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06. Standards For Long Term Care Facilities: The Need For Reform

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STANDARDS FOR LONG-TERM CARE FACILITIES: THE NEED FOR REFORM

If regulation of LTC is ever going to become a rational process, meaningful standards for measuring the process of delivering services and, to a lesser extent, criteria which indicate the outcomes of LTC must be developed and implemented. The present "state of the art" regarding standards is oriented toward those which measure the physical plant in which LTC is rendered and few standards exist which even approach LTC outcome estimations.

Further complicating the standard's issue is the problem of who will evaluate the facilities. At present the federal government operates as technical assistant in the process, developing model standards, training state inspectors, spot checking LTC facilities and monitoring state efforts. States have the ultimate responsibility for developing and enforcing standards but many have diffused the responsibility to the extent that the agency that reimburses LTC facilities is not the one that inspects them and in others various kinds of inspections are never coordinated, nor are results correlated so that the regulative burden is eased.

In this chapter, arguments are developed for the consolidation of state control and a federal takeover of the standard sitting process. Both arguments have merit and neither reflect the dismal enforcement patterns which currently compose the status quo, a process that is wasteful, expensive and in many cases, irrelevant.

STATE DOMINATED STANDARDS OF CARE

Description Of The Current System

The federal government, primarily through the Department of Health, Education, and Welfare (HEW), has played a major role in the establishment of standards of care for LTC facilities. HEW is responsible for assuring that Medicaid patients receive quality care in the nation's skilled nursing facilities (SNF's) and intermediate care facilities (ICF's). The standards are measured by federal survey forms SSA-1569 for SNF's and SSA-3070 for ICF's. These survey forms are used to determine the eligibility of a facility for Medicare and Medicaid payments. If a facility is in compliance with standards, then HEW will issue the facility a Medicare/Medicaid provider agreement. Facilities which have been issued such an agreement will be reimbursed for the care given to it's Medicare and Medicaid patients.

In addition to the federal survey forms for LTC facilities, HEW requires that a Periodic Medical Review (PMR) be performed on each Medicaid patient in a LTC facility. The PMR is a two-part review. The first part requires an assessment of patient records and patterns of care. This includes items such as: inspection of medical orders, nursing care plans, special therapy needs, and physician's notes. The second part of the PMR requires direct patient observation to determine the patient's weight status, personal hygiene, functional level, skin care and the like. The PMR is required on a yearly basis for each Medicaid patient.

The federal government provides training and education programs for state surveyors. The purpose is to train surveyors in the federal regulations and in conducting the federal facility survey. HEW has developed two courses for surveyors. The first, the Oklahoma Course, is a self-study course which utilizes films, tapes, and work books. The second is a two-week course at the

University of Maryland. HEW has contracted with the University to train surveyors in federal regulations as well as to provide technical and consultive services to LTC facilities.

In summation, the federal role, is limited to the setting of the standards and training of state surveyors. Their interest is to insure that Medicaid patients (for which they pay the bulk of the bill), are receiving quality health care in LTC facilities. In addition, HEW issues Medicare/Medicaid provider agreements to those facilities which are meeting standards.

The states have jurisdiction over the issuance of operating licenses to LTC facilities in each of their states. Facilities are granted a license based upon their meeting state rules and regulations. States may revoke, suspend, or fail to issue a license, in conjunction with state law. All facets of LTC facility licensure lie within the power of the states.

The states are responsible for monitoring facilities for comliance with state standards for Medicaid reimbursement. They are also responsible for conducting the federal surveys for skilled nursing homes and intermediate care facilities. "States have the option of selecting the agency (or department) to be responsible for administering the Medicaid Program."[1] After conducting the federal surveys, the agency will recommend whether Medicare/Medicaid Provider agreements should be continued. Final approval for these agreements rests with HEW. The states are also required to conduct the Periodic Medical Reviews for all Medicaid patients in LTC facilities within the state.

In addition to monitoring for federal and state standards, the states are responsible for enforcing those standards. When deficiencies are found, the survey team will require the facility to present a written plan of correction for the deficiencies. The team will return to check whether the

plan of correction has been carried out. If facilities do not correct the problems, the states may initiate court action in an attempt to close a facility. Some states have instituted a system of fines and penalties for non-compliance with standards.

In summary, the states are responsible for the licensing of facilities, setting state standards for operation of LTC facilities, monitoring for compliance with federal and state standards via the surveys, recommending to HEW on Medicare/Medicaid Provider Agreements, and in enforcement of standards through court action or by other means. It is recognized that this description of the states role, as well as the federal role is brief and certainly incomplete. However, it is a sufficient description to develop an understanding of the current system of standards of care delivery.

State Control of Standards

The primary purpose of this work is to defend the state's retainment of the functions of monitoring and enforcement of the standards of care in LTC facilities. It is recognized that the states have experienced some problems in their performance of these functions to date. The contention is, that despite the problems which the states have had, that they are best able to enforce standards of care. The alternative to state control is the federal takeover. A federal takeover would not be an improvement, it would be a step backward. The federal government is neither prepared, capable, or desirous of assuming these functions. A federal monitoring and enforcement system is likely to be a disaster. The victims of the disaster would be the elderly in our nation's nursing homes.

The defense of the states is based on a two part argument. The first part looks at the federal government to see how well they have performed the functions under their jurisdiction. It seeks to predict what success they may have based on their track record in the standards area. The second part of the argument looks at how the states are meeting the challenge of carrying out their role in standards monitoring and enforcement.

Part I: The Federal Inadequacies

There is simply no model on the federal level for making a prediction of how effective they would be in the monitoring and enforcement of standards of care. The federal government's traditional pattern has been, and is likely to continue to be, one of supplying the dollars for programs technical assistance and requiring monitoring of the program by the state or locality. The federal government is not yet capable of enforcing standards of care. This does not rule out the possibility that they could develop an organization capable of monitoring and enforcing standards. But just imagine the costs. One of the major issues in long term health care today is the skyrocketing costs. Do we complicate an already serious financial problem by spending a huge amount of money in setting up a bureaucratic structure to monitor LTC facilities when we already have a system to accomplish this job? The answer to this question should be NO.

