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WHO WILL TAKE CARE OF ME IN 2020 ?

A SPECULATIVE LOOK AT GOVERNMENT-FUNDED

DRAFT LONG TERM CARE DRAFT

Edited by Edward H. Downey and Robert Guhde from original student manuscripts submitted to the first annual Public Management Simulation held at Brockport, New York between May 1 and August 30, 1979.

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At this time, we would also like to offer our congratulations to Jeanne Hutchins, Jean Doremus and Laura Volk, members of the Brockport Team who have recently won the Grant Garvey Award for the outstanding student manuscript in Public Administration in 1980. Their paper, "A National Cost-Containment Strategy for Long Term Care" was a direct outgrowth of the PMS process and will appear in the Public Administration Review later this summer.

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Appendix I

TEAM POSITION PAPERS

Syracuse University

Medicaid Reimbursement for Long Term Care: Problems and Options

Barry Bozeman, Faculty Adviser
Rick Hug
Paul Schryba

State University of New York at Albany

Long Term Care: Medicaid Reimbursement
Does High Cost Yield High Quality?

Walter Balk, Faculty Adviser
Maria Muscarella
Jean Rosenthal
Garrett Sanders

State University of New York at Brockport

The Long Term Care Medicaid Reimbursement Problem

Carl Ekstrom, Faculty Adviser
Jean S. Doremus
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INTRODUCTION

The use of students to produce major policy studies has received some recent publicity with the publication of Energy Future by Roger Stobaugh and Daniel Yergin. These authors used Harvard doctoral candidates to do policy research in an area of major importance. MPA candidates at the State University of New York College at Brockport, the Maxwell School at Syracuse University and the State University of New York at Albany, participated in a recent policy study of this type initiated by the editors.

The Public Management Simulation (PMS) was conceived as a unique way to combine teaching and research in public administration. The ideal of combining teaching and research all too often finds its expression as a classroom lecture on somebody's pet study or as the lonely process of grinding out a dissertation or thesis. While both of these methods have undeniable merit, they tend to lack the vitality and challenge that comes from working with a group of intelligent and informed people to understand complex social phenomenon. PMS provides an alternative that utilizes the students as policy researchers with the added stimulus of an adversary setting. In this instance the PMS was used to develop alternatives for government funding of Long Term Care.

In the "normal" classroom situation a teacher should leave students with a more or less specified set of skills and knowledge. PMS attempts to provide a specified set of skills by showing students how to do policy research. The knowledge students gain is unspecified because it is unknown. It is up to the students to apply the skills to gain the knowledge.

Briefly, the PMS was done in two stages. In the First Stage, teams of students from three MPA programs were asked to develop policy alternatives to

the present system of Medicaid funded Long Term Care. Each team submitted their policy alternatives (see Appendices I, II and III) to a panel of judges who ranked them. In the Second Stage, a seminar composed of MPA students, who did not participate as team members, was formed to further develop policy alternatives. The students in the seminar were asked to develop policy to support one of two opposing strategies: the federal takeover of Medicaid funding for Long Term Care vs. the maintenance and possible strengthening of state control of Medicaid funding for Long Term Care. Each seminar participant was required to develop a paper in one specialized area that supported one of the strategies. These papers have been incorporated into this monograph.

In compiling the monograph the editors made every attempt to preserve the participants' papers in their original state. However, we did have to delete some portions of some papers that covered material in others. In addition, deletions and additions were made to aid transitions between chapters and sections of chapters. Finally, we engaged a professional editor to screen out grammatical and spelling errors. Other than that, the chapters in this monograph are solely the work of the seminar participants.

The object of the second stage of the PMS workplan was to use the team responses as a stepping stone for the development of even more rigorous policy alternatives to the funding of Long Term Care through Medicaid. None of the nine seminar participants had been a team member in the first stage; however, they all received copies of the packets sent to teams, were present at the Brockport conference where teams made their presentation, and were given copies of team position papers. The separation of team membership from seminar participation was considered beneficial because it allowed the seminar participants a better opportunity to critique the work of the teams and use it as a

base for the further development of policy alternatives. The key activities in stage two included: the subdividing of the problems into narrower issues associated with the Medicaid funding of Long Term Care; providing seminar participants with an opportunity to develop policy alternatives on Medicaid and Long Term Care; holding a debate which would allow the participants to test the viability of their positions; and critiquing the participant's written proposals to help them produce publishable final drafts.

The seminar used an adversary setting to analyze the problems before it. Half of the seminar developed policy alternatives based on the strategy that the federal government should take over the Medicaid funding of Long Term Care while the other half of the seminar was asked to support the maintenance and possible strengthening of state control. One of the unproductive outcomes of the adversary setting is that each side may attempt to damage the effectiveness of the other by withholding information, focusing on personalities rather than issues, ignoring the opponents' arguments and other similar behaviors of a destructive nature. It was felt that by having the participants work in dyads (teams of two) where each member advocated one of the strategies for a particular issue, many of the negative aspects of the adversary setting could be overcome. The seminar participants spent most of their time working in dyads and only broke into two larger debate teams (one to argue for federal control and the other to argue for state control) on two occasions. On the first occasion teams met to coordinate their debating strategy and on the second, the debate itself was held.

The subdivision of the Medicaid funding of Long Term Care into narrower issues was accomplished using the Norminal Group Technique.[1] The Seminar was

[1] Andre Delbecq, et.al., Group Techniques for Program Planning (New York: Scott, Forsman and Company, 1975)

randomly divided into small groups to develop a list of the most important issues. After this was accomplished, the groups were brought into a plenary session to combine their lists. In this way, five issues were uncovered regarding the Medicaid funding of Long Term Care:

1. What administrative structure is appropriate?
2. How will standards of care be developed and tested?
3. How will it be financed?
4. How will the moral issues be dealt with?
5. How will the appropriate options to the patient be determined?

Two seminar participants were assigned to each issue: one would develop policy based on the strategy of a federal takeover and the other would explore the continuation of state control.

The first assignment for each of the dyads was to submit an initial position paper of approximately ten pages. These papers were exchanged among dyad partners and submitted to the seminar directors. After reading each others initial position papers, the dyads worked to develop a common information base and an understanding of each others arguments. This was done to counter some of the negative aspects of the adversary setting mentioned earlier. The seminar directors intervened in instances where members of a dyad could not agree on which points of an issue should be argued or where the dyad had difficulty obtaining or interpreting information. In this way, the dyad partners prepared for the federal vs. state control of Medicaid funding for Long Term Care debate.

The dyads broke into larger debate teams for an all day session to coordinate arguments for the upcoming debate. During this session, the dyad members were given the opportunity to test their positions by presenting them orally

to a group that was working on different issues but using the same overall strategy (i.e., federal control or state control). During the debate itself, all seminar participants also made an oral presentation which provided a further test of the viability of their positions.

After the debate, each participant developed a fifteen page position paper for his or her issue. Each paper was read and criticized by the three seminar directors. Each of the seminar directors sat with the five dyads separately to discuss the criticisms of the papers done by the dyad members and to agree on necessary changes. The final drafts were submitted after the seminar participants had an opportunity to react to the directors' criticisms and are presented in the chapters that follow.

The next chapter entitled, "Uncovering the Issues" was done by Tracey Logel, who provided us with a summary and comparison of the responses made by each of the teams in the first stage of the PMS. Chapter III, "Standards for Long-Term Care Facilities: The Need for Reform" was done by Glenn Boetcher and Sharon Price. It looks at the relative difference between state and federally imposed standards for long term care facilities. Chapter IV, "Appropriate Levels of Care" was done by Judith Simpson and Robert Vogel. This chapter deals with the savings that could be effected by placing patients in the level of care most suited to their needs. Kevin O'Connor and Fred Volpe did Chapter V, "The Financing of Long Term Care." The relative merits of state vs. federal funding are uncovered in this chapter. Chapter VI, "Federalizing the Administration of Medicaid" was done by Sandra Caccamise. It explores some of the issues that surround the federal assumption of the administration of government funding of long term care. Lita Gonzalez and Kathy Palokoff did Chapter VII, "Ethics: The Quality of Life." This chapter takes a look at some of the tough

ethical issues surrounding Long Term Care and the potential impact of a federal vs. state takeover. Chapter VIII, Editor's concluding comments was done to summarize some of the most important points made by the participants.

Before, you the reader, become involved in the monograph itself, we ask you to examine the assignment given to the teams in Stage I. This assignment follows immediately, and will provide you with a greater appreciation of the many complex issues surrounding government funding of long term care.

PUBLIC MANAGEMENT SIMULATION PROBLEM
MEDICAID REIMBURSEMENT OF LONG TERM CARE FACILITIES

I. Introduction

This Public Management Simulation is concerned with the provision of Medicaid reimbursement to eligible long term care patients in a fictitious County. The assignment assumes that political values determine how the costs and benefits of Medicaid reimbursements for long term care are viewed. The determination of costs and benefits affect how Medicaid is perceived as meeting the goal of providing long term care for eligible clients. Recent rises in the cost of Medicaid have focused attention on the perceived cost-benefit ratio and thus the efficacy of the program. The concern for rising costs has resulted in a cost containment effort in New York State's Medicaid program.

Since the mid 1960's, the State of New York, in an attempt to assure a high level of quality in the delivery of long term care services to the elderly, instituted team surveys in compliance with Article 28 of the New York Public Health Law and the provisions of Federal Medicare and Medicaid Laws. Such survey teams are composed of nurses, dieticians, social workers, sanitarians,

and physicians, who make on site visits into long term care facilities. Deficiencies are reported, and corrective action is required of the facilities. This survey process determines facility eligibility for Medicare and Medicaid funds, as well as a New York State Operating License.

In the mid 1970's the issue of cost-containment in long-term care surfaced resulting from the nursing home scandals, the New York State fiscal crisis, and the resulting investigation by the Moreland Commission.* From this particular investigation, a number of recommendations were put forth by the commissioner to be implemented by the State of New York. For example, one cost-containment measure implemented dealt with the auditing procedures of the State Health Department. In the past, the Department had employed very few auditors to review financial statements issued by all long term care facilities in the State. In order to achieve a higher degree of accountability via financial reports, the State of New York hired a considerable number of additional auditors to assure only proper expenditures were reimbursed. The auditors compare reported costs to actual costs and disallow differences. Additionally, ceilings based on average costs of similar facilities were established. If facilities exceed a ceiling, they will not be reimbursed for their overrun. While efforts both in the delivery of quality care and the containment of costs have made some impact, you can assume that political authorities at the federal, state and local levels, as well as the public, are not satisfied with their results. All continue to see an ever expanding Medicaid program with long term care being a major factor in the increasing cost of government.

The Public Management Simulation requires you to state the political values which will guide you throughout the rest of the simulation. These values will assist in meeting the requirement of communicating your perceptions of the

*See attached report

costs and benefits and thus major problems associated with Medicaid reimbursement for long term care. After stating the major problems, you should determine their causes and develop strategies, structures and mechanisms that will diminish their effect. Some of the constraints you face are described in the following pages.

