which are equivalent to or higher than the Federal conditions of participation. I believe that the role of HCFA should be one of reviewing the States to assure that their program effectively meets the needs of the Federal Government. Those States that do not meet these standards should receive support by training from HCFA which would enable them to develop an organization which can adequately function for these purposes. Federal funding should be withheld from those States which are not able or unwilling to implement such a program.

In respect to the proposal for reduced inspections in long-term care facilities, it is my opinion that such a program is entirely inappropriate. Nursing homes do not have the sophistication or depth of management required for long-term stable operation. The loss of any key employee such as the administrator, director of nurses, chief housekeeper, or dietary supervisor can cause a serious deterioration of services within a matter of weeks. We have observed this phenomenon time and again in the State of Maryland.

In Maryland we conduct quarterly visits in nursing homes. Our experience has shown us that this is the only way to assure a continuity of appropriate services to the patients. We recently received from Health Care Financing Administration's central office a list of facilities for which they recommend a reduced survey schedule which was based on their past records. Our continued quarterly inspection process demonstrated that better than 30 percent of the facilities recommended for reduced inspections had conditions of participation out of compliance which were observed and immediately corrected. Adherence to the suggested Federal schedule would have meant that these conditions would have remained out of compliance for as long as 2 years. Neither the Federal Government nor the States will be able to assure the public that nursing homes are providing acceptable care if the reduced inspection schedule is implemented.

Maryland is currently experimenting with an abbreviated survey process which concentrates on key elements and the delivery of services and output while minimizing and in many cases eliminating paper review. We review the provision of services and assume that if such service is being rendered in an acceptable manner, then all of the minutiae and details must be in compliance. Therefore, we do not find it necessary to dig into the massive paperwork necessarily entailed in the operation of a health care facility.

We would suggest very strongly that if it is in the intent of HCFA to reduce the regulatory impact on the long-term care industry that it (HCFA) develop an abbreviated survey process. It is our experience to date that in utilizing this process we can cut the time of surveys in a facility by approximately 50 percent with full capability of discovering violations and deficiencies which reduce the quality of care.

It is my sincere belief that if these two proposals are adopted there will be a rapid deterioration of services in nursing homes that will return us to conditions that existed in the late 1960's and early 1970's. I am in agreement with the trend to deregulate, but I think it would be a serious mistake to emasculate the program at the risk of our frail elderly nursing home population.

ITEM 3. STATEMENT OF THE AMERICAN BAR ASSOCIATION COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY

In a statement released March 21, 1982, Secretary Schweiker expressed both his concern for the elderly living in nursing homes and his confidence in the existing health and safety requirements' protection of the vulnerable elderly:

"* * * [I] will not imperil senior citizens in nursing homes, our most vulnerable population, by removing essential Federal protections * * * The [existing] health and safety standards are effective if properly enforced. Our efforts will focus on those facilities that have been identified as not meeting current standards. We will inspect those facilities more often than in the past and as often as is necessary to bring them up to standard."

These comments will examine the proposed survey and certification regulations in light of the Commission's longstanding concern with assuring adequate and safe facilities for the Nation's institutionalized elderly.

At the outset, any definition of "substandard facility" must be broad enough to include facilities having an aggregate of violations of individual standards within the conditions of participation as well as those with major life-threatening deficiencies. Life-threatening deficiencies are easily identifiable both in terms of likelihood of citation by surveyors and verification of correction. Yet, an aggregate of more subtle deficiencies can have as serious an impact on the quality of life of nursing home residents. For example, unauthorized opening of resident mail, mishandling of residents' personal funds, and improper imposition of physical and chemical restraints may not be viewed as life threatening, but taken in the aggregate these infractions of individual components of the conditions of participation may, in fact, pose serious threats to personal autonomy.

Facilities that are marginal because of such repeated infractions pose special enforcement problems. Without specific mechanisms for identifying and monitoring such facilities they will continue to provide no better than substandard care. The proposed regulations, while deleting requirements viewed as overly burdensome on facilities with a history of compliance, fail to replace these with procedures aimed at bringing substandard facilities up to standard.

JCAH Accreditation of Long-Term Care Facilities (Section 490.6)

The proposed use of JCAH long-term care accreditation as meeting certification requirements cannot provide adequate oversight of substandard facilities. JCAH's past experience in the accreditation of hospitals cannot be easily applied in nursing homes. The acute care setting of a hospital differs significantly from the long-term care nursing home setting. Nonmedical standards such as resident's rights, resident activities and quality of long-term care are as important, if not more important than standards regarding physicians' visits or skilled nursing services. In addition, the reality of nursing home ownership data reveals differing motivations for obtaining JCAH accreditation. While 80 percent of the Nation's hospitals are nonprofit, a large majority of nursing homes are private and for-profit facilities. (A 1977 national survey found that only 26 percent of all nursing homes were nonprofit or public institutions.) A marginal for-profit nursing home, by seeking and obtaining JCAH accreditation, may avoid obligations such as the development and execution of a plan of correction for existing deficiencies, since the State survey agency will have little or no role in oversight of the facility. A final major distinction between hospitals and nursing homes is the tremendous amount of public funding contributed to nursing home care. One-half of the government's medicaid expenses are used to finance nursing home care. Heavy public funding of such care justifies a greater public role in the regulation of nursing homes than that presently undertaken regarding hospitals.

If the Department does not withdraw the JCAH proposal, several additional requirements should be incorporated into the regulatory monitoring process to alleviate problems presented by the proposed system.

JCAH Long-Term Care Accreditation Standards and Surveyors

The JCAH long-term care standards should adequately address the unique aspects of nursing home care. Factors such as ancillary services (e.g., social work, mental health), patient activities and recreation, and residents' rights may be prominently incorporated into the standards. This can best be assured by expanding representation on the panel currently revising JCAH's long-term care standards, to include nurses, social workers, mental health professionals, and consumer representatives.

In addition, long-term care survey teams should include nursing home professionals and paraprofessionals to assess the delivery of nonmedical services in a nursing home.

Disclosure of Accreditation Reports

Section 490.6(c) requires an accredited nursing home to display its JCAH survey report, yet there is no requirement that a copy of the report be forwarded to the Health Care Financing Administration (HCFA) and to the State survey agency. This requirement is essential if State agencies and HCFA are to be aware of facilities which have been accredited with deficiencies. It is only with this knowledge that HCFA and the State survey agency can effectively monitor marginal facilities. States should not be expected to visit nursing homes for the sole purpose of discov-

ering what JCAH found in that particular facility. In addition, with cutbacks in funding and personnel, States will be unable to go to every nursing home to read its posted accreditation report.

Two additional uses currently made of detailed State survey agency reports highlight the importance of both a detailed JCAH survey report and the provision of the report to State survey agencies. Individuals bringing a private cause of action against a nursing home, or State agencies bringing enforcement actions, often use the survey report as evidence to substantiate the presence of facility violations and deficiencies. This evidence plays a crucial role because of the difficulty of obtaining testimony from facility residents.

The survey report is also an important component of evaluations for nursing home administrators and other licensed professionals employed by the facility. The nursing home's compliance history will reflect the skills of its administrator and staff. Without a requirement for submission of the report to the State agency, it will be very difficult to evaluate licensed facility personnel.

At a minimum, the regulations should adopt the medicare provision regarding JCAH accreditation of hospitals which requires accredited hospitals to supply HHS with their accreditation reports upon request. Section 490.16(b) gives HCFA or the State survey agency responsibility for determining whether an accredited nursing home is deemed to meet the conditions of participation. This cannot be done absent an examination of the accreditation report.

Section 490.34 sets out a detailed plan of correction procedures for those facilities certified by State survey agencies with deficiencies. This provision is a needed one, and its application should not be limited to facilities surveyed by the State agency. It must also be applied to JCAH facilities accredited with deficiencies.

VALIDATION SURVEYS OF JCAH ACCREDITED FACILITIES (SECTION 490.18)

The Department's proposed use of validation surveys as a quality checkup on a random sample of facilities which have been reviewed and accredited by JCAH cannot alleviate the shortcomings of the JCAH proposal. Validation surveys reach only 2 to 5 percent of all certified nursing homes, resulting in the great majority of these surveys being directed only at facilities with major compliance problems. Validation surveys cannot provide effective oversight of JCAH accredited nursing homes when so few homes can be reached.

The problems with validation surveys are further exacerbated by the proposal giving JCAH oversight responsibilities once a deficiency has been found as the result of a validation survey (section 490.18(e)(3)). JCAH is not a regulator and cannot be expected to take on a workable enforcement role.

MAINTENANCE OF ACCREDITATION PENDING RESOLUTION OF FACILITY DISPUTES WITH JCAH

Another potential problem with the proposed use of the JCAH accreditation system involves a facility threatened with deaccreditation by JCAH. Pending the resolution of an attempted deaccreditation or controversy regarding an alleged violation of JCAH standards, the nursing home maintains its accreditation. There is no required disclosure of the controversy to HCFA, the State survey agency, or the public. This is contrasted with decertification, which is an essentially public procedure. In addition, where a validation survey results in a finding of a violation of a condition of participation by an accredited facility, the facility would be entitled to an informal review by HCFA (section 490.18(h)). This two-tiered review procedure allows the maintenance of JCAH accreditation by substandard facilities for an extended period of time.

Many of the commission's recommended changes in the proposed deemed status system are in response to the very limited role of the public in the JCAH accreditation and oversight process. Public representation by a nursing home consumer or advocacy group on JCAH's governing body with responsibility for oversight of the organization could play an important role in remedying this lack of public input into accreditation decisions.

The adoption of these recommended changes in the JCAH monitoring procedures can significantly improve the oversight of substandard facilities.

Those States which choose not to opt for JCAH accreditation of medicaid facilities will retain principal oversight responsibility. Several provisions in the proposed regulations will have a substantial impact upon their enforcement activities.

FREQUENCY OF SURVEY CYCLE (SECTION 490.10(b))

The 1981 Omnibus Budget Reconciliation Act's withdrawal of the 12-month limitation on provider agreements left HHS with considerable discretion regarding the frequency of survey cycles. The commission supports the decision to set a 2-year maximum survey cycle rather than a 3-year cycle, and to inspect facilities with poor compliance histories more often than annually (section 490.10(c)). Yet we caution against an interpretation which construes "poor compliance history" to mean a history of major life threatening deficiences. Nursing homes which have a history of repeated less serious violations which in the aggregate result in the rendering of substandard care should also be considered as having a poor compliance history. A definition to this effect in the regulations would clarify the proper construction of the term.

QUARTERLY STAFFING REPORTS (47 FR 23404, No. 2); 90-DAY FOLLOWUP VISITS (47 FR 23405, No. 3); AUTOMATIC CANCELLATION CLAUSE (47 FR 23405, No. 5)

The proposed more frequent survey cycle for substandard facilities should be accompanied by the retention of those mechanisms mandating careful scrutiny of the correction of deficiencies. Secretary Schweiker's stated goal of focusing enforcement efforts on these facilities can be furthered by retaining the currently required quarterly staffing reports, 90-day followup onsite visits, and provider agreement automatic cancellation clauses.