Since the federal government has not been involved in the monitoring of LTC facilities, we are unable to evaluate their performance in this area. Let us therefore examine what evidence we do have in their involvement in LTC. They have been primarily involved in the setting of standards for LTC facilities. How well have they performed this task?

The development of standards which seek to measure the quality of care rendered in nursing homes and other long term care facilities has been recognized

as crucial in assuring adequate patient care. The Moreland Act Commission in New York State commented on the work performed by the federal government in this area.

> ...the Department of Health, Education, and Welfare at the federal level 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.[2]

The standards of care are measured by means of the federal survey documents. The Moreland Commission commented on them.

> The survey inspections concentrate on the written word and can be passed largely by "paper compliance." Thus of the 526 identifiable items in the 68-page federal skilled nursing home survey inspection report, the Commission's review indicates that 290 items can be answered by the surveyor exclusively with reference to written plans, policies, and records. In the Commission's view, only 30 of the 526 items might require direct observation of patients.[3]

How can we hope to achieve adequate measurement of the quality of care rendered to patients in facilities when the survey document designed to measure quality requires so little observation of the patients. The federal government has failed to perform its task of assuring patient care through the development of meaningful and useful standards.

> "...the variety of federal Medicare and Medicaid regulations present in many respects an array of empty boxes. The task of developing meaningful explicit and enforceable minimum standards of care remains to be accomplished."[4]

How well has the federal bureaucracy been able to meet the legislative intent of Congress? The Department of Health, Education, and Welfare was directed to provide a unification of standards for the Medicare and Medicaid programs. This was an attempt to clear up a chaotic situation which had existed with differing Medicare and Medicaid definitions of facilities and standards for those facilities. Congress made it clear to HEW that standards should be raised in the process or at least not lowered. The results of the

regulations issued by HEW in July 1973 were anthing but a raising of the standards, in fact, the standards were significantly weakened. "Important standards were deleted, qualified, or nullified by exceptions; generalizations were substituted for specifics."[5]

Hearings were held of the Subcommittee for Long-Term Care after the issuance of the HEW standards. Testimony in the hearings voiced displeasure with HEW's failure to meet the legislative goal of raising standards. Congressman Robert Steele charged that the standards, "failed to guarantee adequate patient care in several major areas."[6] For example,

> "HEW flatly refused to issue even minimum ratios for personnel per patients, describing such ratios as 'a false benchmark.' HEW's failure to set ratios will mean that unlicensed aides and orderlies will continue to provide 80 to 90 percent of the nursing care in long-term facilities."[7]

Dr. Raymond Benack, the founder of the American Association of Nursing Home Physicians, put the HEW failure in more descriptive language when he said,

> "This new regulation turns back the hands of time where (a nursing home) becomes an institution of death to which we condemn the chronically ill patient."[8]

Both the Moreland Act Commission and the Subcommittee for Long-Term Care hearings have demonstrated the federal government's failure in general, and the Department of Health, Education, and Welfare in particular, to provide the states with a set of standards that protect the long-term care patient. This is the job of the federal government. Is it rational to turn over the functions of monitoring and enforcement of standards of care to the federal government when they have been so lax in the development of meaningful standards for performance of those functions? Should we spend millions of dollars in setting up a federal system for monitoring and enforcement? If we do this, is the federal government likely to improve on the state's performance? Do we have any solid evidence to suggest that the federal government will be better than the states in performing monitoring

and enforcement. Based on the federal government's track record in setting standards for LTC facilities the answer to all of the questions is a definite NO.

Part II: The States Are Improving

Obviously, one would be foolish to claim that all states are doing a fine job of monitoring and enforcing standards of care in LTC facilities. This is simply not the case. The states have a great deal of room for improvement. What is important to realize however, is that the states are attempting to improve their system.

In January of 1975, the Moreland Act Commission was set up in the State of New York to investigate government's monitoring and enforcement efforts in the state. The result was a blistering report of fraud, abuses, and misconduct in long-term care facilities. The report made public, a number of problems in the state's monitoring and enforcement efforts. But the very fact that the state saw fit to investigate itself is encouraging. The state recognized that it had problems with it's monitoring system and sought to uncover and correct them. This kind of action is necessary in government to maintain high quality service. It should be asked if the federal government would be willing to do the same.

The state of New York's Office of Health Systems Management (the agency responsible for monitoring LTC facilities in the state), contracted with the Rensselaer Polytechnic Institute for a study of their agency and to make recommendations for improvement. This is another example of a state's willingness to improve in performance.

The state of Wisconsin has been active in the development of an innovative project which attempts to cut surveyor time in monitoring nursing homes. The idea is to quickly assess whether a home is providing quality care. One of

the problems that has been mentioned earlier in this inquiry was that the surveys contained a large number of items, many of which do nothing to measure the quality of care rendered in a facility. The Wisconsin Demonstration Project seeks to shorten survey time through the use of a sampling approach to the survey. The objectives of the program area:

a) To quickly determine if the nursing home is doing the job.

b) To assess where the care system is breaking down.

c) To focus on problem areas and recommend actions to resolve these problems.[9]

If Wisconsin has success with the project, it could be used as a model for monitoring activities in the other states as well. A testing of new programs is essential to improve the functions of government. The state of Wisconsin is actively involved in doing just that.

The states of Illinois and Michigan have been involved in attempts to develop programs which link quality health care to reimbursement. Reimbursement under the Medicaid program for LTC facilities was determined by a multitude of factors associated with the operating costs of the facility. No consideration was given in the formula for the quality of care rendered to patients. A home providing quality care received the same rate as a home giving poor care if the homes had similiar operating costs. The Illinois and Michigan plans call for additional reimbursement above expenses for those homes judged to be giving good care. Previously, homes had no incentive to offer quality care financially speaking.[10] If we hope to promote quality care in our nation's LTC facilities, a system must be developed which rewards, not penalizes, quality care. The states of Illinois and Michigan are paving the way.