II. Federal Constraints

In 1966 the Federal Government introduced into the tangled web of programs which support health services, the Medicaid program. The Medicaid program provided open-ended categorical funding for medical assistance to welfare eligible clients. The only federal constraint is that the federal share of Medicaid must be equal to or greater than 50% but not more than 85% of the cost of the program, and that the state of local sources will fund the difference. States are free to accept the Medicaid Program or decline it. New York was one of the first states to adopt the program and only Arizona does not have a Medicaid program.

III. State Constraints

In the State of New York 45% of the cost of the Medicaid Program is attributable to long term care, but only 17% of the recipients of Medicaid are over 65 years of age. With this fact in mind you will be able to see the importance of the following constraints.

A. The state share of the Medicaid program, as specified by the Social Security Act, is described by the following percentage formula:

$$\text{State Share} = S^2/N^2 \times 45 \quad \text{or}$$

$$45/N^2 \times S^2$$

where N = 3 year average <u>national per capita income</u>

and S = 3 year average <u>state per capita income</u>.

The Federal Share is the balance, that is:

Federal Share = 100% - State Share,

but within the 50 - 83 percent limits.

This formula has the effect of systematically discriminating against states which have higher per capita incomes compared to a formula which does not contain an exponent. The following example illustrates how the Federal share would vary using the same ratio formula with and without the exponent.

<u>With Exponent</u>

Rich State: Assume state per capita income is $5000, and national per capita income is $4000.

$$1.00 - \frac{5000^2}{4000^2} \quad (.45)$$

$$1.00 - \frac{25,000,000}{16,000,000} \quad (.45)$$

$$1.00 - (1.56) \quad (.45)$$

$$1.00 - .703$$

= 29.7% viz., 50% because of prescribed limitations

Poor State: Assume state per capita income here is $3000 while national per capita income remains $4000

$$1.00 - \frac{3000^2}{4000^2} \quad (.45)$$

$$1.00 - \frac{9,000,000}{16,000,000} \quad (.45)$$

$$1.00 - (.56) \quad (.45)$$

$$1.00 - .253$$

= 74.6%.

<u>Without Exponent</u>

Rich State $1.00 - \frac{5000}{4000} \quad (.45)$

$1.00 - (1.25) \quad (.45)$

$1.00 - .563$

$= 43.7\%$, viz., 50%

Poor State $1.00 - \frac{3000}{4000} \quad (.45)$

$1.00 - (.75) \quad (.45)$

$1.00 - .337$

$= 66.3\%$

B. The Medicaid Program is becoming an increasingly large percentage of the state budget in New York which incidentally is the country's most expensive Medicaid program. In fiscal year 1976 the total payments for Medicaid in the U.S. and New York are shown below.

All expenditures U.S.*	$14,985,883,434
All expenditures N.Y.*	$ 3,241,796,716

*state, federal, local

New York spends approximately 24% of the total US Medicaid dollar! Of the 3.2 billion above, $2,958,316,016 was eligible for federal funding. The federal share in New York was $1,512,211,372 or 51.1% of the total eligible for federal funding. Table 1 shows how New York compares with six other selected states in this regard.

TABLE 1

SELECTED 1976 STATE EXPENDITURE PATTERNS: MEDICAID PROGRAM*

	% FED FUNDS (adj.)	% STATE FUNDS	% LOCAL FUNDS	TOTAL EXPENDITURES	THEORETICAL FEDERAL SHARE %
CALIFORNIA	43.5	40.8	15.6	2,045,304,289	50
INDIANA	56.8	43.1	0	209,075,461	57.47
MISSISSIPPI	80.3	19.7	9	118,926,914	78.28
NEW YORK	46.6	30.2	29.2	3,241,796,716	50
OHIO	55.1	44.9	0	449,070,708	54.49
TEXAS	53.4	36.6	0	631,608,025	53.59
WYOMING	60.5	37.05	2.45	6,721,190	60.94

*In this table the funding percentages are determined by taking total expenditures for Medicaid and computing the federal percentage after the federal government has determined which state expenditures are eligible for reimbursement. The formula-determined federal share is included for comparison purposes so that real federal share can be contrasted with theoretical share.

C. New York is now operating under severe internal funding constraints and, as a consequence, the political cost of increasing state and local expenditures is very high. Table 2 shows state and local taxes as a percentage of personal income for the seven states used in Table 1. It is obvious that New Yorkers are heavily taxed, with residents paying 16.6% of personal income as state and local taxes. No other state is comparable in this regard and one can assume that it would be difficult to increase already high taxes.

TABLE 2

SELECTED 1974-75 STATE AND LOCAL TAXES AS A PERCENTAGE OF PERSONAL INCOME

	Total		State		Local	
	Percent	Rank	Percent	Rank	Percent	Rank
CALIFORNIA	14.6	3	7.6	19	7.0	3
INDIANA	11.1	32	6.7	31	4.4	27
MISSISSIPPI	11.8	22	9.0	7	2.8	43
NEW YORK	16.6	1	8.0	13	8.6	1
OHIO	9.7	50	5.1	48	4.6	25
TEXAS	10.6	41	6.1	42	4.5	26
WYOMING	13.4	9	7.9	15	5.5	10

Source: NYS Statistical Yearbook, 1977.

IV. Local Constraints

Medicaid costs not covered by the Federal government are shared 50/50 by each county and New York State. The costs are a significant part of county budgets. In fiscal 1979 it is estimated that $68,650,000 will be spent in Medicaid in Ames County. Of this amount, the county will be responsible for paying $16,725,500 from local revenues which is approximately 10% of total local revenues. The 1979 Ames County Budget reveals that nearly 29,000 people are eligible for Medical Assistance, but only 26,600 currently utilize the service. The greatest number of eligible clients are children within the Aid to Dependent Children category. However, among the eligibles, those whose numbers are fewest create the highest cost. Here we refer to the approximately 2700 people

receiving services in nursing homes. The cost of nursing home care constituted over 47% of the entire Medical Assistance expense in 1977 and is projected to account for 48% of the program expenses in 1978.

Medical Assistance costs grow for many reasons beyond the control of local governments. The principal reasons are the continuing increase in hospital and nursing home rates (inflation), and the continuing "thaw" of the so-called "rate freeze" established by the State of New York. Medicaid rates which are set by the State Health Department are consistently and successfully challenged in the courts, resulting in higher rates granted to hospitals and nursing homes. The State has been taken to court over 1500 times, and in most instances, hospital and nursing homes were awarded what they sought in their law suits.

In the past, the Federal Government has taken over some programs such as the Aid to the Aged, Blind and Disabled (AABD). This program has now been folded into the Supplemental Security Income or SSI program; however, the County is still responsible for continued participation in supporting medical expenses for this group. Individuals within the SSI program account for nearly 68% of total Medical Assistance expenditures and are not public assistance grantees within Ames County. Thus, the SSI program has helped to swell the ranks of those eligible for Medicaid, thereby further increasing the costs. The aforementioned clearly establishes the basis for an increase of almost $5 million in the projected cost for the combined categories of hospital and nursing home care for 1978 over the demands of 1976.

In addition to the unmanageable vagaries of inflation, the rate freeze thaw, and the growing Medicaid roles are the following systems constraints.

A. Private pay rates at the two levels of long term care, Skilled Nursing Facilities (SNF) and Health Related Facilities (HRF), are higher than Medicaid reimbursement rates. Refer to the sample of nursing home rates in Appendix I.*

This results in the following effects:

1. Nursing homes are less inclined to take Medicaid patients.
2. Many Medicaid patients who are certified as eligible for care in SNF's are occupying hospital beds as acute care patients.

In Ames County, on the average, the patients must wait 44 days in the hospital at a cost to Medicaid of four to five times more per day (hospital costs per day for acute care average $208 in Ames County) than the cost that would be incurred if they were in a nursing home. It is estimated that if the 44 day waiting time was reduced to zero, Medicaid costs would be reduced by five million dollars in Ames County. Patient backlogs in Ames County are illustrated in Appendix II.* The five Ames County One Day Census in Appendix III* show the profile of available beds in nursing homes and waiting patients in acute care beds in hospitals.

3. Since private pay patients pay more than Medicaid patients it is argued that they subsidize the Medicaid patients. On the other hand if Medicaid reimbursement rates are increased to match private pay rates, there is no guarantee that private pay rates will not increase thus maintaining the inequity. The inequity may continue because nursing home proprietors might argue that the Medicaid increase simply makes up for low rates in the past but is not enough to meet spiraling health care costs.

*The appendices has been deleted from the text of the question.

B. Nursing homes are wary of taking patients whose present financial condition indicates that they will go on Medicaid in the near future. When a patient can no longer pay for nursing home services from non-Medicaid sources, the nursing home will apply for Medicaid. Unfortunately, it takes county, state and federal offices approximately three months to determine patient eligibility. During this time, the nursing home may provide care for the patient in the hopes of being reimbursed for that care after eligibility is determined. In instances where the patient is found ineligible, the nursing home has to absorb the costs incurred during the three month wait. Even when the patient is eligible it aggrevates the nursing homes cash flow problems because they have had to wait three months for payment.

C. The Medicaid reimbursement rate is different for each nursing home (see Appendix IV for the rates at Ames County Facilities). The method of determining the reimbursement rate is to divide a nursing home's operating costs and property costs for a given year by the patient days for that year. An inflation factor is also included. The method of calculating the reimbursement rates for the last three years is shown below:

$$\text{1979 reimbursement rate} = 1.236\left(\frac{\text{1976 operating costs}}{\text{1976 patient days}} + \frac{\text{1977 property costs}}{\text{1977 patient days}}\right)$$

(Note the 23.6% adjustment for inflation in the 1979 rate.)

$$\text{1978 reimbursement rate} = 1.135\left(\frac{\text{1976 operating \& property costs}}{\text{1976 patient days}}\right)$$

(Note the 13.5% adjustment for inflation in the 1978 rate.)

$$\text{1977 reimbursement rate} = 1.1245\left(\frac{\text{1975 operating \& property costs}}{\text{1975 patient days}}\right)$$

(Note the 12.45% adjustment for inflation in the 1977 rate.)

Although the State Health Department determines these formulas, County Social Service Departments are responsible for disbursing the funds.

V. Simulation Assignment

Your team is charged with developing a ten page paper (double spaced) that meets the following demands:

1. Make a clear statement of the political values that your team will use to guide you through the simulation.
2. Using the political values stated in number one above, specify the major problem(s) associated with Medicaid reimbursement for long term care.
3. State the causes of the problems developed in number two above and develop specific strategies, structures and mechanisms that will diminish the effect of the causes.

If you wish to attach appendicies to your ten page paper you may do so, but please keep them to a minimum. Make eight copies of your paper and bring them with you to Brockport on June 22, 1979. On June 23 you will give a brief oral summary of your paper (15 - 20 minutes) to the judges and teams from the other schools. You should be prepared to answer questions from the judges and other teams regarding your paper. Your paper will be included in a monograph that will be published at the end of the summer.