Quarterly staffing reports are an important component of effective enforcement. Deficiencies in staff numbers and training are one of the most serious problems in nursing homes. A change of ownership or administrators can cause rapid deterioration of what were formerly adequate staffing patterns. The transfer of the quarterly report to State agencies may trigger an investigation of staffing in a facility whose report indicates detrimental changes in staff levels or training. The proposed reduction of this transfer requirement to one requiring only that personnel records be maintained in the facility cannot ensure adequate staffing (section 490.20(b)). If, upon survey, the facility was found to have failed to maintain these crucial personnel records, the failure would constitute only a violation of one standard within a condition of participation.

The proposed deletion of the provider agreement automatic cancellation clause and the relaxation of the 90-day followup onsite visit (section 490.12(e)) also hinder State agencies' efforts to bring marginal facilities into compliance. If enforced, the provision requiring cancellation of the provider agreement upon failure to correct cited deficiencies would force marginal facilities to correct the numerous, smaller deficiencies that render them substandard. A 90-day mandatory onsite survey to confirm the correction, or progress on correction of deficiencies, serves the same purpose. Both the State survey agency and the provider would be aware of a time limit within which some substantial progress on correction of deficiencies would have to be made. The confirmation of corrections by telephone or mail simply cannot take the place of onsite inspections. Correction of obvious life-threatening deficiencies (e.g., no smoke detectors or sprinkler system) may be verified by telephone contact or review of purchase orders and other documentation of correction submitted to the agency by mail. However, an aggregate of small deficiencies involving matters such as patient activities, adequacy of care, or staff training would not be easily amenable to correction in response to so casual a followup format.

FAILURE TO IMPLEMENT 1980 OMNIBUS BUDGET RECONCILIATION ACT INTERMEDIATE SANCTION PROVISION

In 1980, Congress responded to the enforcement problems presented by a system whose only enforcement mechanism was decertification of a nursing home from medicare and medicaid participation. It did so by enacting an intermediate sanction provision into the medicare and medicaid statutes (42 U.S.C. sections 1395cc(f), 1396a(i)(1)). That provision authorizes the Secretary to deny reimbursement for subsequently admitted medicare and medicaid beneficiaries where a survey reveals deficiencies that do not jeopardize the health and safety of residents and so do not justify decertification. That denial can be continued until the deficiencies are corrected. This intermediate sanction provision can be an effective tool for bringing marginal facilities into compliance.

The proposed regulations' focus on facilities with major life-threatening deficiencies cannot adequately protect the vulnerable elderly. Secretary Schweiker affirmed the importance of the conditions of participation in his decision against making any changes in them. That affirmation should be supported by mechanisms sufficient to

effectively police compliance by all nursing homes, including marginal facilities providing substandard care which often present the most difficult kind of enforcement problems to State survey agencies.

ITEM 4. LETTER AND ENCLOSURE FROM MARTIN A. JANIS, DIRECTOR, OHIO COMMISSION ON AGING, TO SENATOR JOHN HEINZ, DATED JULY 27, 1982

DEAR SENATOR HEINZ: The Ohio Commission on Aging would like to submit to you this agency's comments on the proposed subpart S revisions regarding the survey and certification of nursing homes participating in the medicare and medicaid programs. It is our understanding that the Special Committee on Aging has conducted hearings on the proposed subpart S revisions. Please consider the enclosed comments as written testimony for the hearing record.

If you or your staff have questions about this agency's comments, please feel free to contact the commission's State nursing home ombudsman, Jayne Moser at 614/466-1220. She will assist you in every possible way.

Thank you for your continued interest in serving the needs of your older citizens.

Sincerely,

MARTIN A. JANIS, *Director.*

Enclosure.

Following are the comments of the Ohio Commission on Aging in response to the proposed rules, "Medicare and Medicaid: Survey and Certification of Health Care Facilities" as published in the Federal Register, vol. 47, No. 103 on Thursday, May 27, 1982, reference HSQ-502-P.

I. GENERAL COMMENTS

Based on our experience in Ohio, the proposed rules as they relate to SNF's and ICF's in general reflect a seeming lack of understanding of the nursing home care delivery system in the Nation. Under the guise of regulatory reform, these proposed rules would create another layer of review which would further reduce the ability of the State survey agencies and HCFA to monitor the services provided in SNF's and ICF's throughout the country.

It is difficult to respond the proposed rules regarding "flexible surveys" and concentration of survey activities on facilities with a "record of marginal compliance" when there is the possibility of Joint Commission on Accreditation of Hospitals (JCAH) deemed status becoming a part of the long-term care survey and certification system. Possible JCAH deemed certification negatively impacts on the other proposed rules, some of which have some merit if considered independently of the JCAH issue. However, with the prospect of JCAH deemed status looming in the future, we must first look at the other proposed rules in the context of their relationship to a survey system which would include JCAH as an "enforcement" entity.

II. DEEMED STATUS FOR SNF'S AND ICF'S ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH)

(A) The Ohio Commission on Aging is strongly opposed to the proposed rules which would enable SNF's and ICF's which have been accredited by JCAH to be deemed to meet the conditions of participation in medicare and medicaid. Although the use of JCAH accreditation in lieu of a State survey would only occur with State concurrence, the reality of the situation would be that the States would have no alternative but to accept deemed status, in light of the continual dwindling of Federal funds to the States for certification survey activity. So, with Federal survey funds cut severely and the likelihood of an inability to meet survey schedules with the current, reduced funding level, the States would have no real option regarding this provision.

(B) If the JCAH deemed status provisions were implemented, there would be in effect another entity involved in insuring service delivery in long-term care facilities. The States would be in an untenable position of relying on information from an entity over which they have no control. There would be dual systems of criteria used to review facilities. Even the possibility of the States monitoring facilities with marginal compliance would result in legal entanglements which could further delay the enforcement agency's taking effective action.

(C) Long-term care facilities are not hospitals. The acute care setting with its frequent interaction with the community, and the visible participation of the medical profession, makes the hospital a more appropriate place to consider JCAH accredita-

tion as deemed status for participation in the medicare and medicaid programs. The State agency must be involved in determining compliance (not just after the deemed status is questioned), in order to have some accountability to the taxpayers who are paying for the care in these facilities, and to the residents who are dependent on the services provided. To extend the JCAH deemed status to SNF's and ICF's because there has been some successful use of the system in the acute care setting demonstrates an obvious lack of understanding about what long-term care is.

(D) The issue of availability of JCAH survey information in not adequately addressed in the proposed rules. There is an obvious conflict between the confidential relationship between JCAH and the surveyed facility, and the responsibility of the State to make such information available to the public. Not knowing what the JCAH survey report entails, nor even what criteria are reviewed in a facility by JCAH, it is difficult to comment on whether the provisions in the proposed rules would meet the public disclosure requirements in Ohio statute. There is an overall conceptual problem in the approach to this information. It is apparent that the confidential relationship necessary for JCAH to meet its responsibilities takes precedence over the right of the consumer, be it the government as a third-party payer of the private paying resident, to access the information relating to a facility's capacity to provide services. Requiring the display of the JCAH survey report as a condition for deemed status hardly answers this fundamental question.

(E) Who will respond to complaints about facilities not meeting the conditions of participation? If the JCAH deemed status provisions are implemented, another system is created. It is extremely unlikely that JCAH will have the capacity to respond to complaints in all 50 States. The State survey agency will in all likelihood have the responsibility of responding to complaints that the conditions of participation are not being met. If the complaints are substantiated, the facility might very well be able to use the JCAH survey as a tool against the State survey agency's findings, with the obvious effect of increasing appeal time and creating an administrative nightmare since the review criteria are not identical. It is difficult enough with the current system when the same criteria, but different time periods for review are challenged. HCFA must recognize the appeals issues such a system would create and address those in any proposed regulations.

(F) This agency questions the cost benefits analysis which projects that deeming JCAH accreditation would result in substantial savings. In Ohio, it would at a minimum merely shift dollars from the survey agency to JCAH, whose activities would be reimbursable under the medicaid reimbursement to SNF's and ICF's. The State and Federal survey funds which are used in a monitoring role would be diverted to a private out-of-State entity, which would only have a consulting role. The logic behind that type of "cost containment" and "quality assurance" strategy is difficult to comprehend.

(G) Flexible survey schedules and the elimination of the onsite resurvey requirement, when combined with the JCAH deemed status is totally unacceptable to this agency. In the following section we will discuss those provisions independently of the JCAH deemed status issue.

III. Flexible Survey Schedule

(A) In the background information preceding the proposed rules, section 6, HHS states, "We propose to require at least annual surveys of ICF's-MR because we realize that most of the patients in these facilities (many of whom are children) lack the necessary experience or capability to bring quality of care problems to the attention of outside authorities. For this reason, we believe that annual surveys are necessary to ensure that monitoring officials detect any serious problems promptly." We agree with this approach; but we fail to see why the same reasoning doesn't also apply to the aged, ill residents of geriatric long-term care facilities. The justification for at least annual surveys for SNF's and general ICF's is the same. There are vulnerable people in these facilities for long periods of time, and it is our responsibility to monitor the services in these settings.

(B) It is difficult to oppose the concept of flexible survey schedules which would enable the State survey agency to direct more activity to facilities with poor compliance histories. However, this agency must oppose the proposed rules as found in section 490.10 (a) and (b). The definition for marginal compliance must be clear. The criteria for determining whether a facility needs less frequent inspection must be specific, perhaps tied to certain conditions of participation, or standard within the conditions in order for this concept to have any operational value. Phrases like "as often as necessary" (409.10(b)) can present innumerable problems if such rules were implemented. Considering the reduced Federal funding available to States for

survey activities, the reality of implementing these proposed rules would be a biennial survey system, which would be unacceptable in the changeable long-term care setting.

IV. Mandatory 90-Day Resurveys

We do not oppose revision of the 90-day resurvey requirement. The State survey agency should be able to schedule the resurvey based on the type of deficiency and the plan of correction. For example, if the plan of correction required additional construction which would not be completed in 90 days, the resurvey would be fruitless at that time. However, we oppose elimination of a mandatory resurvey. Amending the regulations to require an onsite visit "only if there is no other way to verify correction of the deficiencies" (section 3 of the background information) ignores the all-too-problematic history of long-term care in this country. Again, if this provision were linked to deficiencies within certain specific conditions of participation the concept might be workable. But the proposed rules as written are not acceptable.

V. Definitions

The definition for "Conditions of Participation Coverage" as found in section 490.2 definitions, is unclear. What "broad clusters of requirements" are being referenced? The conditions are currently "broad clusters" of standards. Is another subsystem being created without specific references? "Substantial allegation" as defined in section 490.2 raises the same questions. These definitions if included in regulations must be specific and have applicable meaning. Experience has shown that such terms can be used in the hearing process and can result in time-consuming and costly legal proceedings.