Pennsylvania has recognized that surveyor education is important in assuring that monitoring of LTC facilities is of high quality. They have established

a Training and Education Unit to develop programs for the state surveyors. The unit has developed a Long Term Care Surveyors Orientation Manual as well as a training course which is mandatory for all surveyors. The course is taken on a part-time basis and takes seven months to complete for new surveyors. The Education and Training Unit is also developing a handbook entitled, "What To Look for in Measuring Quality of Care."[11] The state has recognized that the federal courses offered for a two-week period are insufficient training to assure survey consistency and accuracy. Consistency in surveying is desirable and should be pursued through programs like those in Pennsylvania.

The states have been criticized by some for slow action and failure to close facilities which have been found to be substandard. One must be aware that such action carries consequences which may be undesirable. People who live in those homes can be harmed by such action. Aldrich studied patients who were moved from one facility to another. The relocation was not necessitated by any change in the health of patients, but rather of administrative need. The patients were moved to homes that were judged to be providing equal or better care than the first home. The anticipated mortality if the patients had remained in the first home was 19 percent. The actual mortality rate of the patients moved was 32 percent. Much of this increase for the year could be attributed to a very high rate during the first three months after relocation. During this time period, the actual rate of mortality was over 3 times the expected rate.[12] In making a decision to attempt to close a facility, this effect on patient well being must be considered. The state must also be sure that patients can be placed in other facilities before moving on a closure. It is crucial that the agency be sensitive to patient's health and well-being. Whether a federal agency, responsible for so many patients, could be sensitive to these considerations is questionable.

The willingness on the part of states like New York to make public their administrative problems and to seek solutions is refreshing. The innovative approaches to difficult problems in states such as Wisconsin, Illinois, Michigan, and Pennsylvania is encouraging. The states have a large stake in the protection of their elderly in LTC facilities. Their hard work and dedication will pay off in assuring adequate care for the nation's elderly. The states have much to do in order to meet the challenges of the future. They are preparing for that future, through action today.

Conclusion

The federal government has had primary responsibility for the setting of standards of care in the nation's LTC facilities. They have failed to develop meaningful and enforceable standards. The challenge of today is to develop standards which measure the quality of care. The federal government has failed to meet that challenge. Can they be expected to improve on the state's performance in monitoring and enforcement function? Their handling of their role as standard setters indicates that they can not. Should we spend huge sums of money in the blind hope that the federal government will be able to provide an improvement? The money would be wiser spent it seems, in providing states with assistance to develop their already existing structures. The federal government has had the responsibility for assuring that standards aplied to nursing homes and intermediate care facilities measures whether those facilities are delivering quality care. When the federal government can show that they have met this responsibility, the time for consideration of an expansion of the federal role will be here.

The states have been under attack for failure to effectively monitor and enforce standards of care. The states have demonstrated a willingness to improve their performance through self-investigation, the seeking of outside assistance, and the development of innovative programs. The states have much to accomplish. Federal financial assistance could be of great help. States must, and are capable, of being snesitive to the needs of the elderly. Only through continued effort on the part of the states, with federal development of standards, will the job of effectively monitoring and enforcing quality health care be truly accomplished.

FEDERAL DOMINATED STANDARDS OF CARE

Description Of Current System

Since the inception of Medicaid, states must meet the minimum federal standards for the delivery of LTC. However, states have the option of developing their own standards in addition to those established at the federal level. For the most part, state standards are refinements of federal regulations. States will often take a federal standard and change the wording or add criteria for use in their survey documents. And in many cases, those standards are duplicated. In New York State, a 1979 survey conducted by the Rensselaer Polytechnic Institute found that in the 500 page survey document many of the items were duplicates of federal standards, only the wording was different. What has evolved out of this system is variations in standards from state to state. "Most experts in the field of long-term care argue that nursing home standards are essential to reach the desired goal of quality care. Early hearings by the Subcommittee on Long-Term Care documented that standards varied greatly from State to State as did the quality of care."[13] The resultant inequities in the types of care and facilities available are indicative of the problems with the entire LTC system.

Standards determine the amount of expenditures that a state must allocate for LTC under Medicaid. In those states where standards are higher than the federal, it costs more to deliver LTC, as has been found in the states of California and New York. Higher standards, or refinements of federal standards, increase the operating costs of LTC facilities, thus, increasing the Medicaid bill. For example, if the federal standard for a skilled nursing facility requires a registered nurse eight hours a day, seven days a week and the state standard requires a registered nurse twenty four hours a day, seven days a week, the costs are higher for that state. Another example of the disparities between federal and state standards can be found in the standard

regarding nurse to patient ratios. The federal guidelines state that each facility have qualified nursing staff, while the State of Connecticut requires one nurse for every thirty patients.

Most central to the issue of standards is what they measure. The current standards measure the ability of a facility to deliver quality care not whether in fact quality care is delivered.

> The federal Medicare/Medicaid nursing home regulations and the State Hospital Code provide a body of detailed rules and standards. For the most part these are not directly addressed to matters which might be of ultimate concern to patients, relatives and other interested laymen: whether the quality of care rendered in the homes is appropriate and sufficient to maintain, as best as possible, health and functioning or whether the atmosphere is one of humane attention. Nor, for the most part do they set explicit standards for particular "processes" of care--whether care provided by physicians, nurses and ancillary and support personnel is thorough and appropriately performed. The regulations and code are directed, rather, principally at such phenomena as minimum qualifications for key facility staff members, the existence of written plans and policies for component services, staff coverage, minimum required number of physician visits, standards of record keeping, and, of course, detailed requirements on the type of facility construction, room areas, corridor width, number of lavatory and toilet facilities, and the like.[14]

Further, the New York State Moreland Commission found in 1975 that

> ".....poor quality care, at least as measured by the department, was as likely to be rendered in structurally sound facilities as in homes not fully compliant with physical structure code provisions."[15]

This dispels the myth that facilities in compliance with the standards render quality care. However, it does bring to the forefront the issue of what quality care is.