The assignment before you is both complex and of real importance. It is hoped that your work will be beneficial to you and to the many people directly affected by Medicaid reimbursement for long term care.

UNCOVERING THE ISSUES

The goal in this chapter is to uncover the issues as viewed by the three student teams. First is a synopsis of the papers in the order they were presented at the competition in Brockport. Each is outlined in terms of stated values, problems and causes, and recommended solutions. A few of the questions and answers asked after the presentation are included at the end of each synopsis. An analysis of the similarities and differences among the team approaches to the problem is presented. The chapter concluded with some unanswered questions and paradoxes that arise in the long term phase of health care. The complete team answers may be found in the Appendix to this monograph.

Syracuse University: Medicaid Reimbursement for Long Term Care: Problems and Options

Stated Values

The Syracuse team stated that the following three political values have inadvertantly shaped the problems underlying the entire Medicaid program:

1. Respect for individual rights
2. Private sector involvement and accountability
3. Economy, efficiency, effectiveness and equity

Problems and Causes

In addition, seven problems with the long term care (LTC) system exist under Medicaid. Briefly those problems are:

Problem #1 - Environmental factors. The LTC sector is a part of the health industry but deficiencies in other areas such as preventative medicine and ambulatory care affect the resources needed for long term care. Other environmental factors include changing demographic trends, and uncontrolled due to third party reimbursements which encourage inefficient use.

Problem #2 - Inefficient mechanism for long term care placement. Placing patients under a more costly care than needed is inefficient. An organized placement system is imperative for cost efficient long term care.

Problem #3 - Restricted levels of care definitions and limited reimbursement alternatives result in poorer care at higher cost. Patients who do not fit neatly into categories (levels of care) often receive inadequate care.

Problem # 4 - No incentive for institutions to take Medicaid patients. Lengthy periods in determining eligibility, price ceilings set below private rates and a cost reimbursement system based on a facility's equipment sophistication, lead to inequitable care.

Problem #5 - Greater accountability in the reimbursement system is needed. Increased coordination among regulatory agencies to avoid overpayments as well as under-payments.

Problem #6 - Limited federal participation in LTC places an undue burden on state finances. LTC costs should be shared equally.

Problem #7 - Patients remain in acute care beds longer than necessary. A shortage of SNF beds and an excess of acute care beds is the incentive for keeping patients longer than necessary.

Solutions

Short term solutions can be implemented almost immediately to provide better care, individual freedom and still be cost effective and accountable. To achieve this end, the Syracuse team recommends establishing central administration units to determine level of care, case management and placement in the LTC system. A casework system -- using a team of physicians, nurses and social workers would determine placement and ensure optimal match between patient needs and level of care. This system would result in cost reduction by eliminating misplacement, thus, freeing beds for needy patients and reducing hospital backlog. This casework system approach would enhance accountability by allowing better assessment of the quality of care actually received relative to the placement goals set for the patient. The Syracuse team felt this structure attacked problems 2, 4 and 5, while coming closest to meeting the political values.

Further recommendations include expanded study of alternatives such as hospice care (now used for terminally ill), to add flexibility to the system. To finance these alternatives they recommended a grant system similar to that of New York State Senate Bill 1107 which provides aid for facility expansion. Whenever possible, expansion of alternative levels should be through the conversion of existing facilities.

In conclusion, the Syracuse team recommended that federal regulations mandating the reasonable cost reimbursement system be changed to allow for a negotiated reimbursement system. Negotiated rates would allow operators to receive an amount commensurate with market rates.

Rate inflation is a problem of the health care industry in general and ultimately can only be cured at the federal level. Federal attention should be directed to the LTC industry, an ombudsman position should be created to give infirm patients a voice, and performance audited pilot programs should be instituted. These actions will not cure all Medicaid's ills but do represent significant steps toward eliminating many of them.

Questions and Answers

Question - Should the standards set by various states be lowered to the federal level?

Answer - With the creation of central administrative agencies or units, there would be a need for equity in formulas of reimbursement across the country. Many states currently reimburse at a level higher than the federal standard.

Question - Wouldn't ombudsmen put pressure on the system to provide increased levels of care in response to complaints?

Answer - It was pointed out that the Office for the Aging in Albany, New York, has an ombudsman who is attempting to set up a voluntary ombudsman system in regions or counties across the state. The team expressed the view that an ombudsman would lead to better understanding of what is adequate care for patients and inevitably to increased accountability.

Stated Values

Albany's team began its analysis with a quote from The Sociology of Health Care - Robert Enos, "Society has the obligation to assist the poor and the aged. Among the ways it should help them, is providing minimal levels of health care."

The analysis was based on the following values: 1) Quality health care should be provided by the government for those who need it, 2) Care should be provided as inexpensively as possible, and 3) Changes in the Medicaid System should not cause an increase in bureaucratic machinery. The team further stated that "while the basic goal of Medicaid has not changed since its inception in 1966, the means of achieving this goal has. A 'new' value, cost minimization, has entered the scene." Their basic premise is that government must learn to speak the language of the "profit motive". Government can do this by:

1) Recognizing that cost containment is a critical factor in providing Medicaid.

2) Eliminating the waste and inefficiency of Medicaid administration.

3) Providing appropriate placement for Medicaid patients.

Problems and Causes

How to provide quality care at minimal cost is the key problem. Currently there is overuse and inappropriate use of services by long term care patients. Government regulations make it more profitable for a nursing home to care for a private patient than a Medicaid patient through long delays in determination of eligibility and lags in the actual dollar reimbursement. There is an overall lack of coordination and consistency among the regulations put forth by three governmental levels - Federal, State, and County. These bury the private nursing home owner under a sea of bureaucratic "red tape". For example, discrepancies in Federal and State regulations require different numbers of professional staff per occupied bed and force the nursing home owner to meet the most demanding and/or expensive standard.

Solutions

The Albany team makes three general recommendations for the administration of Medicaid. Based on their belief that government has a choice in determining

the future of long term health care, they suggest the development of mechanisms that use the profit motive toward the end of improving long term health care. Second, a provision should be made in the Federal/State cost-sharing equation to reflect the number of state residents utilizing Medicaid services, and the quality of that state's service. The equation should reward states that have the most effective Medicaid program. Third, they call for the reduction of paperwork, duplicated regulations, and administrative inefficiencies. The three levels of government should strive for coordination of regulations to facilitate long term health care services.

Questions and Answers

Question - How do these recommendations decrease bureaucracy? It would seem that the better accounting and added supervision would increase it?

Answer - An actual reduction will be dificult. What we are suggesting is cutting down on the excesses -- the build up of regulations that have no end bearing on the patient. Some increases are necessary in order to put a check on the system but we foresee these increases offset by the decreases in excess paperwork and regulations that do not apply to the care of the patient. In the short run, an increase in bureaucracy is necessary to establish the needed system of auditing but in the long run costs will be minimized.

Question - Why wasn't it recommended that the family be made more responsible? Why aren't we responsible for our Mother and Fathers at least to a limited extent?

Answer - It really should be a family problem but what do we do with the patient whose family doesn't care? Can we not provide care to a sick patient because the family refuses responsibility? In light of the fact that the American family is not as cohesive as it used to be, we have not included this in our list of recommendations. Part of the lobbying that has gone on has taken the responsibility of the family away. There is no question that some of the placements in nursing homes are definitely social problems. Patients may have

some minor medical ailment that qualifies them but more often than not, it is because they are not wanted at home anymore.

Question - Why aren't patients questioned on the quality of care they are receiving? Have patients been polled in an attempt to measure the quality of care as seen by the patient?

Answer - Yes, there have been polls but we cannot speak to their results.

SUNY - Brockport: The Long-Term Care Medicaid Reimbursement Problem - Public Policy Analysis and Strategy Development:

Stated Values

Using a systems approach, the Brockport team analyzed current public policy and explored alternatives. "Medicaid reimbursement costs reflect the system's failure to create a cost-effective balance between the supply and demand, government and the private sector, quality and price, provider and consumer, flexibility and control." The following are the political values central to their analysis:

1) All individuals should have access to basic health care and related social services.

2) Government has an obligation to ensure reasonable access for all to long term care.

3) Free enterprise is essential to our democratic and economic order.

4) The lower the level of government responsible for administering a service, the more responsive to the needs of the people and efficient the service provided.

5) The role of the family unit in providing long term care is of primary importance.

Problems and Causes

This team began by defining the Medicaid reimbursement problem as only the tip of an iceberg. They stated that, unfortunately, most people know very little about the reimbursement system and fail to consider the giant bulk of ills below the surface. It was for this reason that they chose the following three problem

sectors. Each sector encompasses a multitude of underlying complexities and they believe short term solutions are not realistic. An "ecology effect" exists within the health care system whereby a solution or change in one area in turn affects another.

Problem #1 - High Cost. Two elements are missing from the Medicaid system which lead to high costs -- 1) a cost control component, and 2) clearly delineated national spending priorities.

Problem #2 - Failure of the market mechanism. When there is no ceiling on the amount of resources made available, there is an incentive for both supplier (physician) and consumer (patient) to generate as much consumption as possible resulting in overconsumption. One possible cause of the failure of the market mechanism is the inelastic demand for services - the patient wants treatment irrespective of cost.

Problem #3 - Faulty allocation and distribution of resources. Physicians, facilities and services are clustered in and around middle-class urban areas, leaving rural citizens and the inner-city underserved. Government intervention would help ensure a fair and equitable allocation of long term health care resources.

Solutions

The Brockport team presented interim solutions that would eventually lead to a comprehensive, single-agency provider. These specific recommendations are addressed to 1) various levels of government, 2) institutions and 3) physicians. In short, they suggest the current Medicaid distribution formula be replaced with one similar to revenue sharing, and that government encourage policies which offer an incentive to cut costs and discourage excessive profits. Expansion of reimbursement policies to include outpatient services in ambulatory care centers, doctor's offices and home delivered health services, would greatly reduce deliberate misplacement of patients. Physicians should be required by law to

serve a percentage of Medicaid patients to help insure quality care and service delivery to all who need it.

Uniform cost-effective policies and procedures must be established and health care facilities should be assisted in implementing them. The current duplication of service encouraged by the element of competiton can be eliminated through mergers and sharing of services. The American Medical Association must be urged to lift its restriction of medical student enrollment numbers each year. In addition, the medical students should be educated in use of cost-effective methods of health care.

The above suggestions will pave the way for a change over to single-agency solution called HEALTHPLAN. HEALTHPLAN is the framework for financing and delivering a comprehensive system for long term care. Primary beneficiaries are the elderly who become seriously ill. HEALTHPLAN applies the basic concept of insurance for acute care to cover long term care expenditures.