VI. Conclusion

The Commission on Aging must oppose implementation of the proposed rules as written. Some of the concepts presented might have value if further developed (such as the flexible survey schedules, and the revision of the mandatory 90-day resurvey requirement). The proposed rules do not consider the operational problems which would be encountered. The role of the consumer in the process is ignored and our responsibility as government agencies to insure quality and monitor services, which the taxpayers support, is overlooked.

ITEM 5. STATEMENT OF THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO/CLC, WASHINGTON, D.C.

The Service Employees International Union thanks the Senate Special Committee on Aging for this opportunity to submit written testimony for the record regarding the Reagan administration's proposed changes in enforcement of nursing home standards of care.

SEIU urges the Congress to halt the administration's proposed weakening of enforcement of standards of care and drastic reductions in funds for nursing home inspectors. From our unique position of representing more than 70,000 nursing home workers as well as nursing home inspectors in many States across the Nation, we believe a frequent and well-staffed public inspection procees is vital to maintain at least minimal standards of care in health and safety conditions in our Nation's long-term care facilities.

As taxpayers as well, we believe that it is essential to retain public control and administration of inspections. Only by keeping inspections in the public realm will we have some measure of assurance that our scarce tax dollars are well spent.

The following testimony details our specific concerns and experience with existing and proposed certification/inspection regulations and the inspection process in general.

Currently, States must use State-employed inspectors to certify whether or not nursing homes meet basic staffing and health and safety standards and quality of care standards.

The proposal to use the Joint Commission on Accreditation of Hospitals to inspect homes would jeopardize the entire enforcement process for several reasons:

(1) JCAH inspection would amount to self-inspection by an industry notorious for understaffing, putting profits ahead of the needs of patients and decent working conditions. The commission is entirely controlled by providers; there is no consumer or worker role.

(2) The JCAH director of long-term care has already stated "JCAH does not and will never regulate." Clearly, as a private organization JCAH feels accountable to members' facilities and not the general public.

(3) Where JCAH is the inspector, States would be ending public access to inspection information. JCAH makes its reports available only to the facility. JCAH inspections are considered confidential and would remain so under the proposed regulations.

(4) In general, use of JCAH would gut the ability of States to enforce standards by splitting off the certification process (to JCAH) from the complaint and correction enforcement process (remains with State or Federal agency).

Officials within the JCAH would support us when we assert that the JCAH is not an enforcement agency. Nor is the commission set up to monitor and pressure facilities to correct deficiencies with full public disclosure and leverage.

In our experience with the JCAH inspection of hospitals (SEIU represents some 150,000 hospital workers), the JCAH sees itself as accountable to key administrative and medical staff rather than general public concerns as to facility conditions and practices. Time and again we have sought JCAH assistance and actions to correct violations of JCAH's own standards only to find little or no response. For example:

SEIU's New York State members have been repeatedly frustrated by JCAH standards which vary from facility to facility. The lack of public input to JCAH decisions or access to the detailed results of accreditation reviews has left the staff at New York psychiatric facilities unable to protest or sound the alarm when deficiencies exist.

In Virginia, similarly, JCAH did not respond to SEIU's and staff nurse letters requesting information on JCAH accreditation reviews of a community hospital. Since the JCAH is not required to respond, the accreditation process was in effect removed from all real public accountability in Virginia.

These are just two examples of a chronic problem in using the JCAH as an enforcement agency.

In hospitals there is clearly far less need for constant monitoring by outside inspectors. Pressure from patients and their families, competition for physicians and for well-insured patients, as well as generally more quality-conscious reimbursement practice give most hospitals strong incentive to keep up their facilities and maintain high quality care. This means that inspection by JCAH is more in the nature of a Good Housekeeping stamp of approval than a surveillance or policing mechanism.

The same is not true in nursing homes. In nursing homes, the immobility of patients, a tight financing system, and the general lack of public contact give incentives to cut corners and make profits at the expense of vulnerable senior and disabled citizens. The long history of nursing home scandals bears vivid testimony to the incentive to make a profit at any and all cost.

In nursing homes, public regulation and tight control are essential. In SEIU's experience a well-staffed, concerned team of public inspectors can be a forceful mechanism for residents and their families to enforce standards of care. A few examples will illustrate the vital role that public inspectors can play.

In Rhode Island, SEIU's members have used public State inspectors to keep nursing home workers informed of State standards. Workers themselves can then help monitor patient care deficiencies. SEIU Rhode Island nursing home workers have used this knowledge to alert inspectors of unsafe fire and safety conditions, chronic staffing shortages, and deficiencies in the dietary department.

Similarly, California SEIU locals have found public inspectors who are willing to give training workshops for workers in nursing homes. This simple, logical process provides a counterforce to temptation of our employers to cut corners and care standards. By giving workers knowledge of these public standards and access to public inspectors, the entire system is strengthened at minimal regulatory expense.

Workers in nursing homes also, with a publicly controlled and administered inspection process, have the protection of a public agency should employers seek disciplinary action for justified complaints of patient care violations. In the areas of staffing and dietary standards, in particular, this protection potentially could stop some of the worst patient abuses by allowing workers to sound the alarm without fear of loss of job or disciplinary actions. Finally, in regard to JCAH administration of the program, SEIU locals across the country have been able to use the current provisions for public access to inspection reports and findings to pressure for improvement in homes. JCAH reports, in contrast, are rarely available and if available, often are laundered for public consumption. We fear that regardless of a particular State's intentions, turning the inspection process over to JCAH would in effect result in closing the door to public regulation and control of the quality of care in nursing homes.

In summary on this issue, we want to stress our two major concerns:

(1) The inspection process must be publicly run and controlled, not turned over to a private agency.

(2) The process must be well staffed to meet the patient and taxpayer concerns that public health dollars go as far as possible in providing decent health care.

In addition, the proposed regulations have the following shortcomings:

—States would also be permitted to allow JCAH to use its own standards, which could differ considerably from public—Federal and State—standards. The proposed regulations fail to mandate any mechanism for public review, comment or oversight for the formulation of enforcement of JCAH standards.

—Permit States to inspect homes every other year rather than the current requirement for annual inspections. Two years is far too long for any nursing home to go unmonitored for an inspection cycle. Conditions change rapidly—especially with current pressures to cut budgets and tighten nursing home rates. With home patients staying an average of 2 or less years, many residents and their families will never have access to inspection teams.

—Eliminate the current requirement to resurvey a home with violations 90 days after the initial survey. The new regulations propose to allow inspectors to phone or receive written reports from administrators (on their honor) that corrections have been made. This proposal would clearly take the teeth out of the entire enforcement process.

—Eliminate the current requirement that a home be automatically terminated unless deficiencies are corrected by a specified date. The termination clause is an essential tool for enforcement of standards for pressuring homes to correct deficiencies and bring homes up to standards.

—Eliminate current requirements for quarterly staffing reports. Instead, the proposed regulations would ask for staffing surveys as necessary and require the staffing reports be available at least at the time of inspection. Staffing documentation is vital for an ongoing record of facility compliance. It is important that regular reports be available and kept accurate.

In general, the entire set of proposed regulations would cripple the survey and inspection enforcement process for nursing homes. Coupled with the Reagan administration's drastic cuts in funds for nursing home inspectors, these proposals would end up getting what little protection currently exist for vulnerable patients and workers in nursing homes.

SEIU believes that setting standards for health care facilities and enforcing these standards is a fundamental role of government and should not be turned over to private agencies or be dependent on self-regulation. With Federal and State governments currently providing some 57 percent of all nursing home revenues, the inspection process is one of the few mechanisms taxpayers have for assuring money is spent for health care and that this care at least meets minimal standards.

We therefore oppose the basic reasoning and details of the proposed regulations. Cutting back on funds and inspection requirements is against the interest of nursing home patients, home workers, and a general public concern for avoiding waste or misuse of tax dollars.

On behalf of all SEIU members, we thank the committee for this opportunity to submit written testimony. If the committee should need further documentation, examples or explanation, the staff of SEIU in Washington, D.C. will be at the committee's disposal.

ITEM 6. STATEMENT OF THE AMERICAN NURSES' ASSOCIATION

The American Nurses' Association is pleased to have the opportunity to present comments about the proposed rules for "Medicare and Medicaid: Survey and Certification of Health Care Facilities." ANA has a long history of involvement with governmental and nongovernmental agencies toward the improvement of health care and safety standards which guide the delivery of nursing services to the Nation's elderly.

ANA agrees with and supports HCFA's objective to streamline the cumbersome and inefficient processes which escalate costs and which do not provide the maximum assurance that the health and welfare of beneficiaries are protected. We are, however, deeply concerned that components of the proposed rules may not only fall short of meeting these primary objectives, but would also serve to jeopardize the strides made in attaining minimum standards of care and safety to residents in long-term care facilities. It is within this context that we raise the following questions and concerns about the proposed rules.

Mandatory 90-Day Resurvey

How will State agencies know that deficiencies are corrected in a timely fashion? While the flexibility aspect of this proposal has definite appeal, it lacks specific assurance that basic principles related to the correction of significant deficiencies will be enforced.

Although the arbitrary nature of the 90-day limit cited in the notice of proposed rulemaking may be real, the elimination of all specified time limits is unwarranted. A more reasonable and responsible approach would be to classify deficiencies into several categories and to assign a time limit for correction to each category. Additionally, it would seem appropriate to specify how the facility should document its compliance when an onsite visit is not required. Although 90 days is not a magical number, it seems that the correction of deficiencies in a timely fashion is essential, whatever the time limit may be. Another concern is the lack of information forwarded to State agencies regarding deficiencies found during a JCAH accreditation visit.

Cancellation Clause Provision

What will happen to the enforcement process? ANA has definite concerns about this proposed rule and supports the retention of the existing provision that facilities with serious and persistent deficiencies should have their provider agreement automatically canceled.

The association believes that survey agencies should monitor the correction of deficiencies according to their severity which is based upon the existing or potential impact on the health and safety of residents. Time intervals for correction of these deficiencies must be appropriately determined and enforced. State agencies must receive prompt and accurate reports of the deficiencies which exist and the terms for correction. If private organizations are to assume a role in performing part of the certification process, it only seems to follow that the enforcement process should be strengthened, not loosened.

Flexible Survey Cycle

Will a flexible cycle save money and/or provide for quality surveys? In principle a flexible survey cycle is desirable; some facilities would be surveyed more than once a year and others could be surveyed less frequently, but within a 2-year timespan. The cycle could depend on the performance rating assigned to the facility after the initial review. However, in a time of budgetary constraints at the State and Federal level, does it not seem likely that this provision would be interpreted to permit agencies to conduct surveys only every 2 years? This is not a pejorative statement about the abilities or sensitivities of survey agencies, but reflects the kinds of difficult choices that State agencies will be forced to make within existing monetary constraints. Just as in past decades when State agencies had insufficient funds to support a topnotch consultation service to assist all facilities to correct the deficiencies, so the existing economy will dictate the level of activities by the State agency.