Our current system measures the processes of delivery and not whether quality care is the outcome. Since federal and state standards might be indicators of the ability of a facility to deliver quality care, they do

not directly measure quality care. We are thus confronted with the dilemma of what is quality care. We should measure care directly rather than rely upon proxy measures such as fire escapes, bedding, and other physical standards. Our measurement of quality care must also include the end results, the outcomes of the system. New standards must be developed incorporating the human factors of care. The inputs or processes of the system, i.e., facility structure and staff qualifications, should be measured against the outputs or outcomes of the system, i.e., the actual care the patient receives. Further, these standards must be validated. Validation of standards are vital to the enforcement function, as the courts have shown that without a valid measurement tool, facilities containing violations will be allowed to remain open. Our judicial system wants facts not interpretations of standards, shouldn;t our health system demand the same?

In order to correct the current deficiencies, the federal government would be responsible for designing and validating new standards for quality care. This could be done by developing indices of care items that would incorporate facility structure, staff qualifications, care rendered, etc. The results for each facility would then be compared to the national norms in order to determine the quality of care delivered. The costs of designing such an instrument is unknown. However, there would most likely be a corresponding decrease in other areas of LTC costs, as some state standards that are costly would be eliminated.

Federal Control of Standards

The monitoring and enforcement of LTC standards for Medicaid are currently under the jurisdiction of the states. As with varying standards, monitoring and enforcement practices also vary from state to state, as well as within states. A 1979 study conducted in New York State summarizes

the problem. "State policy and guidelines are not always clear, available or uniformly applied."[16] The major problems with monitoring and enforcement are identified, as follows:

1. The qualifications and training of surveyors.
2. The emphasis on paper compliance.
3. The duplication of surveys by state, county, and city agencies.
4. The lengthy legal process.
5. The interference of political officials.
6. The states failure to act on inspections.

The Senate Subcommittee hearings on long term care in 1974 indicates the system.

> "For all the talk of uniform minimum standards, enforcement is still haphazard, fragmented and generally inadequate. The States license nursing homes and inspect them in accordance with their own licensure laws; the same State people conduct Medicaid and Medicare inspections (using federal criteria), certifying facilities for participation in these programs. There has always been great disparity in the matter of this enforcement...."[17]

The key to a uniform monitoring system is the qualifications and training of those who survey LTC facilities. At the present, state to state variations and the lack of uniform standards create an atmosphere that subjects surveyors to individual interpretation and value judgments. The system is then left to the whims of local inspectors. The unbridled flexibility distorts the system further, as who measures the facilities determines whether quality care is delivered. In New York State, Rensselaer Polytechnic Institute found that the:

> "Survey consistency and inconsistency seems to be largely related to surveyor qualifications and turnover. Different surveyors give different emphasis and interpretations....the federal and self-taught training programs were insufficient... that the Office of Health Systems Management/Central fails to provide the type of orientation, training and in-service programs necessary for effective performance...there are no written procedures for quality monitoring..." The qualifications of those

> doing the monitroing comes into question, as some states recruit high school graduates, who are unskilled, and yet other states recruit professionals in specified fields. All in all, the inspection process has become a national farce. In 1971, an "HEW report concluded that in the majority of States' Title 19 standards were not being effectively applied...."[19]

Since states inspect only for compliance with Medicaid standards, there is an emphasis on paper compliance. Approximately fifty-five percent of the 68 page federal skilled nursing home survey can be exclusively answered with reference to written plans, policies and records. Of this, only 30 out of 526 items involve direct observation of the patient. In 1975, the New York State Moreland Commission found that "the survey inspections concentrate on the written word and can be passed largely by paper compliance."[20] In 1979, a report on regulating long-term care in New York State still finds paper compliance to be a major problem with the survey process. "Paper compliance is too often the dominant activity...much documentation is repetitive and non-productive."[21] As a result, paper compliance becomes of the contributing factors that allows substandard facilities to continue to operate.

The duplication and fragmentation of state inspection and enforcement practices further contributes to the breakdown of the system. In many states, there are as many as four state agencies involved in monitoring and enforcement of LTC facilities. One agency would be responsible for licensing and inspection. Another agency reimburses the facility. And yet another may be involved in placement of clients. Finally, a fourth agency may be called upon in order to close a facility. This is further complicated by the fact that "most states have four components to their inspection system: sanitation and environment, meals, fire safety, and patient care."[22] To further complicate the process, facilities are often inspected by city and county agencies as well, to insure compliance with local codes.

Duplication of inspections has led to poor communications between the various inspection agencies.

> "A study in Wisconsin showed that the separate agencies involved had little communication with one another. The filing system was in shambles. Sanitarians' and engineers' inspection reports were in one file cabinet and nurse inspectors' reports were in another with no attempt to coordinate the two. Inspection forms were duplicated, various sections of the law were misapplied, and the information on many nursing homes was lost."[23]

As a result of poor communications between local and state agencies, one agency may be attempting to close a facility, another may find it in compliance, and yet another may be placing clients in the facility.

The lengthy legal process that a state agency must utilize in order to close down a facility often is a hinderence to enforcement.

> "Most health departments believe that fines are relatively ineffective in prohibiting abuses and that the cumbersome administrative or legal procedures involved in closing a home make the effort counterproductive. They feel that judges have a bias against depriving the operator of a livelihood, particularly if the operator shows that the matters have been or will be corrected."[24]

The lack of support from the courts has aided the states in adopting a permissive attitude towards enforcement.