Everyone would be eligible at age 65 and could choose from a broad range of available services according to personal need, i.e., nursing home care, foster care, day care, home health care, meals on wheeels, etc. By financing HEALTHPLAN through general revenues, there would be an intergovernmental transfer of resources. This transfer would be from current income earners to the current covered population. A built-in co-payment concept will help eliminate the present tendency to over-consume through exaggerated statements of disability. Through a certification method by a panel of professionas, U.S. residents age 65 or over would be deemed eligible. Once certified, the individual would pay a deductible fee for the services chosen. Ten percent of average income for a household is the suggested amount. States could participate in this program by paying part of the deductible for needy residents. Consumers would be expected to pay in full for additional cost of care more luxurious or service intensive than a set standard. Thus, rate setting and standard setting for a maximum standard of care by type is crucial.

The key value stressed in a national long term care insurance program is consumer choice. The consumer has better knowledge of his tastes and personal situation and, if provided with access to long term care resources and to sound information, can make decisions about care that will maximize his own quality of life.

Questions and Answers

Question - How does your team propose to better regulate physicians and thereby have them toe the mark, so to speak, and do their job?

Answer - We suggest a measurement system similar to one in California called TAR. In TAR a limit has been set on the cost of service for the individual patient. They have found this to be extremely cost effective. Another suggested watchdog is the computer. This can be used to analyze charges compared to treatment and the sophistication of the necessary equipment used in that treatment. The area of health care is unique in that it is one of the few supply and demand situations where the supplier is in complete control.

Question - The solution you have presented gives the impression that it is related to much more than just solutions to long term care problems. The whole plan seems to be fundamental revision of the method of providing all health services. Is this what you had in mind?

Answer - No, the solutions are not meant for any more than long term care. HEALTHPLAN is not a total national health insurance plan.

Question - Have you given any consideration to patients already in long term care facilities? Those on Medicaid have had to turn over all of their income under the current system. Where do they find funds to purchase any portion of the services they need?

Answer - Quite frankly, we had not considered this problem.

Analysis

In essence, all three teams outlines the underlying political values as 1) government has an obligation to provide quality health care and to ensure that it is accessible to all who need it, 2) that while providing that health care, respect for individual rights and freedom must be maintained, and 3) that this health care be provided as inexpensively as possible. There appears to be general agreement that the single most troublesome aspect of Medicaid is the provision of quality care at a minimal cost. The need for increased accountability at all levels of administration is a key recommendation made by all the teams.

A certain amount of disagreement exists in the values each team states. Syracuse and Brockport include free enterprise in their list while the Albany team does not. On the other hand, Albany emphasizes the need to avoid increasing bureaucratic machinery and includes this as a value. Brockport's team took their list of political values even further adding 1) that services administered at lower levels of government are more responsive to the needs of the people and more efficient to provide at that level and 2) the importance of the family role in providing long term health care.

As indicated under common ground, all three teams listed the need for increased accountability as a value but only the Syracuse team shows the current lack of accountability as a problem. Interestingly, Syracuse was also the only one pointing to limited federal participation as placing an undue burden on individual state finances. The Brockport team lists the failure of the market mechanism due to the inelasticitiy of the demand for services as the number 2 problem with the system. Patients want to be treated regardless of cost, they say, and with the lack of any ceiling on the amount of available resources, the result is overconsumption. The other teams did not include this in their problem analysis.

Both Syracuse and Brockport include the problem of inefficient allocation and distribution of resources as a major cause of sub-standard care for large segments of the population. Physicians, facilities and services are clustered around middle-class urban areas, leaving rural citizens and the inner-city poor underserved and their facilities underfunded.

Each team took an entirely different approach in recommending solutions to the problems they outlined. Albany's recommendations are general in nature. They suggest a change in the Federal/State cost-sharing equation that will reward states with the more effective Medicaid programs; urge that the three levels of government coordinate regulations to eliminate duplication and inefficiencies; and state that long term health care can be improved if the government develops a "mechanism" that uses the profit motive. While the mechanism is not specified, this approach appears to be in keeping with the current system of combined state and federal financing of long term care in locally controlled private and non-profit nursing homes.

The Syracuse team offers solutions that can be implemented in the near future. The establishment of central administrative units, increased levels of care and a negotiated reimbursement system are recommended. However, they fail to tell us how to successfully negotiate the rates of reimbursement and still keep costs down. Some facilities request increases based on their financial needs for general care that may not apply directly to the long term care patient. In other words, Medicaid may pay for upgrading services not associated with Mediciad long term care recipients. The creation of an ombudsman position to represent patients is also suggested by the Syracuse team. Although accountability would be enhanced through an ombudsman program, the very nature of this positon suggests higher costs. While patients should have a voice regarding the kind of health care they receive, an ombudsman could conceivably pressure for even higher levels of care than necessary. The end result might add to already skyrocketing costs.

Creating central administration units to assume the responsibility for determining levels of care, case management, and patient placement is suggested by this team of students as the key solution to the many inefficiencies within the long term care system. However, they fail to say whether these units will replace any current levels of administration or if, instead, another layer of fat will be added to an already bulging bureaucracy.

The Brockport team presents us with interim solutions which ultimately set the stage for their long run recommendation called HEALTHPLAN. These solutions represent an intricate patching up of the many interrelated problem areas within the current system. They begin by suggesting a formula similar to revenue sharing in place of the present distribution formula for Medicaid, make numerous recommendations for various administration and health care facilities, and even suggest changes within the medical profession. How to implement these changes and who will monitor them is not clear, plus, the team does not mention the cost of such changes. There is the possibility that the expense to enact the solutions could far out weigh the ultimate cost savings.

The team's ultimate solution, HEALTHPLAN is a co-payment form of insurance designed to equalize the burden of long term care. Ideally, it will serve as a cost container through each patient's nominal contribution toward total costs. The patient will be purchasing a portion of the care he needs and therefore, will be more cost conscious eliminating the current tendency to over-consume services. Just how this will apply to the poor patients already on Medicaid and receiving public assistance is not evident. It is questionable if there is a way to avoid over servicing such a client. They cannot afford to contribute toward expenses as would be required under a co-insurance plan, thus, their situation would remain the same as under Medicaid. There will not be any incentive to be cost conscious and choose cost-efficient long term care.

A need for change within the current health care system is evident and the problems to be solved are numerous. The student teams in this competition have

showed innovation in meeting this challenge. They have approached the problem from different perspectives and uncovered many of the underlying issues. They have discovered that the task of making changes within this intricate system of health care is not an easy one. Changes made at any level have repercussions in all segments.

In analysing the political values, uncovering the issues and recommending solutions, they have faced some interesting paradoxes within the long term health care industry. For example, is it possible to contain costs and still provide quality care? In holding the line against the inflationary trend within this industry, the providers of care may well choose to cut corners on services patients are now receiving. There is also the question of whether the system should be administered at the state and local level under uniform federal guidelines or should there be more federal control? Some groups argue that the federal level is too far removed from the day-to-day problems of the patients, and therefore, cannot effectively administer the various health care programs. Other groups argue that the system of free enterprise is allowing the private facilities to "rip off" the Medicaid system. This brings up the patients, public or privately owned long term care facilities. Without the profit motive of the private facility, is there a way to insure up-to-date, quality care in a publicly owned unit? In the chapters that follow these conflicts will be further evaluated.

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.

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APPROPRIATE LEVELS OF CARE

Consumers of long-term care are primarily the elderly, whose numbers are approaching 25 million; they comprise almost eleven percent of this nation's population.[1] They experience higher incidents of chronic disease and long term illness, with the most serious health care problems occurring in those over 75.[2] These health care problems are usually costly because of the need for hospital and nursing home care, as well as other forms of intervention, and the unavailability of suitable, less costly alternatives, particularly in rural areas. In addition, these problems are compounded by lack of mobility, poor nutrition, lack of primary care and other elements often related to limited financial resources.

One approach to the problem of costly yet often inappropriate and inaccessible long term care is an increased federal or state role in directing, controlling and financing long term care services. Major strategy elements would include increasing the available range of services, achieving an appropriate mix of services, relieving part or all of the existing financial burdens on states and localities and stemming current cost escalation through appropriate utilization. Further analysis of this problem, and of potential strategies and solutions, requires a long-term care policy framework. A policy framework would set forth certain values, standards and directions as a means of specifying current problems and measuring the adequacy of potential solutions. Such a policy should include at least the following elements: (1) Choice among appropriate care alternatives and maximum functional independence consistent with need and cost effectiveness; (2) Availability of comprehensive evaluation and re-evaluation of patient needs. Also, given that needs and service delivery options vary from locality to locality, a policy governing long-term health care should recognize the need for a degree of local determination and participation and for plurality

in service models and sponsors.

Services And Levels Of Care

Implementation of the first part of a long-term care framework, choice among appropriate care alternatives, requires the development of health and health-related services with levels of care of sufficient range and distinction to enhance patient care and progress towards the highest level of functional independence. Care along this continuum of services should also recognize and account for the interrelationships of health and other human needs such as psychological well-being, socialization and emotional stability, and balance administrative and logistical limits as well. Such limits may apply in view of cost effectiveness standards or, in reality, the requirements of good patient care.

A spectrum of services, varying in degress of intensity, is necessary to meet the needs of individuals requiring long-term care. In this regard, Eric Pfeiffer noted that "no well-established definitions had been made of what was meant by 'services'. Some existing definitions of services are related to a specific provider, such as a nursing home, a day care center, or a mental health hospital. Analysis of these so called services indicated that they were not separate and distinct services but they constituted complex service packages.... Not all nursing homes provided the same set of services."[3] The following service elements could be included:

- nursing care
- therapy
- dietary
- socialization
- recreation
- chore service
- friendly visiting
- home modifications
- transportation (including non-health related)

- psychological
- social service
- medical equipment
- home health aide (dressing changes, bathing, etc.)
- respite care (allowing brief rest for those caring for someone at home)
- day care (services at a central site that enable one to remain at home)
- housing or rent subsidy
- support for thefamily (who is caring for an individual)
- dental care
- eye care
- preventive medical care (including primary care)

These services may be available at various levels of care. Kathy Powers, a Rochester Health Planner, describes and elaborates on levels of care.

> Levels of Care refers to the spectrum of residential care settings in which various degress of medical, nursing, social, domiciliary and support services are available. These settings include hospitals and other institutions, supervised homes, and independent living.
>
> Increasing numbers of studies reflect public interest in the need to appropriately meet the care needs of the elderly and disabled. A number of people feel that more emphasis needs to be placed on the functional ability of individuals rather than on a person's disability, diagnostic category, or disease. Many times in spite of the long lists of medical problems, the elderly or chronically ill person demonstrates an ability to compensate which is remarkably efficient and the individual can function within normal limits. When intensive services are necessary, it is desirable that the level of health care services received is appropriate for the health care needs of the individual.
>
> The services provided to meet client needs depends on the availability and accessibility of services in an area. The more comprehensive the level of care the more costly. For example, the acute hospital provides the most comprehensive and costly level of health care. Institutional care with built-in services is more costly than providing some individual services to meet client needs in their home. Many times clients do not need all the built-in services that an institution may offer and therefore it is imperative that the client needs be assessed and reassessed to insure the appropriate use of limited health care resources. As a result, the needs of the individual can be met in the lowest level of care rather than the individual having to conform to the institutional services available.[4]

The Genesee Region Health Planning Council developed level of care definitions as part of a methodology to estimate bed needs. They are described and illustrated here to demonstrate two vitally important points in arguing for a

full range of services. First, the levels are discrete in order to distinquish the problems and limitations of the individual and the support required to enable that individual to function. Second, the levels represent increasing functional independence for the individual. Thus, if the appropriate level of care is available the individual can function at the highest level possible for him or her, and continue to make progress from one level to the next to the extent of the individual's capabilities. The following, selected from those definitions, seem to offer an adequate spectrum of levels of care.