The association is also concerned about the implicit disregard for the population currently residing in skilled nursing facilities and intermediate care facilities. Intermediate care facilities for the mentally retarded (ICF/MR's) have been exempted from this provision for good reason; however, the significant populations of individuals with mental illness/mental retardation and behavioral problems currently in ICF's and SNF's are not afforded a similar provision. This population, as well as the many thousands of individuals who are seriously ill and have complex health problems in SNF's are a significant percentage of the whole. What assurances are there in the regulation that these populations will be adequately protected?

Deemed Status for SNF's/ICF's/HHA's Accredited by the Joint Commission on Accreditation of Hospitals

Will the deemed status provision be an actual cost savings to the Federal Government? The proposed regulations are set forth within the context of a social and political environment in which these rules would result in a cost saving. Medicare participating SNF's and HHA's are estimated at nearly 600 in the Nation. Medicare/medicaid and medicaid only participating SNF's, ICF's, and HHA's are estimated at about 20,000. JCAH estimates their capacity to serve 5,000 long-term care facilities will take 3 years.

The HCFA projected cost savings are predicated on the assumption that all eligible facilities will seek JCAH accreditation and all State agencies will accept deemed status for an eligible facility. When would we expect to see cost savings? The basis

for this assumption should be examined very closely before making far reaching decisions.

It seems more than reasonable to expect that costs for survey processes will remain the same in constant dollars for some time to come. Regardless of the numbers of JCAH accredited facilities, State agencies will continue to be responsible for the remaining facilities, and will require sufficient manpower and financial resources to meet their responsibility. Funding to the State agencies for these purposes, one must speculate, must remain at appropriate levels and the need for funding will probably not diminish over time.

How shall State/Federal agencies be held accountable to the public funds if JCAH performs the accreditation process? Another concern related to this proposal is the locus of the Federal Government's accountability for the use of public funds and for the enforcement of the total scope of standards for long-term care facilities. JCAH has not been and should not be expected to become an enforcement agency. The locus of public accountability must remain in the appropriate Federal/State agency. How will the Federal/State agency be assured of access to the survey information? The proposed regulations recognize that JCAH survey reports have historically been confidential; the regulatory change includes a proposal that the health care facility post current JCAH survey reports for public inspection. ANA believes that the regulation should be modified to require that facilities which seek JCAH accreditation supply a copy of the survey report to the appropriate State or Federal agency so that these bodies can meet their public accountability. Although State agency validation surveys will provide some data for the State agency, the random nature of selection of these facilities preclude that the State will have sufficient information for those facilities given deemed status. Additionally, the regulation should require that survey reports are written in easily understood language so that the public has access to information and not just access to paper.

Summary

The American Nurses' Association is firmly committed to its support of the Federal Government's role in assuring access to health care for its citizens, especially those populations at highest risk (i.e., the elderly and chronically disabled). Congruent with this position is our support of the Federal Government's role in monitoring and enforcing the level and quality of care which it finances. This responsibility cannot be relinquished or in any way relegated to others without a comprehensive and planned analysis of the existing human, financial, and technical capabilities in those mechanisms (bodies) to which this responsibility may fall.

The certification and enforcement mechanisms identified in the proposed rules for "medicare and medicaid: Survey and certification of long-term care facilities" have substantially weakened existing mechanisms for mandatory resurvey, the survey cycle and cancellation clause provisions. It appears that the proposed regulatory changes were drafted from the perspective of the universe of eligible long-term care facilities that are already JCAH accredited or are considered to be "good" facilities. We question the use of such an assumption and would encourage HCFA to further study and revise these rules in light of our questions, prior to final publication.

ITEM 7. LETTER FROM PETER W. HUGHES, LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, TO SENATOR JOHN HEINZ, DATED AUGUST 10, 1982

Dear Senator Heinz: Thank you for the opportunity to submit written testimony, for the record, on the proposed regulations governing nursing home survey and certification (subpart S). AARP is pleased to present our view on problems with the current system, the impact of the proposed regulations, and suggestions for alternative reforms.

Problems With the Current Survey and Certification System

The fundamental defect in the current survey and certification system has long been identified by both the Department of Health and Human Services and the Congress. The overriding problem is that Federal regulations focus on facilities not patients. A facility's capacity to deliver a given level of care is more important than whether the patient actually receives this care or whether the care even meets minimum standards. By requiring States to focus on the structure of nursing homes and a "paper review" of facilities' theoretical capabilities for providing care rather

than whether the care is actually being provided, the enforcement mechanism has made only marginal success in elevating patient care practices.

In addition, reductions in Federal funds for State survey and certification activities has reduced the States' ability to enforce nursing home standards. The 24.6-percent reduction in Federal funds for State survey and certification activities since 1980 has resulted in States' reducing their survey and certification staffs by 35 to 45 percent. It is obvious that the proposed subpart S rules are substantially based on this reduced level of Federal support for State survey and certification of nursing homes. AARP firmly believes that rules affecting the enforcement of health and safety standards in nursing homes should not be promulgated on the basis of budgetary savings. America has sufficient resources to insure the health and safety of its most vulnerable citizens.

Impact of the Proposed Regulations

The changes in subpart S proposed by HHS do not improve the survey and certification procedures currently in force, and, if implemented, would have a severe negative impact on this Nation's 1.3 million nursing home residents.

Moreover, the reduction in onsite survey and certification inspections implicit in these proposed regulations and the reduced level of Federal funding for State survey and certification activities runs counter to a recent General Accounting Office (GAO) study on patient characteristics and State medicaid expenditures for nursing home care. That GAO study indicates that patients now entering nursing homes are even more dependent and disabled than previous patients and that this trend is likely to continue. GAO notes that the increasing demand for nursing home services, plus State and Federal efforts to reduce costs, makes an adequate inspection and certification program crucial to the health and safety of nursing home patients.

The Department's approach to the subpart S rules is fundamentally flawed in that it fails to recognize the frailty of nursing home residents and the bleak history of neglect and abuse in the nursing home industry. The Department's proposal to allow a private organization to accredit nursing homes exemplifies their willingness to abandon government responsibility and accountability for enforcing nursing home standards. AARP believes that it is not appropriate for the Federal Government to delegate nursing home survey and certification responsibilities to a private organization that is not accountable to the public.

The medicaid program finances over 50 percent of all nursing home care in the United States. Government, being a major financier of care, has an obligation to nursing home patients and to the taxpayer to ensure that its nursing home expenditures are made according to law. That is a nondelegable, public obligation for which public officials are accountable.

The "deemed status" arrangement envisioned under the proposed rules weakens enforcement of nursing home standards by separating enforcement from survey and certification. Moreover, patients' rights to quality care are not viable without a strong, comprehensive and accountable entity to enforce those rights. A nonaccountable private organization cannot provide the level of protection necessary to ensure safe, compassionate, high quality nursing home care.

Moreover, HHS proposed to go from an annual survey cycle to a "flexible" survey cycle by which all nursing homes would be inspected every 2 years and poor or marginal facilities inspected at least every year.

This represents a reduction in the frequency of inspections required under current regulations. Such flexibility will not enhance nursing home care; most likely, it will lead, over time, to a deterioration in care because, faced with deep budget cuts, States will not have sufficient funds to inspect more frequently than every 2 years. In addition, since nursing home patients' average stay is 2 years, it is likely that many patients and families may never have access to an inspection team.

The Department's subpart S proposals include the elimination of two enforcement provisions now in provider agreements that are essential safeguards for nursing home residents.

The automatic cancellation clause and the time limit on provider agreement clause are necessary to insure prompt responses to identified deficiences in nursing home care.

By having definite time limits in provider agreements, nursing home administrators readily appreciate the obligation to operate their facility according to law on penalty of nonrenewal. Such time limits give those accountable to the public, maximum leverage to insure that deficient facilities will come into compliance. Without such limits, administrators could use the courts, at tremendous public expense, to

delay public officials from decertifying recalcitrant facilities that are endangering patients' health or safety.

Similarly, the automatic cancellation clause motivates administrators to promptly correct serious deficiencies to avoid the operation of this clause. Considering the extreme vulnerability of nursing home patients, these mechanisms are prudent safeguards and must be maintained.

ALTERNATIVE REFORMS

The purpose of nursing home survey and certification should be to assure that residents are receiving the care they need. The focus should be on assessing the physical, social, and psychological needs of nursing home patients; and a facility's evaluation should be on the basis of the actual delivery of such needed services.

Toward that end, AARP was encouraged by the Department's development of the patient assessment and care evaluation system—PACE—in 1975. PACE is a base for measuring a patient status, the care given and the outcome of care. It provides an excellent mechanism to change the survey and certification process from one of paper compliance to one in which the determination of compliance is on the basis of outcome of care and thus the quality of care. Unfortunately, though PACE has been successfully demonstrated, the Department has abandoned the PACE approach to survey and certification.

AARP firmly believes that a PACE type approach to nursing home survey and certification is more consistent with an effective, cost conscious inspection program and the need to insure quality care. Unfortunately, the subpart S rules proposed by HHS do not provide adequate enforcement procedures. We urge HHS to withdraw the proposed subpart S rules in favor of developing regulations that focus on the actual quality of services received by nursing home patients.

Sincerely,

PETER W. HUGHES,
Legislative Counsel.

ITEM 8. LETTER AND ENCLOSURE FROM PATRICIA NEMORE, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, WASHINGTON, D.C., TO SENATOR JOHN HEINZ, DATED AUGUST 12, 1982

DEAR SENATOR HEINZ: On behalf of the National Gray Panthers, we are pleased to respond to your invitation to submit testimony on the proposed changes in the survey and certification process for nursing homes. We very much appreciate the committee's interest in this subject.

The National Gray Panthers is a nonprofit organization incorporated in Pennsylvania, with its headquarters in Philadelphia. It has an estimated membership of 40,000 persons, residing throughout the United States, who seek to reform and improve various laws and institutions which affect the lives of older people. Among the concerns of the Gray Panthers is the quality of life for nursing home residents, most of whom are older people.

The National Senior Citizens Law Center is a national support center, funded by the Legal Services Corporation and the Administration on Aging, specializing in the legal problems of elderly poor people. NSCLC tasks include working with legal services and aging advocates on problems affecting nursing home residents.

The Gray Panthers' testimony consists of the formal comments it submitted to the Health Care Financing Administration on the proposed rule on the survey and certification of health care facilities in medicare and medicaid (subpart S), and this letter, which summarizes those formal comments.

SUMMARY OF NATIONAL GRAY PANTHERS' COMMENTS ON SUBPART S

GENERAL COMMENTS

The Gray Panthers opposes the proposed changes in subpart S. They represent an abdication of responsibility on the part of the Federal Government to protect the lives and well-being of over a million nursing home residents, and to insure the proper expenditure of billions of Federal dollars. In the name of flexibility, the Federal Government seeks to shift critical decisions with tremendous fiscal implications to the States, whose budgets are already strained to the limit.