In those cases where a state is successful in closing a facility another problem confronts them. What happens to those patients who must be moved as a result of a closing? During the early 1970's, a number of states claimed that they did not have sufficient bed space in other facilities. Further, professionals pointed out that the wholesale movement of clients from one facility to another would be disruptive and harmful to them. In essence, states are incapable of closing down a facility and provide no mechanism for relocating patients. Rather than seek to develop alternatives, patients are kept, by the states inaction, in substandard facilities.

Political interference at the state level has long been a hinderance to the enforcement of standards. In testimony given before the Senate Subcommittee on Long-Term Care, various state elected officials have been approached by providers to intervene on their behalf in order to keep their

facilities open.

> During the Subcommittee's Illinois hearing a witness with access to State health department files testified:
>
> "The 69-bed Kosary Nursing Home in Finley Park has had consistently bad reports for the past four years. Most inspectors have recommended the place be closed but it has remained open.
>
> It now appears political pressure was applied in 1968. A memo found in Illinois files of Inspector F.H. Williams to the coordinator of the licensure and certification section mentions the political implications involved.
>
> These implications apparently stem from queries by State Representative Walter Babe McAvoy to Dr. Yoder, head of the Department of Public Health, in regard to Kosary Nursing Home. A license was issued that year.
>
> In the following two years, 1969 and 1970, inspectors again found conditions bad and recommended no relicensure. The home remains open today (1974)."[25]

The State of Illinois was not alone, for political interference was exposed in New York State and other states across the nation. Our state politicians and top appointed officials have protected the provider and ignored the substandard conditions and abuse the elderly are subjected to.

States continue to fail to act on inspections and enforce standards. In many states, inspections are infrequent either due to the lack of a formal system or understaffing, as evidenced in Utah where in 1971 only two people were assigned to inspect 136 homes. Giving facilities advance notice of an inspection is a common practice in most states. "The practice is apparently fairly common nationwide. There is little doubt that it undermines effective inspections."[26] It is further common to find that in most states inspections become nothing more than a pro forma ritual or paper compliance. Follow-up on negative reports and recommended closings have either been minimal or ignored. State enforcement focuses on the physical plant and not patient care. The crux of the problems associated with enforcement are directly attributable to the states lax enforcement efforts. This allows the elderly to become the victims of the system with Medicaid footing the bill.

Other Factors Affecting Standards and Costs

In examining the issue of standards of care for LTC facilities, there are a number of other factors that either determine standards, affect implementation of standards, or where standards are lacking, contribute to the high costs of delivering LTC. Thoste other factors include the role of the pivate sector, the market mechanism and the individual state's policies and practices. It will be deomonstrated that these significant other factors impose their own standards on the system, contributing to higher costs for LTC and circumventing (in some cases) federal standards.

The private sector has had a direct impact on the delivery of LTC services and has played an indirect role with regard to standards. Technological advances in medical care have provided man with increased longevity and have become capable of prolonging life through artificial means. This increases LTC costs. Acute care facilities (hospitals) and physicians directly increase the costs of LTC by prescribing excessive treatment or performing unnecessary surgery on the elderly infirmed. The costs are further increased by utilizing extraordinary measures to prolong life by employing machines and other life preserving measures that may not in the end prolong life, but avoid the inevitable outcome of death. In essence, the private sector is determining standards through its prescription of unnecessary treatment for the elderly, further increasing the costs of long-term care.

States through the lack of any uniform placement standards for placing clients in appropriate care facilities also contribute to the high costs of LTC. Placement is currently done on a fragmented basis by the family physician, a social worker, or the family itself. Inappropriate placement was found in the State of New Jersey, where many patients were placed in facilities providing a higher level of care than was actually needed.

> "The medical evaluation teams judged that 35 percent of currently institutionalized at the IV (B) intermediate care level could be discharged if appropriate alternate settings were available...The medical evaluation teams held that 72 percent of those cases recommended for alternate care - or 25 percent of all IV (B) patients - could be cared for in alternative, congregate living arrangements."[27]

Since there are no existing standards for placement, variations can be found within states in determing what level of care is needed. In the New Jersey study, it was found that:

> "Local office variations in recommendations for alternate care are attributable in part to the mix of patient illness and type of institution in each office, but the variations also appear closely related to office caseloads and the subjective personal judgements of individual medical evaluation teams."[28]

As a result of the lack of uniform standards for placement, California estimated that it could save $13.7 million in fiscal 1972-73 if 60,000 patients currently in nursing homes were placed in intermediate care facilities- If a patient is inappropriately placed, particularly at a higher level of care than is needed, higher costs are associated with that placement. The lack of placement standards imposes its own standards on the delivery of LTC services.

The market mechanism itself is also a contributing factor in the lack of uniform placement standards. If the market does not provide the facilities necessary to meet the varying levels of care necessary to serve our elderly population, then patients must be assigned to whatever existing facilities a community has, regardless of the level of care needed. As a result, the market mechanism by providing or not providing various levels of care facilities determines the standards for placement. Inappropriate placements as a result of the failure of the market to meet the needs of a community will result in higher costs for care.

The profit-making and voluntary nursing homes have a direct impact on the standards of care provided and the placement of clients under the curent

system. These homes generally select the healthiest, most able of the elderly to care for. This practice lowers operating costs to the owner of proprietary facilities and allows a higher profit under Medicaid. The voluntaries also reap the benefits under Medicaid, as their "profits" are seen in higher salaries. Further, the more skilled nursing required per patient, the higher the costs to the owner/operator. Thus, the owner/operator determines the level and stadards for the care that the facility will provide. Another aspect to the issue of placement is that in certain instances the client determines the level of care based on what the patient can afford and desires. In essence then placement may be determined on what the patient can purchase, regardless of its appropriateness. The profit motive of proprietary facilities and our current reimbursement practices under Medicaid are not incentives in favor of quality care. Since the financial reimbursement system is not accountable for the quality of care that is delivered, the profit-making and voluntary facilities can impose their own standards.