A2. Long-Term Hospital is a level of care for persons with long-term illness or disability who require very high levels of nursing care on a continuing basis, i.e., virtually total care, beyond the capabilities of most nursing homes and/or patients who are prone to episodic medical emergencies requiring immediate physician intervention. All of the personnel required for hospital care are required as well as most of the equipment and department services, with the possible following exceptions: operating rooms, intensive care or coronary care units and an emergency department.

A3. a. Skilled Nursing Facility provides care for patients who require continuing 24-hour nursing care and/or supervision, and/or rehabilitation or teaching program. These patient needs frequently follow early discharge from an acute hospital setting and the patient needs cannot be met at home or in a lower level of institutional care.

b. A skilled nursing facility also provides care for patients with long-term chronic illness, whose primary need is relatively complete activities of daily living (ADL) care, skilled nursing care or supervision and medical supervision, when these care needs cannot be met at home or in a lower level of institutional care.

This level provides close medical supervision and 24-hour nursing care and/or supervision, as well as physical, occupational, speech and hearing therapies, social work, dietary, dental, podiatrist and pharmacist services, an activity program and electrocardiography. Services of a clinical laboratory and radiology must be available on the premises or by a satisfactory arrangement, as well as appropriate consultant services including psychiatry. A medical records system and patient charts are essential.

A4. Health Related Facility provides services to persons who because of physical, mental or social needs require institutional services in addition to board and lodging, but do not require the extent of services typically provided in a skilled nursing facility or higher level of care.

Persons who need care in and can in fact live best in a health related facility meet the following criteria:

a. They are ambulatory with or without mechanical aids.

b. They may need minimal to moderate help in one or two activities of daily living.

c. They may need help in taking medications.

This level provides nursing supervision, recording of health information, dietary supervision, and minimal to moderate assistance with the activities of daily living. This level also provides for the supervision of mildly to moderately confused persons who are not a danger to themselves or others and who do not present major behavioral problems.
Supervised Boarding Home provides care for individuals who are medically stable, ambulatory with or without mechanical assistance, not more than minimally confused, do not require constant supervision and are able to take their own medication. They may also provide therapeutic diets of unsophisticated nature and minimal assistance with bathing, dressing and toileting.
Regarding medical care, an individual may require no more than regular ambulatory care; nursing supervision is provided by community health nurse; assistance with or supervision of activities of daily living is given by non-professional personnel rehabilitation is available on ambulatory basis or from a visiting therapist; recreational and socialization activities are provided.
Home Health Agency (except hospital level home care) for individuals requiring only regular ambulatory care plus community health nursing; physical, occupational, speech therapy; and home health aide--supervised by a community health nurse.
Non-Professional Support Services provides no nursing services. Assistance is provided for meals, shopping, laundry, etc. The individual must be medically stable, alert and ambulatory with or without mechanical assistance, and able to manage personal care.[5]

The availability and accessibility problem is a vital one. The problem of misplacement can be illustrated by the Monroe County bed surveys done in 1969-70 and 1975 which found that only 52.1% of skilled nursing patients and 23.4% of health related facility patients belonged at those levels of care in 1969-70;[6] the figures were 90.4% and 65.0% in 1975.[7] In fact, recent gerontological studies indicate that "as many as 40% of the elderly in nursing homes do not really need to be there."

Evaluation And Placement

A second important policy element, in addition to the availability and accessibility of a range of services, is an evaluation and placement process designed to evaluate the needs of individuals in relation to the range of services available. Evaluation and placement experiements have demonstrated the value of such a process. For example, an evaluation and placement project

was conducted in Monroe County, New York. Placements as a result of the evaluation process were 20% more accurate than placements described in studies conducted earlier in the same locality.[9] The evaluation process was also independently evaluated with similar results. Obviously, such procedures would be essential to effective utilization of the various levels of care cited above.

Two important points should be noted here regarding evaluation and placement. For the evaluation and placement process to work, it must include private pay patients as well as those supported by the government for a private pay patient able to select at will an unsuitable level of care would destroy the integrity of the system. Secondly, institutional admission policies could not be used to selectively screen out individuals.

Perhaps the necessity of such services is best summed up by the report of the Maryland Commission on Intergovernmental Cooperation which states that, "The importance of Geriatric Evaluation Services cannot be overemphasized in regard to its role in channeling at-risk individuals to the most appropriate alternative - emphasizing source of care. This function not only serves the individual best but also services to minimize the cost of the health delivery system."[10]

APPROPRIATE CARE: A CASE FOR FEDERAL CONTROL

Review of the Present Situation

Having discussed the future need for long-term care services, a policy framework, the need for a continuum of appropriate services, evaluation and placement procedures and level of care designations in the Introduction, one can review the present situation against that standard. Certainly, the combination of Medicaid and Medicare programs were developed to improve access of the needy and the elderly to health care services. Stephen Loebs, a Medicaid specialist, suggests that this intent has been met to a degree. He points out, however, that "political ideology and attitudes toward the poor"[11]

are a determinant in the range of services provided in the states, that there have been different degrees of response by the states to ensuring equitable access to services, and that this variation can be expected to continue if states retain control of the Medicaid program.[12] A comprehensive study of need for and availability of alternate care services (i.e. other than institutionalization) by the Western Wisconsin Health Planning Organization further supports the contention that a more equitable comprehensive plan is needed. This study concludes that "growth (of alternate care services) will be impeded until regulations and funding mechanisms are revised."[13] In the background report to that same study, John Hutchins, a health planner states that there is a "consensus that a readily available, full spectrum of care is needed for the elderly. There appear to be opportunities for improving the care and quality of life for the elderly and for substantial cost savings".[14]

Without question, the range of services currently provided under Medicaid, when compared to those discussed in the Introduction, is inadequate, the coverage is inequitable, and the rate of cost increase is unacceptable. Undoubtedly, demographic and health status factors will continue to seriously aggravate these circumstances in the foreseesble future. While many services are currently covered by Medicaid (inpatient hospital, outpatient care, laboratory and x-ray, skilled nursing, physician visits and home helalth care [but only certain services in the home similar to current coverage as above]). Eligibility for services varies from state to state in a number of ways as do the services covered with some states choosing to provide more than the minimum required for participation. The rate of cost increase is driven by general inflation in medical care costs, increasing eligibility as individual resources are consumed by general inflation and the cost of institutional health care, and increasing utilization as growing numbers of individuals reach the age where more and greatly intensified services are needed.

Federal Assumption of Greater Role in Long Term Care

There are two possible solutions to the Medicaid/Medicare problems. The first would be to improve the existing Medicaid (and Medicare) program in the context of the current funding formula. However, making more services available to a wider range of recipients with the federal and state governments sharing the increased expenditures under the current formula does not seem like an alternative with sufficient incentives to encourage change. Alternately, one might rearrange services in a more efficient manner within current expenditure constraints, but this seems unlikely to insure availability, access or equity.

The second option is for the federal government to assume a greater responsibility for the direction, control and financing of long-term health care as a means of achieving the standards set forth above. The hallmarks of such a proposal would include relieving the escalating cost burden of long-term health care on state and local governments, improving service through greater accessibility and availability of appropriate levels of care, long-term cost effectiveness and cost restraint, timely delivery of services and timely payment, better coordination of service delivery and better planning and evaluation through standardization and uniformity of data.

An important determinant in the choice of options is political feasibility. It is unlikely that the states would or could underwrite the costs of developing a full range of services. Revenue sources in the states are less elastic than those of the federal government and tax rate increases are subject to more local constituent pressure.

The goals of improving service and achieving long-term cost effectiveness and control could be achieved within the following parameters of a federal take-over of major responsibility for long-term care services:

- establishment of minimum federal guidelines regarding levels of care to be available and minimum services to be provided within those levels,
- emphasis on the development of less costly, more appropriate services, and establishment of requirements for planning and evaluation of care alternatives and for eligibility
- provision for continuing participation and local determination within the guidelines particularly in the areas of determining unique local needs and the construction of models or alternatives with a greater emphasis on accomplishing this at the regional and local level
- increasing the federal cost share, insuring that long-term care expenditures by state and local governments are stabilized for a period of five to ten years especially to the point that when they would resume participation in sharing cost increases, those increases would be at a rate consistent with general cost increases and furthermore would be predictable based on the experience of providing a full range of services for an eligible population over an extended period of time.

Federal Guidelines

Establishing minimum federal guidelines would be the initial step in insuring that appropriate services are available. One factor contributing to inappropriate placement of individuals in skilled nursing and health related facilities is the lack of suitable alternatives in the community. A 1970 study in Monroe County, New York found only 52.1% of the patients in nursing homes required that level of care and similarily only 26.1% in health related facilities.[15] A similar study of placement in 1975 showed improvement due to expansion of home care services and better evaluation and placement procedures, but the problem of inappropriate placement still abounds in Monroe County as well as the rest of the country. The establishment of federal guidelines would standardize and

assure minimum services within specified levels of care thus alleviating the problem, while containing costs.

Local Participation

Local participation and determination is essential because needs would vary from region to region in the country. It would be necessary, for example, to determine the quantity of a particular service needed in any single locality as well as the possible models for providing the service. Concentration of the elderly population, geographic characteristics and existing services would all have to be taken into account in developing needed services. Also paramount in terms of loca participation is the existence of state administrative and regulatory functions that would be absolutely essential components of operationalizing a greater federal role in financing long term care.

Federal Assumption of Cost

A major feature of a federal takeover is the federal assumption of the cost of financing long term care. First, most states would be given dramatic relief from rising long term health care expenditures. This would be accomplished by freezing the current contribution from a state or locality for a period of five to ten years while increasing the federal contribution both absolutely and as a percent of total expenditures in each state. In doing so, the total amount of money for long term care services is increased while the state and local contributions are stabilized. The increased amount is then used to develop new services, particularly those of less intensity and lower cost and to phase out services where excess exists. In doing so, the system could reach an equilibrium of 2020 that would be less costly than continuing our present course and provide more appropriate services.