The Gray Panthers also objects to the clearly illegal activities of the Health Care Financing Administration in implementing by memoranda several of those changes proposed in the subpart S notice of proposed rulemaking, changes that can only be

made by regulation. Two memoranda, issued in March and December 1981, direct the States how to proceed in their survey processes in view of fiscal year 1981 and fiscal year 1982 budget cuts. Among the recommended practices are the elimination of (required) onsite resurveys except when no other method can be used to verify whether corrections have been made, and the elimination of (required) annual surveys for certain facilities. As part of the process of identifying those facilities to be surveyed less than annually, one memorandum ranks some but not all of the standards within the conditions of participation. A facility's survey schedule is then determined by its level-of-compliance based only on the ranked standards. Thus certain of the duly promulgated regulatory standards governing nursing homes are rendered meaningless by being eliminated from the rankings. The Gray Panthers strongly objects to the bypassing of the required public rulemaking process that is reflected in the contents of these memoranda.

JCAH DEEMED STATUS

The Gray Panthers opposes the proposal to give deemed status for certification to nursing homes accredited by the Joint Commission on Accreditation of Hospitals. It does so on three grounds:

(1) JCAH standards are not equivalent to Federal standards. In some instances they are weaker, and, in any case, their development is not subject to public accountability. Moreover, residents of a JCAH-accredited facility would be confused and frustrated in efforts to enforce their federally protected rights, being unsure whether to invoke the JCAH standard or the Federal standard.

(2) JCAH lacks any enforcement capability. Its reports are not publicly available. Under the proposal, interested individuals and State enforcement officials would have to make special trips to a facility to see its report. A facility's compliance history would not be available at all for public and private enforcement proceedings. Other agencies, such as State nursing home administrator licensing boards and health planning bodies, would be denied important tools for their work.

Deemed status could lead to a further erosion of the enforcement capability of State licensing agencies that are already feeling the effects of Federal budget cuts. Deemed status would result in duplication rather than savings where State agencies would have to redo JCAH's work in order to investigate complaints, impose intermediate sanctions, or delicense or decertify substandard facilities.

Neither JCAH nor HCFA stated how each agency will work with the other and with the State agencies concerning facilities where deficiences are found to exist.

(3) The JCAH proposal appears to conflict with some statutory requirements, such as the medicaid requirement that State licensing agencies perform the function of determining which facilities are eligible to participate in medicaid.

QUARTERLY STAFFING REPORTS

There is widespread belief that staffing is a critical element of quality of care in long-term care facilities. The proposal eliminates universally required reports without providing any concrete guidance as to when staffing reports should be required. Such guidance might include requiring reports when complaints are received about a facility and when there is a change in ownership, management or critical personnel within a facility.

MANDATORY 90-DAY ONSITE RESURVEYS

The current mandatory onsite reinspection is replaced with a flexibility that provides opportunities for industry pressure. No standards are provided for determining when surveys should be onsite, and when mail or telephone verification of corrections is sufficient. The current requirement serves an important function: insuring that corrections of deficiencies, even if not completed within the 90 days, are begun.

TIME-LIMITED PROVIDER AGREEMENTS

Since Congress has repealed the requirement for 12-month provider agreements, States may experiment to determine whether open-ended agreements or those of specified duration best serve the goal of providing quality care for residents. Open-ended agreements may serve the important function of introducing an element of surprise into the survey process. On the other hand, in some States, it is legally easier to not renew an agreement than it is to terminate an ongoing one. In those States, agreements of a specific duration might be preferable. Whichever method is used, it should be accompanied by a requirement for automatic cancellation.

AUTOMATIC CANCELLATION CLAUSE

Automatic cancellation clauses appear to be a highly effective tool in bringing about compliance. This is a logical interpretation of the Department's statement that most facilities are subject to the clauses and yet more than 90 percent of them correct deficiencies so that the clauses must be rescinded. Facilities need only show that they are making "substantial progress" toward correction to avoid the threat of automatic cancellation. The Department's suggestion that the alternative sanction of termination is available is disingenuous. Termination fails to bring about improvements in the quality of life for residents, requires the involuntary relocation of residents with attendant possibilities of transfer trauma, and results in a reduction of the number of beds available for medicaid recipients.

FLEXIBLE 2-YEAR SURVEY CYCLE

The Department has not set forth any criteria or standards for determining how frequently State agencies will need to survey facilities. State agencies, financially pressed from budget cuts, may use the proposed 2-year maximum as a general standard rather than as the outer limit. They may also revise their licensing requirements accordingly. Two years is too long for a long-term care facility to go unmonitored. It is common experience that "good" facilities can rapidly deteriorate following a change in ownership, management, or key personnel. Moreover, the Department's rationale for retaining a 1-year cycle for intermediate care facilities for the mentally retarded (ICF's-MR)—that most of the patients lack the necessary experience or capability to bring quality of care problems to the attention of outside authorities—pertains equally to nursing home residents. Many nursing home residents have no family or friends, are frail, and fear retaliation from staff of the facility if they complain too much. They are, thus, dependent on the inspections of State agencies.

The National Gray Panthers urges this committee to act to insure that the Department of Health and Human Services' proposal is not implemented.

We thank you for this opportunity to present testimony.

Sincerely,

PATRICIA NEMORE.

Enclosure.

COMMENTS OF THE GRAY PANTHERS ON PROPOSED RULE-SURVEY AND CERTIFICATION OF HEALTH CARE FACILITIES (HSQ 502-P)

INTRODUCTION

The Gray Panthers opposes the Department's proposed revisions in the survey and certification procedures as they pertain to long-term care facilities. We urge the Department to withdraw the proposal and to renew discussions of means of upgrading both nursing home standards and survey procedures toward the goal of improved care for residents.

Our opposition to the current proposal is based on our belief that by implementing the proposed changes, the Federal Government would be abdicating its responsibility to program beneficiaries and to taxpayers to insure that Federal funds are spent for quality care. The nursing home industry has grown primarily because of the influx of massive amounts of Federal dollars over the last 16 years. Yet now, in the name of flexibility, the Department proposes to turn virtually all responsibility for survey decisions over to the States. The decisions have potentially serious ramifications for the health and safety of nursing home residents. They also have serious fiscal implications for already overburdened State budgets.

GENERAL COMMENTS

The GAO Report

The Department's proposal to cut back Federal oversight of nursing home standards coincides, we are told by the Government Accounting Office, with the emergence of two conflicting trends. (Preliminary Findings on Patient Characteristics and State Medicaid Expenditures for Nursing Home Care. GAO/IPE-82-4, July 15, 1982.) These trends are (a) the increasing disability and dependence of nursing home residents, and (b) the increasing difficulties the States are having in paying for medicaid nursing home care. The message suggested by these trends is clear: now is not the time to reduce public oversight of long-term care facilities.

HSQB Memoranda

We strongly object to the Department's failure to state, in its recent NPRM, that is has already purported to accomplish, by at least two memoranda, what can only lawfully be done by regulatory change. While it steadfastly maintains that the current proposals are not based on budgetary considerations, similar requirements, set forth in the memoranda, were designed specifically in response to Federal budget cuts.

On March 11, 1981, Edward L. Kelly, Acting Director of HHS' Health Standards and Quality Bureau (HSQB), sent a memorandum entitled "Revised FY 1981 and FY 1982 Budgets for Medicare and Medicaid Survey Activities" to all 10 HCFA regional administrators. The Kelly memorandum explains that both the revised fiscal year 1981 budget and the proposed fiscal year 1982 budget would "drastically" reduce funds available for medicare and medicaid certification activities. The memorandum continues, "States must be prepared to immediately phase down to a level which enables them to operate in a manner that will not exceed funds available within budgetary levels approved by Congress," page 1. To assist regional offices prepare the States for anticipated budget cuts, the memorandum provides "guidelines," recognizing that many changes under consideration will require "top level approval, the development of criteria and computer screens, and regulatory and legislative changes," page 2.

While stating that surveys of SNF's "will remain the highest national priority," the memorandum contains "suggestions providing * * * some additional flexibility to minimize costs for title XVIII surveys," page 2.

Among other suggestions, the memorandum states that no followup visits need be made "when a SNF has been issued a full 12-month agreement without conditional clauses," page 3. If conditional agreements are signed, however, the memorandum purports to waive the current regulatory requirement for mandatory 90-day onsite resurveys, 42 C.F.R. § 405.1903, stating that an onsite visit could be made "only when no other method can be used to verify whether the required corrections have been made," page 3. The memorandum provides examples of when an onsite survey may be avoided—"to verify corrections of deficiencies in personnel requirements, internal organizational structure, or provider policies.

On December 29, 1981, Aris T. Allen, M.D., Director, HSQB, HCFA, sent the 10 HCFA regional administrators a memorandum entitled "Scheduling Facilities for Survey in Fiscal Year 1982." The Allen memorandum states that certain facilities need not be surveyed annually.

The memorandum begins by noting that section 2153 of the Omnibus Budget Reconciliation Act of 1981 repealed the statutory requirement for time-limited agreements for SNF's. It then notes that budget reductions "compel us to allocate the bulk of our available resources to surveys of poor and/or marginal facilities," page 1. HSQB, the memorandum continues, has "outlined current national priorities for provider standards enforcement and identified key requirements (KR's) which might serve as the basis for selecting providers for surveys in the current fiscal year," page 1. Key requirements are essentially some but not all of the conditions and standards within each condition of the conditions of participation for SNF's and the standards for ICF's. Each key requirement is assigned a letter grade of A, B, or C. Class A requirements "are those requirements, which if not met, are most likely to have an immediate adverse effect on patient health and safety," page 1; class B, "those requirements, which if not met, are likely over time, to have an adverse effect on patient health and safety," page 1.

The memorandum then sets out three level-of-compliance categories for facilities. "Facilities deficient in one or more class A requirements" should all be surveyed during fiscal year 1982 "because they have established a record of poor compliance with program requirements," page 1. The decision to survey "facilities meeting all class A requirements but deficient in one or more class B requirements," page 1, should be "based on established national priorities, and on other available information concerning the current status of compliance with major requirements, for example, beneficiary complaints," page 2. Finally "facilities meeting all class A and class B requirements * * * have established a record of compliance with major program requirements and, in the absence of more current adverse information, should *not* be surveyed in the current fiscal year [emphasis in original]," page 2.

While the Allen memorandum says that the lists of providers in each of the three level-of-compliance categories are provided to "assist" regional offices and State agencies allocate available survey resources in a rational manner and that regional offices are "not bound to follow them exactly," it cautions, "However, I would suggest you have a rationale for using different approaches," page 2.

If something similar to the approach set forth in the Allen memorandum is under consideration for the flexible survey cycle, we wonder what opportunity the States will have to incorporate their own experiences with a particular facility into the decision of how often the facility should be surveyed.

1980 Subpart S Initiatives

Finally, in our general comments, we wish to point out that two of the four objectives identified by HCFA in its February 29, 1980 notice to develop regulations have not been addressed at all in the current proposal. Those two objectives are improving the quality of surveys and including patients (whom we call residents) and consumers in the survey and certification procedure. These are two objectives the pursuit of which we strongly encourage.