While the levels of care available varies from state to state, standards for determing what those levels of care are also vary. In part, levels of care are determined by each state in terms of what it will cover under Medicaid for LTC. Further, standards for levels of care are determined on what is available. While some states may provide a full range of LTC services under Medicaid, ranging from skilled nursing homes to home health services, other states may only cover skilled nursing facilities and health related facilities. Further, what one state defines as a skilled nursing home, another state may define as a health related facility.

> "State-to-state comparison of nursing and rest home beds are difficult as no national standards exist for classifying and licensing nursing and rest homes with the exception of federal regulations for Medicare and Medicaid certification. What are four levels of care in Massachusetts may be six or two in another state."[29]

On the basis of available data, individual state's policies in delivering LTC are often determined by the socio-economic status of a given state. According to Thomas R. Dye, a noted scholar in policy analysis, rich states which have greater resources tend to have higher levels of expenditures in areas such as Medicaid funded LTC. Thus, wealthier states can have larger and more comprehensive programs, as they can afford more. Further, the poorer states can ill afford large programs, which result in limited services under LTC. In examining Table I, on pages 54-55, we can see Dye's theory at work. In those states where the financial resources are limited due to socio-economic factors, there is a heavier emphasis on intermediate care facilities in the allocation of their Medicaid dollars and very little emphasis on skilled nursing facilities (Alaska, Idaho, Iowa, Louisana, Nebraska, Oklohoma, Tenessee, etc.) On the other hand, the more affluent states (New York and California) allocate a greater share of the Medicaid dollar to skilled nursing facilities. A state's ability to deliver LTC is determined by the wealth of a state, which creates greater disparities and inequities from state to state. According to the Department of Health, Education and Welfare, in 1976 a larger portion of Medicaid payments went to intermediate care facilities than to skilled nursing facilities in contrast to 1975 when 20 percent went to skilled nursing facilities and 17.7 percent went to intermediate care facilities. Further Table I's percentages for intermediate care facilities also includes facilities for the mentally retarded.

State variations can be attributed to demographic and socio-economic differences; wide variations as evidenced in Table I will continue to exist, limiting residents in many states to very few alternatives. State variations result in inequities in the range of services available to the elderly, which impacts on the standards for placement. Placement will be determined on the

TABLE I[30]

DISTRIBUTION OF MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE

FISCAL YEAR 1976

(Dollars in Thousands)

STATE	TOTAL PAYMENTS	SNF[1/]	ICF[2/]
United States	$13,977,348	18.2%	19.5%
Alabama	170,032	31.9	15.8
Alaska	12,269	17.3	48.9
Arkansas	128,026	15.2	38.0
California	1,773,464	21.8	1.3
Colorado	111,899	16.4	31.6
Connecticut	193,004	41.4	3.5
Delaware	18,677	1.7	24.0
District of Columbia	101,704	2.9	14.7
Florida	189,313	33.9	5.1
Georgia	267,648	23.3	21.9
Guam	917	-	-
Hawaii	44,917	24.5	7.4
Idaho	31,966	16.5	40.9
Illinois	766,165	9.0	18.6
Indiana	207,792	13.1	37.4
Iowa	123,084	0.5	55.1
Kansas	111,978	2.7	36.9
Kentucky	150,422	14.9	22.1
Louisiana	197,067	1.3	41.3
Maine	74,269	2.8	32.4
Maryland	241,365	12.5	12.9
Massachusetts	619,746	14.3	20.2
Michigan	739,213	18.9	13.0
Minnesota	318,858	20.6	37.1
Mississippi	118,633	28.5	4.5
Missouri	123,123	6.6	19.6
Montana	31,241	24.4	25.1
Nebraska	58,881	3.2	48.8
Nevada	23,029	19.4	8.8
New Hampshire	34,087	4.8	53.8

TABLE I
(continued)

STATE	TOTAL PAYMENTS	SNF[1/]	ICF[2/]
New Jersey	$,393,648	1.9%	28.5%
New Mexico	37,813	0.3	27.4
New York	2,958,316	24.4	12.9
North Carolina	200,146	13.1	21.2
North Dakota	25,602	36.3	19.3
Ohio	448,150	20.4	14.2
Oklahoma	162,688	0.2	52.1
Oregon	97,772	2.1	50.5
Pennsylvania	642,746	31.6	14.5
Puerto Rico	67,495	-	-
Rhode Island	86,798	11.2	26.8
South Carolina	107,486	25.8	10.8
South Dakota	25,716	23.3	37.3
Tennessee	188,032	0.5	44.3
Texas	631,050	4.5	55.9
Utah	40,736	17.0	30.1
Vermont	37,457	4.4	32.9
Virginia	182,446	2.8	37.7
Virgin Islands	1,300	-	-
Washington	173,125	37.9	3.8
West Virginia	61,363	0.8	16.8
Wisconsin	418.016	20.9	33.7
Wyoming	6,659	31.6	29.6

1/ Skilled Nursing Facilities

2/ Intermediate Care Facilities, including Mentally Retarded

Source:

basis of what a state can make available to its constituents.

> "Inequities abound in Medicaid. Because the federal contribution depends on the size of the state's program and because larger, wealthier states have better programs, they tend to receive larger dollar contributions from the federal government. Because the states have such leeway, wide variation in benefit levels occur from state to state... The poorest, most rural states have the most inadequate programs."[31]

Another significant area that impacts on the high costs of LTC are the standards of qualifications for the licensing of facilities. Again, licensing standards for facilities vary from state to state. Licensure involves setting standards for facility structure and staff qualifications. While all states must meet the minimum federal guidelines for LTC facilities under Medicaid, state standards determine how much it will cost a facility to operate. If a state sets higher standards for licensure than the federal minimum, it can be assumed that it will cost more to both construct and staff a facility. Thus, increasing the costs of Medicaid reimbursement for that state.