As an example, the Maryland study illustrated the potential savings of $25,690,000 if long term care placements could be shifted to an optimal pattern.[16] While this certainly cannot be achieved immediately, it illustrates the possibilities for developing and appropriately using alternatives to our present patterns of care. In addition, the study estimated the costs for Fiscal Year 1977 for certain services should the federal government take 100% responsibility in Maryland under a national health insurance plan, assuming an optimal mixture of services. Total expenditures for nursing homes would be $71,150,000 compared to an estimated $100,000,000 under the current system; day care, home care and home health combined would be $1,240,000 less under a totally federal financing plan, even assuming all elderly to be eligible and that everyone who needs a service receives it.[17]

The factors used in the Maryland study to estimate the population in need of each level of care were first utilized in a study done in Monroe County, New York. The optimal placements are set forth below.

Percentage of Elderly Population Requiring Each Level of Care
According to Monroe County Study

0.8% - Acute Medical Care

0.1% - Subacute

0.1% - Psychiatric Inpatient Care

0.3% - Intensive Nursing Care

2.7% - Institutional

5.9% - Congregate Living

6.7% - Public Health Nursing Services at Home

83.4% - No Care Needed From Organized Service Agency[18]

Data to make similar estimates on a national level are not readily available. One could assume, conservately, that 5% of the nation's elderly are receiving intensive nursing or institutional care (compared to 3% above) and that this is equivalent to nursing home care for expenditure purposes. If so, national expenditures for nursing home care that totaled $7.1 billion in 1975[19] could theoretically be reduced to $4.26 billion. Even investing in the development of new services and allowing for an increase in the population requiring higher levels of care (i.e. less than the 2% differential calculated above), it seems clear that implementation of the federal takeover of long term care financing would result in a reduced rate of cost increase over a period of years, stabilized state and local expenditures and a continuum of care that more appropriately meets the needs of the elderly population.

There are some adverse consequences to such an approach. The first is a loss of some autonomy by state and local governments. This would be ameliorated to a certain degree by the serious consideration of the appropriate and necessary roles for all levels of government with the federal level setting necessary parameters to insure policy consistency while balancing this with the need for substantial local participation. The incentive of limited and stable expenditures should also reduce resistence to this change. Secondly, total expenditures would have to be increased in the initial years of the change to allow for expansion of services and entry of those currently excluded into the sphere of care.

In addition, many potential problems exist. One faces the policy question of where to draw the line between health services in such a program and other services such as housing and nutrition, a point recognized by the Maryland Commission, who simply reached the conclusion that, to begin with, " the health care system must take the responsibility for the health component of the problem."[20]

Another problem is the magnitude of the required change. It is difficult to estimate the time required to bring on line many new services in diverse areas across the country or to predict the problems to be surmounted in moving away from our current emphasis on institutional care. But the forty years from now until 2020 would offer ample opportunity to initiate and evaluate change, given the point, for example, that the useful life of a facility constructed today would be about forty years and those built yesterday somewhat less. In underscoring this dilemma, the Institute of Medicine suggests an initial restriction for total eligibilitiy to those 75 years and older as a way to get started.[21]

In addition, it should be clear that some services cannot be available in rural areas because they would be too costly on a small scale. However, a fuller range of services than is now available in most rural areas would have some of the same outcomes as already described--greater potential for functional independence for many individuals, less misplacement, and potentially, a reduction in overall costs. For example, day care and respite care services can be provided in existing facilities in order to reduce overhead cost for the program. When the additional cost of transportation is added in, the program can still be less expensive than institutionalization, particularly when transportation expenses can be shared with other community programs. There is also further potential to combine services. When individuals are gathered at a central location for a day care program, for example, they can receive other services such as nursing care and therapy that might otherwise have necessitated home care or eventual institutionalization.

Another possibility, in more isolated areas, is the placement of individuals with families that are willing to care for them--individuals who otherwise would have to be placed in an institution. While not all services could be provided in many rural areas, the addition of some services, as conditions allow, could benefit the individual and the community, and in many cases also be cost effective.

Conclusion

In summary, several problems are addressed by having a fully developed and readily accessible range of long term care services. First, the needs of those requiring long term care services would be more adequately met. No longer would individuals be placed in institutions when a less intensive level of care would suffice. In addition, the individual would have the encouragement and opportunity to improve--to go home from the institutions with the support of an appropriate array of home care services if necessary. They would be able to function at their highest possible level given their circumstances and limitations resulting in an enhanced quality of life for the individual.

Secondly, federal direction and control would insure at least a minimum level of equity and uniformity throughout the country. No longer would there be state to state variations in basic service patterns, service definitions or requirements for eligibility. The national approach would also necessarily be balanced by recognition of local and regional needs and resources so that programs would be appropriate and useful.

Finally, substantial progress can be achieved in dealing with the escalating costs of long term care. Given that we are, for the most part, paying for an excess of the highest and most costly level of care, substitution of lower and less costly modes of care combined with access for those individuals currently excluded from care until they require institutionalization (and thus postponing or eliminating institutionalization) will eventually result in an equilibrium in the system where most individuals are receiving the appropriate level of care. While the overall cost may continue to rise, and will certainly be substantial in developing new levels of care, it will reflect the rational allocation of services and will therefore be subject to more informed judgement regarding the value of the investment.

The policy statement of the Institute of Medicine accurately summarizes the theme developed in favor of a federal assumption of long term care financing.

The committee believes that a fundamental change in federal policy for care of the elderly is required to better meet the needs of functionally dependent old people and their families. The committee therefore recommends that:

> The federal government should reimburse for long-term care provided to the functionally dependent elderly. Long-term care should include both health and social services and should provide for choices between institutional and home-based care. Eligibility for federal reimbursement of long-term care should be based on a comprehensive assessment process.[22]

APPROPRIATE CARE: A CASE FOR STATE CONTROL

It is essential that the levels of care for Medicaid remain at the discretion of the states, planned and administered from a state or regional level, rather than be taken over by the Federal Government.

There are three basic reasons for this status quo position.

1. A federal takeover would cost far more money than is presently being spent, resulting in an even greater percentage of the Gross National Product given to medical care. Health expenditures have risen from $39 billion (5.9% of the GNP) in 1965 to $119 billion (8.3% of the GNP) in 1975.[23] At the present time, there is no segment of our society willing to see this percentage increase.

2. Political power and influence of the elderly will grow with an increasing demand for appropriate, locally based medical care and other non-medical services.

3. The states have a high ability to control the Medicaid programs both fiscally and through regulation of the system. The states have maintained the ability to provide licensure for other functions, and are far better prepared to maintain this function than federal agencies.

Four basic attitudes or sets of pressures determine the quality of health care in any given area: economic, legislative, scientific and humanistic.[24] These attitudes and values vary across the country. The United States is, by its nature, a fragmented society. People have come from different cultures and have chosen to live in different conditions. What is good for one area of the country is not necessarily good for all areas of the country. Health care reflects attitudes, culture, and customs of society. Since our society has prided itself on free enterprise and independence of the individual, it is unlikely that the public would choose to maintain a federal long-term care system for the poor. When administration and planning of levels of care is regional, consumers and providers are brought together. This provides for optional allocation of resources and a greater change of a balance between resources and human energies.

LEVELS OF CARE

There are two major conditions affecting the choice of care levels at the present time:

1. Movement of elderly patients causes major psychological trauma and, in many cases, might prevent cure from occuring.

2. The attitude of long-term care practitioners often favors treatment of symptoms over rehabilitation.

A system where these two conditions are seriously addressed will become a more efficient system. If the overall scheme of care begins at home, or locally, a basic philosophy of prevention and rehabilitiation is possible.

Prevention stressed at the local level may reduce many very expensive entrances into the Medicaid system. Instead of entering a hospital for primary diagnosis of a problem, a patient could be seen at a clinic or some less comp-

rehensive center and referred to an appropriate level of care immediately. The existence of varied levels of care would alleviate one major problem of Medicaid which is the placement of patients in overly costly hospital beds for long periods of time when other levels of care are not readily available. Another major problem, the trauma inflicted upon the ill elderly when the movement from one facility to another occurs could also be solved by housing many levels of care within the same facility. In fact, hospitals are already experimenting with methods of treating the less seriously ill patient. Mothers with new babies are encouraged to care for their newborns themselves, and to become mobile as early as possible; post-operative patients who only need occasional nursing are taking more and more responsibility for their own care in less intensive areas of the hospital. If a patient could switch to a less costly status within the same institution, both the problem of appropriate placement and the problem of movement could be addressed. A patient could be within reach of nursing care and laboratory and testing facilities during those times when the services were necessary, and then could have these costly services reduced as improvement occurs. Such cooperation among hospital administrators, physicians, and nursing home owners would be challenging and would require great cooperation. Such cooperation is more likely at a local level.

States should, in the future, mandate the following three types of services and movement between them should be made feasible:

1. Home Care. If impairment is not severe and home rehabilitation is possible, home visits by physicians' assistants, nurse practitioners, occupational and physical therapists would encourage rehabilitation and could be provided at as low or lower cost than hospital or nursing home care. Prevention of further trauma could be emphasized.

2. Skilled Nursing Facility. This is the one area which could benefit the most from a swing in hospital beds from acute care. So often the bottle

neck for Medicaid patients occurs when patients are left waiting in a hospital for beds to become available in nursing homes. Local and state control of the number of beds available in each facility could help to reduce this problem. Also, when rehabilitation is heavily stressed, there should be increased movement out of the SNF to a lower level of care.

3. Custodial Care. Though it is essential to provide basic care for those patients who appear to need permanent caring, this level also should stress rehabilitation to the level where it is possible.

Given the political future for the elderly and the increase expected by 2020 in the numbers of people over 65, the communities of the future should have the desires and skills to make the care for elderly people more humane. There will be more lobbying groups and more willingness to provide non-medical services for older people.[25] Thus, actual levels of care provided by Medicaid could and should be limited to the above areas.

Since transfers from one area of care to another are fraught with communication problems, counseling, placement, and referral will play an increasingly important role in 2020.

FRAMEWORK FOR LEVELS OF CARE

There are two basic means for controlling quality and quantity of long-term care: regulation and reimbursement. To be effective, these practices need to be timely and enforced. The closer the source of care is to the administration, the better the administration will be.[26]

As suggested earlier, a major problem of Medicaid has been inappropriate placement, resulting in higher costs and unsuitable care. In a New Jersey study it was found that 35% of intermediate care level individuals could be discharged to a more appropriate setting.[27] Here, intermediate care was defined as the

nursing home. Senility problems were more likely to be appropriately placed in a full or intermediate care setting [custodial]. Musculo-skeletal problems were often more appropriately placed in home or day care settings. The study concluded that more than 1,700 persons could be placed at a more appropriate level of care, and, in some cases, at a lower level, if that care were available. Care which meets the needs of the individual is more likely to be made available at a local level of influence and control.

There are many possible frameworks for state funded programs. Any framework should depend upon a tight cooperation among three categories of agencies. There should be an organization to evaluate and place individuals at appropriate levels of care. Screening and evaluation should include a complete medical and psychological workup with interviews with the client and all members of the client's family. The goal of such screening would be to find the most medically and socially fitting placement at the lowest level of cost. If this service is functioning well, state differences in covering different services could be justified. This sytem would also serve those who could afford to pay as well as Medicaid patients. One example of such a program is ACCESS, a service offered by Monroe County Long Term Care, Rochester, New York.