SPECIFIC COMMENTS

JCAH Deemed Status

The proposal for deemed status raises countless questions and poses significant problems in connection with the application and enforcement of nursing home standards. In addition, a number of conflicts with the medicare and medicaid statutes appear to exist in the proposed rule. Moreover, besides the specific problems, we question the propriety of the Federal Government delegating its own responsibilities to a private, provider-run national organization with a distinctly medical orientation and with no enforcement authority.[1]

1. Standards

The medicare statute requires that, for the Secretary to grant deemed status to health care facilities other than hospitals, s/he must find that accreditation by a private body insures that the conditions of participation are met (42 U.S.C. § 1395bb(b)). Secretary Schweiker has purportedly made such a finding, despite the fact that in a number of specifics, JCAH standards do not provide the same protections as Federal standards. In a spot check of HCFA's comparison of Federal and JCAH standards, several areas are identified where JCAH standards require less than those of the Department. For example: (a) The Federal standards require a physician's visit every 30 days within the first 90 days after admission and thereafter, at least every 60 days. JCAH standards require a visit within 45 days of admission and do not specify a cycle thereafter. (b) The Federal standards require that residents must have reasonable advance notice prior to transfer and that spouses have the right to share a room if they so desire. JCAH standards do not contain either provision.

Moreover, JCAH does not, apparently, have separate standards for SNF's and ICF's. In some instances, stronger ICF protections do not appear in the JCAH "equivalent."

A major problem with the current regulations is that they foster paper compliance. JCAH standards do not really differ in this regard. JCAH standards, at times, specify policies and procedures where the Federal standards require a specific action.

JCAH is in the process of revising its long-term care standards. The new standards are expected to be completed sometime in early 1983. Yet the Secretary of HHS has made his findings based on the current standards. Will a new finding be made when the new standards are issued? The statute seems to require it.

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[1] Until January 1982, the JCAH Board of Commissioners was comprised of representatives from the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. In January 1982, JCAH did add a so-called public member to its board. The individual, a Chicago corporate lawyer, is the president of Central Telephone & Utilities Corp., the chief executive officer of Beatrice Foods, and a director of the National Trust Bank of Chicago. His background does not suggest experience with the issues of importance to consumers of health services. JCAH points to this public member, as well as to the "consumer" members of its long-term care professional and technical advisory committee as examples of its accountability to the public. JCAH has, however, repeatedly denied requests by consumers as well as by other health care professionals to add representatives to its decisionmaking Board of Commissioners. See, e.g., William Worthington and Laurens H. Silver, "Regulation of Quality of Care in Hospitals. The Need for Change." 35 Law and Contemporary Problems 305 (1970) (hereinafter Worthington and Silver) and Kenneth G. Crosby, "Accreditation and Associated Quality Assurance Efforts." 13 Professional Psychology 132 (February 1982).

The adoption of private standards as the equivalent of Federal standards violates the Administrative Procedure Act by precluding formal comments from interested parties. The "deemed" adoption of JCAH standards certainly renders meaningless the successful efforts last winter of hundreds of people and organizations to have the Department discontinue consideration of major changes in the conditions of participation.

The difference between HCFA and JCAH standards raises questions about how a resident enforces a violation of a federally protected right. What are the rights of residents in a facility with deemed status, JCAH's rights or those in the Federal law and regulations? Who besides the facility is responsible for infringements of them, JCAH, the State, or HCFA?

To verify that deemed status provides assurance that Federal standards are met, the Department proposes to require validation surveys like those used for accredited hospitals. Yet the validation survey process, and more specifically HCFA's interpretation of the results, are open to criticism. During fiscal year 1980, 61 percent of the hospitals in the selective sample, and 23 percent of those surveyed pursuant to a complaint were found to have significant deficiencies.[2] (At the July 15, 1982 hearing of the Senate Special Committee on Aging, HCFA Administrator Carolyne Davis characterized many of the deficiencies identified in validation surveys as "minor." Yet the fiscal year 1980 report to Congress describes them as "significant" and further refers to findings that each facility was found to be deficient in one or more of the conditions of participation.) Over 50 percent of the selective sample hospitals found out of compliance in the fiscal year 1980 surveys had Life-Safety Code (LSC) violations. HCFA attributes this finding in large part to the fact that all State survey teams, which perform the validation surveys, use fire safety professionals to evaluate compliance with Life-Safety Code. The JCAH survey teams, by contrast, utilize a hospital administrator with training in LSC matters. The gravity of the LSC deficiencies is described in the fiscal year 1980 report to Congress:

"Several areas in which State surveyors cited deficiencies more than three times as often as JCAH surveyors were enclosures and shafts, exits, sprinklers and air-conditioning. Each of these is a critical area in fire safety as each is a major cause of the spread of smoke and toxic gases during a fire."[3]

The disparity in the LSC capability of JCAH and State survey teams is especially significant for nursing home residents since past "horror stories" related to nursing home fires have largely been eliminated through strict enforcement of LSC standards.

Other areas of deficiency in the JCAH survey were reported in the fiscal year 1980 validation survey report. These included laboratory, nursing, and outpatient services. (Independent investigations of JCAH-accredited nursing homes in Michigan have uncovered violations of State licensure requirements such as nursing services, medical services, medical records, residents' rights, and pharmaceutical services.[4]

Validation and complaint investigation surveys are the sole means for HCFA and the State agencies to hold JCAH accountable. Yet the validation regulations make it very difficult to revoke deemed status from a facility found out of compliance. To do so, a finding must be made that a "significant deficiency" exists. However, a significant deficiency will be determined not to exist if—

(i) The accrediting body accepts the State survey agency finding of deficiencies and agrees to monitor the correction of the deficiencies in accordance with specified time frames.

(ii) The State survey agency is unable to justify to HCFA the need for continued full review by the State survey agency to assure correction of deficiencies; and

(iii) The accrediting body provides HCFA or the State survey agency with periodic reports of progress in correcting deficiencies.

Proposed 42 C.F.R. § 490.18(e)(3) (i)-(iii). In other words, absent extraordinary circumstances, if JCAH is willing to take care of the problem, HCFA or the State agency will accept that resolution.

The validation survey process seems to return most of the control back to JCAH, rather than providing the accountability that the Department pretends it will provide.

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[2] Annual report, fiscal year 1980, Medicare Validation Surveys of Hospitals Accredited by the Joint Commission on Accreditation of Hospitals.

[3] Id. at page 10.

[4] Citizens for Better Care, position on JCAH "deemed status" proposal, Aug. 12, 1981.

2. Enforcement

(a) JCAH reports.—JCAH survey results are confidential; the Commission will only release them to the facility in question, which has paid JCAH for the survey. The Department's response to the problem of confidentiality is to require a facility wanting deemed status to "prominently display" its current survey report. This requirement, however, fails to resolve issues of access to and quality of JCAH reports. First, the Department does not require that the report be made available to HCFA, to State survey agencies, to any other public, health-related body, or to the public. No one can see the report without making a trip to the facility. Second, once there, an interested person will only be able to review current information. The history of the facility's compliance will not be posted or otherwise made available. Finally, the survey results that will be available will be only a summary, or "recommendation letter," containing "detailed, itemized accounts of recommended practices which the accreditation committee considers the subject (facility) should establish * * *" [5] A listing of the actual deficiencies found in any facility will not be available for inspection or analysis.

The lack of access to and quality of JCAH survey reports is a critical problem for both public and private enforcers of nursing home standards and related activities. State attorneys general and private litigants have relied on deficiency reports in court actions brought to improve the quality of care in particular facilities.[6] The reports are also necessary, of course, in actions to decertify substandard facilities, or to impose many of the intermediate sanctions, such as receivership and civil penalties, that States in recent years have developed.

Other agencies within a State use the deficiency reports to carry out their duties. The statutorily mandated State nursing home administrator licensing boards, for example, may rely on the reports both to identify possible administrator-related problems and to help establish their cases against administrators whose licenses should be suspended or revoked. HCFA has, in fact, directed the survey agencies to transmit survey information that reflects serious deficiencies to the administrator licensing boards.[7] At least one State, Minnesota, has similar requirements.[8] A second example of agencies using deficiency reports is the health planning bodies, both the local health systems agencies, and the State health planning and development agencies. These bodies are required to make findings concerning the quality of health care in both certificate of need and appropriateness reviews.[9] The work of these and other State and Federal agencies may be seriously hampered by the lack of availability of the JCAH reports.

(b) *JCAH's lack of enforcement authority.*—JCAH has repeatedly stated that it is not an enforcement body and has no interest in becoming one. It is the Government's responsibility, it maintains, to enforce standards. Nor could JCAH take enforcement action even if it chose to. Police power resides with the States. In connection with the licensing of facilities, State agencies may enter facilities for inspection and demand to see records. If demands are not met, they can get warrants from their courts. If deficiencies persist, they can delicense a facility or apply intermediate sanctions.

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[5] Annual report, supra note 2, at page 2. It is interesting to note that HCFA recognizes and appears unconcerned that it receives only the recommendation letter and not the raw survey data from JCAH-accredited hospitals in connection with the current statutorily required validation surveys. HCFA has not always been so casual in this view. In its analysis of comments in connection with publication of the final rule changing the requirements for validation surveys (45 Fed. Reg. 74826, Nov. 12, 1980), HCFA noted that JCAH has recommended defining "survey" as "the accreditation letter and attendant recommendations and comments." Id. at 74828. HCFA's response was, "We did not accept these comments since these are statutory requirements." Id.

[6] See, e.g., *Commonwealth of Massachusetts* v. *Havolyn Management Corporation and Raymond R. Monahan*, Civ. Act. No. 38227 (Superior Court of the Commonwealth of Massachusetts, 1979); *Resident* v. *Emmanuel Family Training Center, Inc., d.b.a. Emmanuel Care Center*, C.A. No. C78-477 (N.D. Ohio, filed April 1978) 12 *Clearinghouse Review* 126 (June 1978) (No. 24,156); *State of Wisconsin* v. *NR-1 Trust*, Case No. J-4382 (Circuit Ct., Milwaukee County, Wis., filed December 1978). This last case is a criminal complaint that resulted in the conviction of a nursing home administrator of homicide by reckless conduct in connection with the death of a resident in 1976.

[7] Health Standards and Quality Bureau, HHS Standards and Certification State Letter No. 264 (November 1979).

[8] Minn. Stat. Ann. § 144A.251 (West Supp. 1982).

[9] See, e.g., 45 Fed. Reg. 69740, Final Regulations on Health Systems Agency and State Health Planning and Development Agency Reviews; Certificate of Need Programs. 42 C.F.R. § 122.310(a); § 123.412(a)(20). The relevant language concerning appropriateness review appears at 42 C.F.R. § 123.607(a).