> "Standards for health facilities have been traditionally set by the states through licensure...However, the requirements and standards for licensure vary considerably. They are usually concerned with the qualifications of the staff, minimum standards of care, and safety of the facilities...Nursing homes are also required to be licensed by each state, but again, there is little uniformity in requirements..."[32]

While the foregoing is an attempt to describe the current system of standards, monitoring and enforcement in the delivery of LTC, it by no means covers the full range of issues. However, as a result of the inequities and abuses in the current system, reform becomes necessary if we are to meet the future needs of our nation. Further, because the states have shown that they are incapable of implementing, monitoring, and enforcing standards to insure that quality care is delivered, a federal takeover becomes necessary.

Why a Federal Takeover ?

If our nation is to be prepared for the future increases in the need for long-term care services to our elderly population, a uniform system of standards, monitoring and enforcement of those services must be developed and under the control of the federal government. While states have attempted to implement, monitor, and enforce LTC standards, we have found that state variations have created inequities within that system. For the most part, states have been found to be negligent of enforcing standards by allowing substandard facilities to remain open. The end result of this failure is that fraud and abuse will continue to be perpetrated against the elderly.

> "Witnesses before the Subcommittee have argued that full reliance on State enforcement will never work under the present system. They urge a program of Federal inspection and direct Federal responsibility for enforcement, in lieu of giving States a blank check."[33]

We have seen that the lack of uniform standards for placement and levels of care results in inappropriate placement of clients, thus increasing the costs. Further, we have found that the roles that the state regulations, the private sector, and the market mechnaism impose their own standards on the system. This further increases the costs of delivering LTC. The need for uniformity, equality and accountability make a federal takeover a national imperative.

The most important aspect of a federal takeover would be the development of a national policy on LTC, defining quality of care.

> "A national policy on long-term care - comprehensive, coherent and attentive to the needs of older Americans - does not exist in the United States today. The need for such a policy becomes more evident with each passing day that brings an increasing number of older Americans."[34]

Our current policies have failed to achieve quality care. Quality care is currently determined by the standards that we use to measure it. However, what we have seen measured is the processes of the system and not the outcomes - the actual care a patient receives. We need new standards that incorporate

quality of care, which can then be measured against the end results or outcomes.

Equally as important as a national policy on LTC, is the increased accountability of the federal government for the costs of LTC. The federal government would have control over the implementation, monitoroing and enforcement of standards, thus controlling the costs of LTC. Support for a national takeover of regulating the LTC sector became evident during the 1977 hearings before the House Committee on Interstate and Foriegn Commerce, Subcommittee on Oversight and Investigation. The AFL-CIO conducted a national survey of nursing home facilities and concluded in its testimony:

> - Comprehensive revision of federal standards into enforcable, workable, intelligible, regulations that emphasize patient care. The answer lies not in more regulations but in making the existing regulations clear and enforcing them swiftly and fairly.
>
> - Pre-emption of state inspections for Medicaid by the federal government.
>
> - Most of the problems in nursing homes can be traced to the profit motive, which is incompatible with social programs. Ultimately, in order to correct the problems of nursing homes, profit must be eliminated from the nursing home industry.
>
> - Graduate phasing out of private, for-profit nursing homes and replacement by nonprofit, religious or government ownership.[35]

Since the mid 1960's, the federal government has become increasingly active in exerting greater control over LTC standards. HEW has increased its role in the monitoring of facilities by conducting random inspections of those facilities for quality control. It was the federal initiative that has brought about improved enforcement and monitoring in some of the states, as a result of numerous hearings about fraud and abuse before both Houses of Congress. There is definately a trend evolving for a federal takeover, "...federal authority is moving rapidly to take direct action in controlling fraud and abuse."[36] Finally, federal intervention has become all the more necessary in an economy where health care costs are escalating faster than inflation.

What Will a Federal Takeover Accomplish?

By adopting a national policy for LTC and defining what quality of care is, we will be providing each American the guarantee that quality care will be provided, regardless of what state they may reside in. It will provide a national direction for the delivery of long-term care to our elderly. It will answer the question of what quality of care is and insure its enforcement. Every American will know who is responsible for the standards of the LTC sector. And finally, every elder American will have LTC available to them.

In order to implement a federal takeover of standards of care, a single federal agency should be established under the Department of Health, Education and Welfare that would be responsible for the following:

1. Developing new standards and systems of measurement that would incorporate quality of care.
2. Implementing and monitoring all LTC facilities.
3. Recruiting and training programs for facility surveyors.
4. Developing placement standards and standards for levels of care.
5. Enforcing federal standards with authority to withhold funds or close facilities who are not in compliance.
6. Developing emergency care facilities for patients displaced due to a facility being closed.
7. Building facilities in areas across our nation in areas where additional care facilities are needed or lacking.

This agency would be decentralized on a regional basis, along the boundaries established by the Health Systems Planning Agencies, in order to implement monitor, and enforce standards. Further, this federal agency would assume the licensing functions now performed by the States for LTC facilities.

The proposed system will provide a uniform system for implementing, monitoring and enforcing standards. It will increase the accountability in the expenditure of Medicaid dollars. It will guarantee that each state will have minimum levels of care available to their elderly population. Through a uniform enforcement system, using validated criteria, incidents of fraud and abuse could be minimized. The system would be easier to administer, as a single federal agency would be responsible. It would end the duplicative nature of current inspections by various state, county, and city agencies. Economies of scale could be achieved, as well as savings to the states who now expend moneys for monitoring and enforcing standards.

In addition, for the first time the federal government would have a direct role and control over the private sector in determing LTC standards. The federal government through implementing, monitoring and enforcement of standards of care would influence the market mechanism to provide the levels of services needed and the quality of care delivered. Further, with a uniform system of standards and enforcement fraud and abuse inflicted upon our elderly could be minimized. Federal government control over the private sector will insure quality control of LTC services.