Working closely with the placement and screening agency would be a number of organizations providing advocacy for people needing long-term care. This agency or agencies, would also provide a setting for political education and support services for all elderly people. One example of such an agency is the Regional Council on Aging in Rochester, New York, which includes the ombudsperson program for nursing home residents and an organization called Citizen Leaders for Action in Rochester (CLAR), a political action group, which provides information and volunteer services for the aging.

The third necessary component for a state administered program is a planning element, such as the Regional Health Systems Agencies, set up throughout the

country in 1974. Presently, these agencies are in the position of being able to evaluate programs and plan new ones through each state.

All three of these processes depend upon tight community cooperation. If this cooperation were carefully controlled, financing and licensing could be handled by the State. In this way, health care needs would match health care services and health care dollars.

AGAINST A FEDERAL TAKEOVER

Several reasons have been given for changing our Medicaid system to a Federal system. There is a suggestion that a federal takeover would increase the available range of services and provide an appropriate mix of services. In order to avoid gaps in service and an enormous waste of dollars, these items could only be facilitated on a regional level.

Another suggestion is that a federal takeover would relieve financial burdens on the states and localities, thereby stemming cost escalation. The burdens should be placed as well as possible where they belong: on the family and community. When there is no direct contact between money and services, it is easy to forget the function of budgeting.

There should certainly be a policy framework for establishing levels of care, but it should be done on a state level with local or regional input. It is easier to be aware of the interrelationships and the need for community co-operation from a local and community level.

Evaluation and placement are obviously a crucial element in establishing levels of care which are most appropriate. This is a policy which would be appropriately mandated at a state level. Eligibility for services will vary according to the needs of the community and the levels of care available.

Improving existing services and working within the regional system is an attempt to stay within the simplest framework possible. To go to the more complex system of a federal takeover before mastering the more simple structures would mean financial and bureaucratic disaster. There would be an increasing possibility that Medicaid patients would fall through the spaces between services. Also, a more complex federal network would remove the consumer—whether the consumer is the patient or the taxpayer— from the provider, inviting waste of human and financial resources. Cost controls work best when they are linked directly to services.

An argument for federal takeover is that it is unlikely that states could or would underwrite the costs of developing a full range of services. The states should not need to develop a full range of services. If anything, the states should act as a control for unnecessary services.

Increasing federal cost share is often thought of as a way to relieve financial burdens for the consumers, or taxpayers. It is ridiculous to think that the taxpayer does not end up paying more. The money still comes from the same source. It is only disguised in the process.

A loss of autonomy by state and local governments would place additional hardships upon the Federalist system, which thrives upon autonomy of state and locality and intergovernmental cooperation.

When levels of care are mentioned, it is difficult to separate the conditions which should exist within a community to promote human dignity and those services so medically necessary as to be provided by the government when they are not affordable. When there are many services and levels of care provided by the government, communities find less incentive to improve the state of its members.

CONCLUSION

The problem of appropriate care levels for long-term care patients may be best solved by having the administration and control of care as close to the consumer as possible. Though federal direction and control would insure a level of equity and uniformity throughout the country, that level would prove to be inappropriate for large segments of our fragmented society. We need to feel responsibility and control of our lives in order to avoid apathy.

Finally, the cost control for long-term care must remain close to those who must pay the bills and those who receive the services. These are the only groups, combined with professional advisors, which can make decisions upon levels of care within Medicaid.

FOOTNOTES

[1] The Elderly Population: Estimates by County 1976, U.S. Department of Health, Education and Welfare, Office of Human Development Services - Administration on Aging, DHEW, Publication No. (OHOS) 78-20248, p. 130.

[2] Institute of Medicine, The Elderly and Functional Dependency, National Academy of Sciences (Washington, 1977), pp. 1-5; National Health Insurance Benefits and Costs for Maryland's Elderly Citizens, 1976 Supplemental Report of the Maryland Commission on Intergovernmental Cooperation (Annopolis, 1976), pp. 6-8.

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[4] Kathy Powers, "Refernece Guide for Levels of Care Presentation", Finger Lakes Health Systems Agency (Rochester, New York, 1978), p. 1.

[5] "Survey of Need for Inpatient Beds and Related Home Health Care Services, Monroe County 1969-70", Genesee Region Health Planning Council, Rochester, New York, 1970.

[6] "Survey of the Need for Inpatient Beds, 1969-70".

[7] "Survey of the Need for Inpatient Beds and Related Health Care Services, Monroe County, 1975". Genesee Region Health Planning Council (Rochester, New York, 1975).

[8] Liz Harnes, "Alternatives to Institutionalization for the Aged: An Overview and Bibliography" Council of Planning Librarians (Monticello, Ill., 1975), p. 2.

[9] T. Frank Williams, John G. Hill, Matthew F. Fairbank and Kenneth G. Knox, "Appropriate Placement of the Chronically Ill and Aged", Journal of the American Medical Association, Vol. 226, No. 11, Dec. 10, 1973, pp. 1332-1335.

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[11] Stephen F. Loebs, "Medicaid - A Survey of Indicators", Hospital and Health Services Administration, 22(4): 63-90; Fall 1977 in The Medicaid Experience, A. Spiegal, ed. (Aspen, 1978), p. 7.

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[12]*Ibid.*, pp. 7-11.

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[14]John Hutchins, *Background Paper on Alternate Care for the Elderly*, Western Wisconsin Health Planning Organization (La Crosse, 1975), p. 12.

[15]"Survey of the Need for Inpatient Beds, 1969-70".

[16]National Health Insurance Costs and Benefits for Maryland's Elderly Citizens, p. 36.

[17]*Ibid.*, p. 45.

[18]*Ibid.*, p. 33.

[19]*The Size and Shape of the Medical Care Dollar*, Chart Book/1975, DHEW, Social Security Administration, DHEW Publication No. (SSA) 76-11910 (Washington, 1976), pp. 26-27.

[20]*National Health Insurance Costs and Benefits for Maryland's Elderly Citizens*, p. 2.

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[22]Institute of Medicine, p. 12.

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[25]*Organizing for Health Care: A Tool for Change*; (1974 United States Beacon Press under auspices of Unitarian Universalist Assn.).

[26]Brody, Elaine M., *Long Term Care of Older People* (New York: Human Services Press, 1977), p. 299.

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THE FINANCING OF LONG TERM CARE

Two arguments, one for full Federal funding and one for a continuance of state - Federal funding of long term care, are made in this chapter. Both arguments have one important area of agreement; they both set forth cost containment as a primary objective of any funding scheme. Furthermore, both suggest that this can best be achieved through some form of prospective reimbursement. Under the present system of retrospective reimbursement Medicaid pays, without limit, for all eligible services provided. This, many believe, encourages the provision of unnecessary services which results in an unnatural escalation of costs. Prospective reimbursement simply means forecasting service needs for some future period (usually one year) and then determining how much will be paid for those services. This would establish a limit or "cap" on Medicaid expenditures which would presumably have the effect of containing run-away costs.

The fundamental difference between the two approaches is related to whether the funding and responsibility for long term care is best handled in a state-Federal partnership or solely at the Federal level. In this regard the burden of proof is on the full federally funded argument simply because it suggests a significant departure from the present arrangement. The argument for continuance of the state-Federal partnership is not, however, made without considerable difficulty due to the many existing criticisms of the status quo.

THE CASE FOR FULL FEDERAL FUNDING OF LONG TERM CARE

The case for full Federal funding of long term care is based on three interdependent conditions. First, it has become increasingly obvious that health care, of which long term care is a part, has become a national responsibility and should therefore be financed at the Federal level. Second, state and local government can no longer afford the rapidly increasing fiscal burden that results from financing long term care. Finally, the federal income tax is the most appropriate revenue source from which to fund long term care by virtue of the fact that it is our most progressive tax.

Federal Precedent

In this century the Federal government's role in public health has gradually evolved towards greater responsibility and increased involvement. In the early part of the twentieth century, for instance, the Federal government enacted the Chaberlain-Kahn Act of 1918 (to combat Venereal Disease) and the Sherphard-Towner Act of 1928 (for maternal and child health). These made public health grants available for the first time.[1] The next step, the Social Security Act of 1935, given impetus by the depression, placed Federal-State financing of public health on an enlarged and regular basis. Next in the chronology was the Federal government's participation in capital expenditures in the health field, or, as it was known legislatively, the Hill-Burton Act of 1946. In the first twenty-five years of its existence, the Hill-Burton Act provided for the construction or modernization of 457,000 hospital and LTC beds, and 1,500 outpatient and rehabilitation facilities at the cost of $12 billion. In 1960, the Kerr-Mills Act was passed which specifically provided for Medical Assistance to the Aged. (MAA).

The Federal government's policy of gradualism up to the mid-1960's seemed to advocate a commitment towards a Federal-State partnership in public health financing. However, in 1965 Congress added two new titles to the Social Security Act, (title XVII and title XIX), which illustrated Federal acceptance of a policy of substantially increased responsibility and involvement in public health, especially LTC. Title XVII, or Medicare, established a compulsory Federal insurance program for persons age 65 years and older. Title XIX, or Medicaid, established a single program to substitute for the four categorical programs previously under MAA. In 1966 with the enactment of the Partnership for Health Act, the Federal government continued with the policy of increased involvement by engaging in sorely needed health planning. These measures, along with the Social Security Amendments of 1972 and the National Health Planning and Safety Act of 1974, exemplify the Federal government's role in the health care arena.

It is evident that the Federal government realized responsibility and took action in varied areas. It attempted to remedy special health problems of the nation, aid state and local governments that couldn't afford the cost of health assistance to their residents, subsidize capital expenditures in the health field, regulate the health field, engage in short and long term planning, and, most relevant to this analysis, provide long term care for the aged. It is the contention of this analysis that full Federal financing of LTC would be a natural and logical progression in Federal public health policy.

State and Local Precedent

The argument for full Federal financing of LTC can also be advanced from the perspective of state and local governments. The financial burden on state and especially local governments from public assistance expenditures

has become increasingly unbearable. Likewise, taxpayer discontent has resulted from rising state and local taxes levied to meet public assistance expenditures (see Revenues section for complete discussion on taxation). The Advisory Commission on Intergovernmental Relations (ACIR), a Washington based study group engaged in major policy studies, illustrates this point by noting that state and local expenditures for public assistance doubled several times from 1950 to 1974.[3] In 1980 it is estimated that state and local Medicaid outlays for LTC will be $4.6 billion[4] excluding administrative costs which in 1977 were estimated to be about $788 million.[5] With these spiraling costs in mind, another ACIR study recommended "that the Federal government assume full financial responsibility for the provision of public assistance, including general assistance and Medicaid."[6]

Full Federal takeover of LTC is aimed at resolving disparities in the Medicaid program's handling of LTC, resulting from differences in resource capacity from state to state. The resource capacity of a state, simply the amount of money a state wishes to spend through Medicaid on LTC, can vary according to the State's eligibility requirements, LTC services covered by the State, and the State's reimbursement policies, all of which are discretionary beyond Federal guidelines.[7] The Federal takeover proposal is also designed to relieve the inequities of fragmentation and the inefficiency of multiplicity within Medicaid program categories relative to LTC. The potential for streamlining the present conflicting and overlapping regulatory deluge would be inherent in the Federal approach to financing LTC. The Federal takeover proposal suggests a single regulatory body to monitor LTC facilities and services as opposed to the present Federal, state, and local regulatory agencies monitoring LTC.