The States' ability to enforce nursing home standards may be seriously eroded by the JCAH proposal. Although the proposal is couched as a State option for all but medicare-only facilities (of which there are very few), the option may be more illusory than real. Governors may view deemed status as a cost-saving opportunity (although it is not clear that it would in fact save money) at a time when there is significant discussion of ways to control the costs of the medicaid programs. Since JCAH-accredited facilities would not require a State survey, the State's budget for its office on licensure and certification could be trimmed. Virtually every State's certification program has already suffered both money and staff cuts due to substantial reductions in the medicare survey budget and to the reduction in the medicaid Federal financial participation from 100 to 75 percent.[10] If deemed status is adopted at the Federal level, moneys for State surveys of medicare-only facilities will be lost whether or not the States opt for deemed status. Since most States combine their licensure and certification activities,[11] a State's licensure capability will also be affected by the losses of Federal funds due to deemed status. Budget considerations may even compel States to grant deemed status of JCAH for their licensing functions. This has been done by a number of States for hospital licensing, and is currently under consideration by others.[12] If it were adopted for nursing homes as well, the State enforcement capability would be virtually nonexistent. Even without deemed status for licensure, however, the cutbacks in Federal survey money connected with the current proposal could cripple the enforcement capability of the licensing agency, with serious repercussions for quality of care in nursing homes.

(1) *Complaint investigation.*—First, the State agency may be unable to respond adequately to complaints. The Department has not provided information about how JCAH handles complaints. Such questions as how the process is made known to the public, if and how confidentiality of the complainant is protected, and how the investigation is carried out remain unanswered. Moreover, regardless of the JCAH complaint investigation capability, many State laws require the health department to respond to complaints about nursing home care. To the extent the States actually did continue to provide funds for this and other enforcement-related activities, duplication of services would result. States would have to pay JCAH surveyors—indirectly, through reimbursement—as well as their own for a variety of functions formerly performed only by their own people.

(2) *Inability to utilize intermediate sanctions.*—Second, a weakened enforcement capability would make it more difficult to impose the variety of intermediate sanctions that many States have, in recent years, added to their nursing home laws. JCAH has no intermediate sanctions, other than a shorter period of accreditation. The trend toward intermediate sanctions has been a good one, enabling States to promote quality care with less recourse to the generally unsatisfactory tool of decertification.

(3) *Difficulty in decertifying.*—Third, in those cases where decertification or delicensure appeared warranted, the State would have no record on which to proceed. (It might not even have any way of knowing it should proceed.) Even a deaccredited

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[10] See e.g., "Survey of State Agencies: Impact of Federal Policy Changes and Budget Cuts on Nursing Homes" prepared by the National Citizens Coalition for Nursing Home Reform, Mar. 12, 1982. Twenty-eight of 29 States responding to the survey had experienced budget cuts, averaging 24.45 percent in fiscal year 1981 and 45.4 percent in fiscal year 1982. Survey results, page 2.

[11] Id. Twenty-seven of the 29 respondents reported total or substantial integration of these two functions.

[12] A document entitled, "State Project Status Report (as of Mar. 31, 1982) and presumably prepared by JCAH, identifies 16 States as having mandatory or permissive legislation authorizing deemed status for hospital licensure. Another 19 States have nonstatutorily based arrangements with JCAH concerning part or all of their hospital survey. (This document is on file at the Washington office of the National Senior Citizens Law Center.) It is impossible, without reviewing the legislative history of each statute, to know why these laws were passed. We can, however, speculate on a number of reasons why deemed status for hospital licensure might be attractive to States:

1. Budgetary constraints may have forced States to look for areas to cut back survey activities; hospitals, served by a large number of highly qualified, professional people might be seen as reasonable institutions to remove from close public scrutiny.

2. JCAH may in fact have a significant ability to persuade hospitals to comply with standards due to a number of aspects of hospital life that can be affected by accreditation:

—Internship and residency programs.
—The ability to attract physicians to the staff.
—The cost of malpractice insurance.
—The creditworthiness of the hospital; and
—The willingness of private insurers to presume claims are valid.

These factors generally do not apply to nursing homes.

facility is not automatically decertified; the State must make its own case.[13] A record would have to be made, through State inspections over a period of time, again duplicating the past work of the JCAH.

(4) *Inability to meet needs of other agencies.*—The State agency capability is also important in other areas. Just as survey reports are used by professional licensing boards, so is the testimony of surveyors used in proceedings to impose a sanction on a licensed person.

(c) JCAH's relationship with HCFA and State agencies.—JCAH may accredit a facility for only 1 year in cases where serious deficiencies are found but promise of improvement exists and there is "no clear and apparent danger to the quality of care or the safety of patients." [14] The Department does not say how JCAH will proceed when it gives a 1-year accreditation. Will it make its findings known to the State agency? Will it report why the facility is being given only 1 year's accreditation and what steps the facility is taking to improve conditions? If it deaccredits a facility altogether, will it notify the State agency? What action will it take if it discovers violations of Federal or State law? JCAH's policy of confidentiality would appear to preclude it from working with State agencies concerning less-than-satisfactory facilities.

Other questions need answers as well. What will HCFA do if a facility that it has identified through the medicare-medicaid automatic certification system (MMACS) as having a sufficiently poor compliance history to warrant an annual survey is given a 2-year accreditation by JCAH? Will it question JCAH's findings? Will it send its own or State agency surveyors into the facility? Immediately? Or only after 1 year? Will HCFA routinely cross-check its MMACS information against a list of 1- and 2-year accredited facilities? Will it even have access to such a list from JCAH?

3. Conflicts with medicare and medicaid statutes

(a) Lack of authority for medicaid-only facilities.—The medicaid statute requires, as part of each State's plan—

* * * (B) That the State or local agency utilized by the Secretary for the purposes specified in the first sentence of section 1395aa(a) of this title, or if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, *will perform* for the State agency administering or supervising the administration of the plan approved under this title *the function of determining whether institutions and agencies meet the requirements* for participation in the program under such plan. [Emphasis supplied.]

42 U.S.C. § 1396a(a)(36). This language appears to preclude the State agency from delegating its statutory responsibility for determining compliance with Federal requirements for program participation. Such a statutory preclusion would prevent States from giving demand status to JCAH for medicaid-only facilities.

(b) Lack of authority for validation surveys.—Validation surveys were authorized for hospitals with deemed status by the 1972 amendments to the Social Security Act. 42 U.S.C. § 1395bb. They were required because Congress was concerned that the Federal Government, prior to that time, had no means of verifying whether JCAH was effectively assuring compliance with Federal standards.

There is no comparable language in the statute relating to the Secretary's authority to grant deemed status for other providers. It is possible that this requirement of validation surveys cannot be imposed by regulation, as the NPRM purports to do. Proposed 42 C.F.R. § 490.18(a).

(c) Statutory requirement that medicare-certified facilities be deemed to meet medicaid SNF conditions.—A skilled nursing facility certified for medicare is deemed by statute to be certified for medicaid. This concept is articulated in three separate places in the law. 42 U.S.C. § 1396a(a)(28) defines "skilled nursing facility" in the medicaid program by referring to 42 U.S.C. § 1935x(j), the medicare definition. 42 U.S.C. § 1396d(i), medicaid definitions, defines a medicaid SNF as one certified as meeting the requirements of § 1395x(j). Finally, 42 U.S.C. §1396i(a)(1) provides that any skilled nursing facility certified under medicare shall be deemed to meet the standards for certification under medicaid. Thus, the State option for dually certified facilities, offered by the NPRM, contradicts the Federal law by giving the State discretion to do what is already statutorily required.

(d) Higher State standards must be applied to medicare facilities in that State.—42 U.S.C. § 1395z requires that where States have higher standards than the Federal

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[13] Sec. e.g., "The Medicare Hospital Certification System Needs Reform," report to the Congress of the United States by the Comptroller General, HRP-79-37, May 14, 1979, at page 19.

[14] *JCAH* v. *Weinberger*, Civ. No. 74 C 1751 (N.D. Ill., Oct. 8, 1975), Medicare and Medicaid Guide (CCH) § 27,522, complaint page 8.

Government for payment to health care facilities, the Federal Government must utilize those higher standards in certifying facilities for medicare. At least one commentator has suggested that in such cases, deemed status cannot apply.[15] Depending on the number of medicare-only facilities in States with higher standards, this could significantly diminish any purported savings to the Department from this proposal.

Quarterly Staffing Reports

The requirement that facilities submit quarterly staffing reports to the State survey agency appears in the second standard, "Staffing Patterns," in the condition of participation for SNF's entitled, "Governing Body and Management." 42 C.F.R. § 405.1121(b). Although the Department asserts that the proposed change would eliminate the need for submission of quarterly staffing reports, in fact, the NPRM would only eliminate the requirement that State agencies review the reports that are submitted. The NPRM does no more than tell State agencies that they need not review reports they receive from facilities.

The Department suggests that staffing deficiencies will be discovered during routine certification surveys. Since surveys, under the NPRM, could occur as infrequently as every 2 years, however, the protection offered by current State agency review of staffing reports four times a year is greatly diminished. Relying on a facility's history of staffing deficiencies, as the Department suggests as a second method of determining when staffing reports should be submitted, is no better. If the NPRM proposal with respect to quarterly staffing reports becomes a final regulation, there will be virtually no history of staffing deficiencies on which State agencies may base their decisions to require the submission of staffing reports.

There is also widespread belief that staffing is a critical element in quality of care in long-term care facilities and that staffing patterns may undergo rapid change following a change in facility ownership or management. At the very least, the Department should give clear direction to State agencies as to when staffing reports should be required, including whenever there are subjective reasons to believe that compliance with staffing requirements is lacking (for example, when complaints are received, as the Public Issue Paper in 1980 suggested), or whenever there are objective changes in a facility's ownership, management, or critical personnel (such as administrator and director of nursing).

Mandatory 90-Day Onsite Resurveys

While the Department asserts that followup of corrections of deficiencies should depend on both the nature of the deficiencies and the plan of correction undertaken by a facility, nothing in the proposed regulations requires that resurveys be timed in this manner. There are no standards set out in the proposed regulations for determining when followup should occur and, in fact, there is no requirement whatsoever that resurveys or followups even occur. The sole reference to resurveys, in proposed 42 C.F.R. § 490.12(e), simply indicates that resurveys should take place onsite only when necessary.

The flexibility given to State agencies by the NPRM to determine how long to allow for compliance replaces an objective time standard with opportunities for industry pressure.

The Department's proposal to replace mandatory onsite resurveys with telephone or mail verification of corrections, whenever possible, is essentially a suggestion of self-survey. Facilities will simply be able to state, without independent verification, that problems are resolved. Again, the Department fails to set out any standards or guidelines for determining when surveys should be conducted onsite and when telephone or mail verification of corrections will be sufficient. The statement in the March 1981 Kelly memorandum that onsite inspections are not necessary "to verify corrections of deficiencies in personnel requirements, internal organizational structure, or provider policies," page 3, makes plain that whatever further guidelines the Deparment proposes, if it proposes any at all, will not cover many deficiencies for which onsite verification is critical. It is clear, for example, that allowing facilities to mail employment contracts to the State agency cannot adequately show that problems of inadequate staffing have been cured.