While there is no perfect system for the delivery of LTC, a federal takeover of the standards of care will reduce greatly the problems with the current system. It would create a single set of standards that would be applied nationally. It would reduce the costs to states and localities, thus freeing up precious tax dollars that could be spent for other much needed services. It would guarantee equal access to quality care in every state. There would be a national effort to contain costs through the establishment of standards that provide quality care. And finally, a federal system of standards of care will insure that by the year 2020, all of those who are elderly and in need of LTC will have it available to them in their own state.

Concluding Remarks

There are those who contend that a federal takeover will not solve our current problems. But can we leave the system the way it is? Arguments supporting a federal takeover follow:

- While it is true that several states have taken measures to enforce and close down substandard facilities, they have done so only through insistence initiated at the federal level.
- The majority of states have done little, if anything, to beef up their enforcement efforts, which is substantiated by the lack of any data to the contrary.
- States have proven that they are incapable of developing alternatives for monitoring and enforcement, leaving that at the whims of the private sector.
- Most states would probably like to rid themselves of the responsibilities of implementing, monitoring and enforcing standards for LTC under Medicaid. They would save money, as well as headaches.
- There is a lack of any evidence that if we leave the current system up to the states to improve upon, very little, if anything, will be done to change the system on a national basis. Without federal direction the disparities, fraud, and abuses of the system will continue.

Standards of care are the foundation of the long-term care industry. Without a national effort to improve the quality of life of those confined to LTC facilities, our elderly can be guaranteed of poor or inappropriate care. Expenditures for Medicaid dollars must become accountable to that level of government responsible for allocating those dollars. Our nation can no longer tolerate the inflationary spiral of an open ended system, that is not accountable for its deeds or actions. A federal takeover is thus mandated.

FOOTNOTES

[1]Stephen F. Loebs, "Medicaid--A Survey of Indicators and Issues," Hospital and Health Services Administration, 22(4) Fall 1977, pg. 65.

[2]New York State, Moreland Act Commission, Term Care Regulation: Past Lapses, Future Prospects: A Summary Report, April 1976, pg. 5.

[3]New York State, Moreland Act Commission, Regulating Nursing Home Care: The Paper Tigers, October 1975, pg. 11.

[4]Ibid., pgs. 10-11.

[5]U.S. Congress, Senate, Special Committee on Aging. Subcommittee on Long-Term Care, Nursing Home Care in the United States: Failure in Public Policy - Introductory Report, 93rd Congress, 2nd Session, November 1974, pg. 46.

[6]Ibid., pg. 47.

[7]Ibid., pg. 49.

[8]Ibid., pg. 47

[9]Rensseler Polytechnic Institute, School of Management, Regulation of Long Term Care in New York State, Troy, New York, Sec. III, April 1979, pgs. 163-166.

[10]Ibid., pg. 101.

[11]Ibid., pg. 152-158.

[12]C. Knight Aldrich and Ethel Mendkoff, "Relocation of the Aged and Disabled," in Middle Age and Aging, Bernice L. Naugarten, ed., (Chicago: The University of Chicago Press, 1968), pgs. 401-408.

[13]U.S. Congress, Senate, Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy - Introductory Report, 93rd Congress, 2nd session, November 1974, p. 65.

[14]New York State, Moreland Act Commission, Regulating Nursing Home Care: The Paper Tigers, October 1975, p. 31.

[15]Ibid., p. 9.

FOOTNOTES

[16]Rensseler Polytechnic Institute, School of Management, Regulation of Long-Term Care in New York State, Troy, New York, February 1979, Sec. II., p. 1.

[17]U.S. Congress, Senate, Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy - Introductory Report, 93rd Congress, 2nd session, November 1974, p. 76.

[18]Rensseler Polytechnic Institute, School of Management, Regulation of Long-Term Care in New York State, Troy, New York, February 1979, Section I., pgs 17 and 23.

[19]U.S. Congress, Senate, Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy - Introductory Report, 93rd Congress, 2nd session, November 1974, pg. 77.

[20]New York State, Moreland Act Commission, Regulating Nursing Home Care: The Paper Tigers, October 1975, p. 11.

[21]Rensseler Polytechnic Institute, School of Management, Regulation of Long-Term Care in New York State, Troy, New York, Section I., p. 18.

[22]Frank E. Moss, Val J. Halamandaris, Too Old, Too Sick, Too Bad - Nursing Homes in America, Germantown, Maryland: Aspen Systems Corp., 1977, p. 153.

[23]Ibid.

[24]Ibid., p. 159.

[25]U.S. Congress, Senate, Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy - Introductory Report, 93rd Congress, 2nd session, November 1974, p. 84.

[26]Ibid., p. 79.

[27]Donald Malafronte, Howard H. Moses, et.al., "Appropriateness of Long-Term Care Placement: A Study of Long-Term Care Patients in the New Jersey Medicaid Program", The Medicaid Experience, p. 95.

[28]Ibid., pg. 96.

[29]Massachusetts, Department of Public Health, Health Data Annual 1977, Volume 4, No. 1, pg. 147.

FOOTNOTES

[30]U.S. Department of HEW, Medical Services Administration, Medicaid Management Reports - Annual Report Fiscal Year 1976, Table 4.

[31]Leda R. Judd, "Federal Involvement in Health Care After 1945," Current History, May/June, 1977, pg. 206.

[32]Dorothy P. Rice, "Health Facilities in the United States," Current History, May/June, 1977, pg. 214.

[33]U.S. Congress, Senate, Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy - Introductory Report, 93rd Congress, 2nd Session, November 1974, pg. 81.

[34]Ibid., pg. 109.

[35]U.S. Congress, House, Committee on Interstate and Foreign Commerce, Nursing Home Abuses: Hearings on Health Care Delivery System in Nursing Homes, 95th Congress, 1st session, March 15 and 16, 1977, pgs. 128-134.

[36]Rensseler Polytechnic Institute, School of Management, Regulation of Long-Term Care in New York State, Troy, New York, February 1979, Section I, pg. 11.