The Department's criticisms of the current mandatory resurvey requirement are not well-founded. The requirement serves an important function: Insuring that corrections of deficiencies, even if not completed within 90 days, are begun. Under the

[15] Worthington and Silver, supra note 1, at page 323.

Department's proposal, if a plan of correction were expected to take 120 days and resurvey on the 120th day showed that nothing had been done to correct the problem, 120 days would have been entirely lost. A continuing State presence helps insure that deficiencies are not ignored until the correction period expires.

Time-Limited Provider Agreements

Since Congress repealed the 12-month limitation on provider agreements, HCFA has authority to enter into agreements of unlimited duration with SNF's.

The elimination of time-limited agreements may serve an important function of introducing greater surprise into the timing of the certification survey. Since surveys will not be timed to coincide with the expiration of a provider agreement, facilities will not know when the certification survey is likely to occur.

There are, on the other hand, benefits to having a time-limited agreement, whether 12 months or more. In some States, the legal requirements connected with the nonrenewal of a provider agreement are less onerous than those necessary for the termination of an ongoing agreement.[16] Thus, time and money could potentially be saved by having agreements of specific duration. Given the legislation repeal of the 12-month requirement, States might experiment to determine which method best serves the goal of insuring quality care for residents. In any event, provider agreements should be required to expire automatically when a change in ownership or management of a facility occurs.

The elimination of time-limited agreements underscores the continued need for the automatic cancellation clause mechanism. If agreements continue without time restriction, there must be a mechanism that leads to automatic termination.

Automatic Cancellation Clause

The Department states that the cancellation provisions "were established to insure timely correction of deficiencies" but have "often proved ineffective, as well as costly and burdensome to administer." 47 Fed. Reg. 23405. The Department reports that since the cancellation clause is applied to all deficiencies, whether major or minor, "a substantial percentage of nursing homes is subject to automatic cancellation at any given time." Id. The Department also reports that since most facilities are able to show progress in correcting deficiencies within the 60-day period, State agencies rescind the cancellation clauses in over 90 percent of all cases. Since rescission generally requires "an onsite visit, documentation, and preparation of new certification forms to continue participation," id., the Department concludes that the entire mechanism is "a sizable burden of questionable value." Id. In the Department's view, eliminating the automatic cancellation clause requirements would enable State agencies "to tailor monitoring in accordance with the nature of the deficiencies to be corrected." Id.

The data offered by the Department in support of its proposal to delete the automatic cancellation clause requirement are subject to an interpretation quite different from the Department's. If most facilities at any given time are subject to automatic cancellation and yet more than 90 percent of them correct their deficiencies so that threats of cancellation must be rescinded, then this mechanism is in fact highly effective in bringing about compliance with the conditions and standards of participation.

Moreover, the automatic cancellation clause requirement only compels facilities to do what they have already committed themselves to do. Facilities with deficiencies develop plans of correction and timetables for correction, which the Secretary (for medicare) or the State agency (for medicaid) has authority to accept. Under current regulations, the automatic cancellation clause comes into effect only if facilities fail either to correct deficiencies or to make "substantial progress" in correcting deficiencies under the plans of correction. The clause does no more than give facilities one last chance to carry through on their self-developed plans of correction. The fact that, according to the Department's data, most facilities do not correct their deficiencies until automatic termination of their program participation is imminent is strong evidence of the continued need for the automatic cancellation clause mechanism. Without this mechanism, it will be difficult for the Department and the State agencies to secure compliance with the conditions and standards of participation.

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[16] See, e.g., *Paramount Convalescent Center, Inc.* v. *Department of Health Care Services*, 15 Cal. 3d 489, 542 P. 2d 1, 125 Ca., Rptr. 265 (1975); *Convalescent Care Center, Inc.* v. *Bates*, Franklin Cty. Ct. App. (May 15, 1975), 44 U.S.L.W. 3539, cert. denied 425 U.S. 952 (1975); *Shady Acres Nursing Home, Inc.* v. *Canary*, 30 Ohio App. 2d 47, 316 N.E. 2d 481 (1973).

The Department's suggestion that other sanctions, such as termination, are available, is disingenuous. Termination is not an alternative sanction. If effective,[17] termination results in the loss of rights of deficient facilities to participate in the medicare and/or medicaid programs. Termination fails to bring about improvements in quality of care or life. In addition, termination reduces the number of beds available for medicaid recipients, exacerbating already serious problems of access to long-term care for program recipients.[18]

Flexible 2-Year Survey Cycle

The Department states that annual surveys "are a needless burden on 'good' facilities (those with excellent compliance records) as well as inefficient use of human and fiscal resources to perform the survey." 47 Fed. Reg. 23406. It observes that as a result of "many participants" and "a shortage of qualified personnel, or both," States are "finding it increasingly difficult to meet the requirement for annual visits to all facilities." Id. The Department does not mention recent Federal budget cuts for survey activities, the statutory reduction in the Federal match for survey activities, or the December 1981 memorandum by Aris T. Allen, M.D., suggesting use of a flexible survey cycle.

The Department states that under the proposed regulations, "Surveys would be required as often as necessary to insure compliance." 47 Fed. Reg. 23406. "Facilities with a history of poor compliance would be surveyed more often than the existing regulations require," id., while SNF's and ICF's with "a history of compliance without problems" would be subject to surveys at a frequency of up to 2 years. Id.

The Department fails to set forth in the NPRM any criteria or standards for determining how frequently State agencies will need to survey facilities. If HCFA intends that the criteria published in the December 1981 Allen memorandum should guide State agencies in scheduling surveys, it should publish the memorandum as an NPRM and allow public comment on its classifications of conditions and standards into key requirements. Use of the 1981 memorandum prior to its being subject to public notice and comment violates the Administrative Procedure Act, since the memorandum substantively and significantly revises the conditions and standards of participation.

While the elements in the Allen memorandum are generally similar to the standards under the conditions, they are not identical. Standards appear in the Federal conditions that are not reflected in the Allen memorandum, and items appear in the Allen memorandum that do not appear as standards in the conditions. Since, if the Allen memorandum is followed, only key requirements labeled "A" or "B" will be considered by State agencies in scheduling surveys, HCFA's classifications of key requirements are critical. Standards that do not have an "A" or "B" rating, or that are not listed among the key requirements at all, are essentially written out of the conditions and standards of participation.

In the Allen memorandum, under the conditions on governing body and management, 42 C.F.R. § 405.1121, the following standards are omitted: Disclosure of ownership, id. § 405.1121(a); staffing patterns, id. § 405.1121(b); bylaws, id. § 405.1121(c); independent medical evaluation (medical review), id. § 405.1121(d); institutional planning, id. § 405.1121(f), and notification of changes in patient status, id. § 405.1121(j). Violations of these standards therefore apparently will not be relevant to determining the schedule for surveys.

Similar omissions appear from the other Federal conditions of participation. For example, from the condition on physician services, id., § 405.1123, two of the three standards are omitted: Medical findings and physicians' orders at time of admission, id., § 405.1123(a), and availability of physicians for emergency patient care, id., § 405.1123(c). From the condition on nursing services, id., § 405.1124, standards are omitted involving rehabilitative nursing care, id., § 405.1124(e); supervision of patient nutrition, id., § 405.1124(f), and storage of drugs and biologicals, id., § 405.1124(i). Omitted from the condition on dietetic services, id., § 405.1125, are standards on frequency of meals, id., § 405.1125(d) and hygiene of staff, id., § 405.1125(f). Omitted from the condition on infection control, id., § 405.1135, are

[17] Termination of a provider agreement is an exceedingly slow process, often taking years. Terminations are an issue that is heavily litigated by nursing homes. See Jane Beyer, "Nursing Home Decertification: Restructuring The Entitlement Analysis" 59 N.C.L. Rev. (1981).

[18] See Office of the Inspector General, "Restricted Patient Admittance to Nursing Homes—An Assessment of Hospital Backup," (Service Delivery Assessment, technical report, September 1980) (secretarial report, August 1980) (Prepared by region X, with region II, IV, and IX), and the Nursing Home Law Letter, issues No. 43 (August 1980); No. 26 (December 1978); No. 21 (May-June 1978), and No. 17 (January 1978).

four of five standards involving infection control committee, id., § 405.1135(a); housekeeping, id., § 405.1135(c); linen, id., § 405.1135(d), and pest control, id., § 405.1135(e).

Items are listed in the Allen memorandum that do not reflect standards in the conditions. For example, the Allen memorandum identifies availability and content as a key requirement under the condition on governing body and management. There is no such standard in the Federal conditions, although the memorandum may be elaborating on the previous standard, patient care policies, id., § 405.1121(1).

A third question about the Allen memorandum is its classification of some key requirements as "C," but its failure to use "C" requirements in stating how surveys should be scheduled.

A second issue with respect to the flexible 2-year survey cycle is that in light of severe budget cutbacks for survey activities, it is likely that financially pressed State agencies will use the 2-year maximum survey cycle as the general standard, rather than as the outer limit. Many States can also be expected to modify State licensing requirements and to follow the Federal pattern with a 2-year State licensing cycle. Two years is simply too long a period for facilities to go unmonitored. It is common experience that good facilities can rapidly deteriorate following a change in ownership, management, or key personnel (such as administrator or director of nursing). To assume that a "good" facility necessarily remains "good" is to ignore experience.

A third issue concerning the flexible survey cycle is that the Department has failed to make its case for eliminating annual surveys of nursing homes. The Department proposes that the survey cycle vary with the type of facility—hospitals, 3 years; nursing homes, 2 years; ICF's/MR, 1 year. It explains that, in the Department's experience, hospitals generally have fewer deficiencies than other categories of facilities and need less monitoring. Continuing annual surveys of ICF's/MR is justified because "most of the patients in these facilities (many of whom are children) lack the necessary experience or capability to bring quality of care problems to the attention of outside authorities." 47 Fed. Reg. 23406. No specific rationale is given for doubling the intervals between nursing home surveys.

The Department's claim with respect to hospitals and ICF's/MR explains why annual surveys in nursing homes are both appropriate and necessary. Experience with long-term care facilities does not suggest the lack of deficiencies claimed by the Department for hospitals. Nursing homes continue to have significant deficiencies that threaten the quality of care they provide. In addition, the Department's recognition that residents of ICF's/MR are extremely vulnerable is equally true of nursing home residents. (See, e.g., GAO report, supra at page 1.) Many, it is clear, do not have the "capability to bring quality of care problems to the attention of outside authorities" and, often lacking family and friends who can visit them, must rely on the independent inspections of the State agencies.

RECOMMENDATIONS

The Gray Panthers urges that the current proposal be withdrawn and that discussions of ways of improving both standards and survey procedures be continued with the participation of consumers, State surveyors and providers. The Gray Panthers further endorses those specific recommendations presented by the National Citizens Coalition for Nursing Home Reform in its formal comments.