Having established precedent in the field, this analysis shall now suggest direction for the next step in the Federal government's policy of gradualism relative to LTC for the aged. The suggestions brought forth in this analysis will only address the financial aspects and implications of long term care. The Federal government will be considered the subsidizer, the referral mechanism, and the provider of LTC in the setting of complete Federal takeover of LTC.

Reimbursement

In fiscal year 1976, government programs paid an estimated $10.5 billion for LTC services; of this $5 billion was paid for by the Federal government and $5.5 billion by state and local governments. Over half of all LTC expenditures ($5.7 billion) were paid through the Federal/State Medicaid programs.[8] In 1979 it is estimated that $8.3 to $8.4 billion in Medicaid money will be spent on LTC services, and by 1985 an estimated $20.5 to $21.6 billion in Medicaid money will be spent on LTC services.[9] To conlcude that there is an uncontrolled upward spiral would not be an overstatement. Under existing guidelines and retrospective reimbursement practices Medicaid expenditures for LTC will increase by about 300% from 1976 to 1985.

Medicaid's open-ended categorical grants to state and local governments have been accused of spiraling costs upward through retrospective reimbursement practices. Under retrospective reimbursement a facility first delivers care to a patient who is presumed Medicaid eligible, and then bills Medicaid afterwards. As early as 1966, H.R. Sommers warned about Medicaid's uncontolled costs due to retrospective reimbursement practives.[10] The Health Care Financing Administration (HCFA) of the Department of Health Education and Welfare (HEW) is also skeptical of present reimbursement practices, as is illustrated by their funding of prospective reimbursement demonstrations under section 222 of the HCFA. In 1977, Robert Derzon, the administrator of the HCFA, said, "We (HCFA)

would like to initiate reforms in reimbursement and redirect incentives away from high cost technological care."[11]

In the full Federal takeover proposal for financing LTC a prospective reimbursement system would replace the retrospective system that currently exists. The reason for the departure from the current system is that it provides little incentive for LTC facilities to operate efficiently or with any sense of "cost conscientiousness". In prospective reimbursement systems the level of the receipts is fixed which will encourage LTC facilities to operate in an economically efficient manner.[12] Thus, prospective reimbursement has the potential to reward efficient LTC facilities and penalize inefficient LTC facilities.

As of 1976, there were some twenty-six prospective reimbursement programs operating throughout the country[13] and because they differed, there is a need for clairification as to what is meant by prospective reimbursement for the purposes of this analysis. In this analysis prospective reimbursement refers to predetermined regional budgets for the delivery of a well-defined array of LTC services for a fixed period of time. Current Health System Agency (HSA) regions would constitute the regional levels at which LTC budgets would be set. (Health Systems Agencies [HSA] are planning and development bodies created by the National Health Planning and Resources Development Act of 1974 [Public Law 93-641]). The United States has been divided into 213 "health services areas", each of which is served by an HSA. Budget allocations would be based upon planning activities of the region's HSA and would take into consideration such factors as the region's LTC resources, the region's current LTC needs, and the region's projected LTC needs. A region's budget would provide for the total LTC needs of the entire service area on a capitation basis. A region's budget allocation would reflect the region's financial responsibility to provide for only those services that meet the region's LTC demands as determined by the respective HSA. Facilities or services that are not needed in a region

would not be considered in the figuring of the region's budget allocation. Once a fixed dollar amount is arrived at and is received by the HSA, (a process which will be discussed below), yearly operating budgets will be apportioned to the LTC providers in the region. The LTC providers would be paid prospectively by the HSA at 1/52 of the providers approved annual budget each week.

With information supplied by the HSA's throughout the United States, a mandatory standard rate (MSR) of reimbursement would be set for each level of LTC offered. Rate adjustments could be made for capital expenditures, but only if the capital expenditure was approved previously by the certificate of needs program of the respective HSA. Another important aspect of this proposed reimbursement system would be that the MSR's would be tied to the Consumer Price Index so that LTC costs would not be allowed to rise faster than other prices in the economy.

Implementation

It would be necessary to amend certain administration procedures to implement this prospective reimbursement system for a full Federal takeover of LTC. First, LTC reimbursement would have to be severed from titles XVIII and XIX of the Social Security Act and be provided for as a complete entity in itself in an effort to improve the monitoring and evaluating of both the LTC program and the remaining Medicaid and Medicare programs. Medicaid and Medicare data would no longer be skewed by the inclusion of massive LTC expenditures. Likewise, LTC data would emerge in a "cleaner" form, free from the statistics of the remaining health field, arming policy makers with better information as a basis for their decisions relative to LTC. In the present system, this type of LTC information flow is impeded by fragmented jurisdictions and conflicting eligibility requirements and level of care categories.

Another administrative change, the establishment of uniform eligibility requirements and levels of care categories, would be the next step in implementing the full Federal financing of LTC proposal. Although it is commonly held that increased eligibility results in higher costs, there is evidence to show that these higher costs due to increased eligibility are only temporary and will slack off in time. In a study by Barbara Boland on the AFDC program it was noted that even under a continuation of the present Medicaid program, increases in the number of eligibles would be a much less important factor because current caseloads are stabilizing.[14] Granting further support to this concept, John Holahan, in his book Financing Health Care for the Poor, suggests that "A program with broad population covereage would avoid the problem of continually rising costs because, while large increases in eligibility and utilization would occur following the initial expansion of coverage, they would not occur over time."[15] While acknowledging that increased eligibility could increase inflationary pressure, Mr. Holahan estimates that prospective reimbursement would do much to mitigate these inflationary price effects.

The next step towards full Federal financing of LTC would be to designate current HSA regions as LTC reimbursement areas. As mentioned above the HSA would be the rate-setting body that would determine the regional capitation budgets for LTC services. The purpose behind using the HSA as the rate-setting body is an effort to tie the planning function (already inherent in HSAs) to the rate-setting function. In 1977 the Institutional Reimbursement Conference Report held that the coordination of the rate-setting function and the planning function should be an essential consideration to any prospective reimbursement system.[16] To do this successfully would mean that the LTC services that are rendered are those that have been deemed necessary by extensive HSA studies on utilization review, needs assessment, accessibility, and resource availability. For too long, LTC utilization rose to the available supply of LTC services, a concept

which has received some support in recent economic studies.[17]

The use of HSAs is meant to foster the concept of regionalization. The aim of this regionalized system is to make substantial gains in access, efficiency, and equity through emphasis on the planning function of the HSA. Increasing access, a desired result of regionalization, might initially raise costs, but, once stabilized, costs would level off over time and the system would prove more cost efficient in the long run. Eli Ginzberg, Director of the Conservation of Human Resources Department at Columbia University, supports the concept of Federal regionalization. He states:

> Many State and Local governments simply cannot cope with the range of complex issues involved in the regionalization of health resources and delivery systems. The widespread weakness of these non-Federal structures is a clue as to how fast and how far the Federal government can encourage regionalization.[18]

In summarizing the attributes of regionalization, a 1952 Presidential Commission's finding are informative. It defined the range of desirable goals of developing regionalization to be (1) increased patient knowledge and convenience, (2) greater access to health care services, (3) higher quality care, and (4) improved efficiency at less cost for health care services.[19]

Revenues

Under the present Federal/State Medicaid program, matching funds constitute the revenue source. The Federal share of a state's Medicaid program is between 50% and 80%, depending upon the per capita income of the state's population. The Federal government pays the remainder of the Medicaid bill after the state pays its share, within the 50% to 80% guidelines.

State and local governments have become increasingly aware of the growing burden of LTC costs, for the state and local shares of the Medicaid program are derived from property taxes and sales taxes. In 1972, ACIR reported that from 1951 to 1971 there were 480 tax rate increases and 40 new taxes enacted into

law by state legislatures to meet the increasing burden of general and public assistance costs.[20] This entire concept, the use of state and local revenues to provide for costly income-redistributing purposes such as Medicaid, has been deemed "particularly questionable and economically inefficient" by ACIR.[21]

Tax efficiency and tax equity are two qualities against which taxes can be evaluated. Tax efficiency measures the way a given tax affects the allocation of resources, taxpayer compliance, and collection costs. Tax equity is concerned with the tax treatment of economically unequal persons, and their ability to pay.[22] Sales tax is usually ranked higher in the efficiency category because it is a broad based tax and has no effect on relative commodity prices; however, sales tax is viewed as a tax on consumption and has a regressive effect on the distribution of income. This phenomenon renders sales tax inequitable by putting a heavier tax burden on lower income people. Property tax ranks low in both efficiency and equity. This is due to the fact that property tax is disproportionally costly to administer and tends to distort the pattern of land use. Plugging the progressive income tax into the framework of tax equity and tax efficiency yields positive results. The progressive income tax is clearly justified on the ability to pay principle and has little effect on the operation of the economy; therefore, it is ranked high in both tax equity and tax efficiency.[23]

Another way taxes can be evaluated is by determining their elasticity coefficient. The elasticity coefficient of a given tax illustrates the responsiveness of the tax to economic growth relative to its base. Therefore, elasticity measures the way in which the tax behaves in comparison with changes in national income. An elasticity coefficient of less than 1 indicates that the change in tax yields was proportionately less than the change in national income. An elasticity coefficient equal to 1 means that tax yields changed proportionately to the change in national income. The elasticity coefficient is greater than

1 when the tax yield changes were greater proportionally, than the change in national income.[24]

In 1965 ACIR published a summary report of the estimated elasticity coefficients of various taxes.[25] The summary showed that the median elasticity coefficients for both property tax and sales tax were less than 1, reflecting that they are inelastic. Conversely, the median elasticity coefficient for the income tax (greater than 1), demonstrating that the tax yield changes were greater, proportionally, than the change in national income.

The evidence of both tax efficiency/tax equity framework for evaluating tax systems and the elasticity coefficient support the premise that LTC revenue would be more equitably derived from a progressive income tax than from state and local property and sales taxes.

Under full Federal financing of LTC, revenues would be derived from the Federal government whose primary revenue source is a progressive tax, income tax. Although this might increase the amount of individual income tax paid across the country, a severe financial burden would be lifted from state and local governments. ACIR concludes that if the Federal government were to take over the entire cost of Medicaid, about two-thirds of the benefit would go to the states and and one-third would go to local governments.[26] Even though this proposal is not aimed at a Federal takeover of the entire Medicaid program, surely substantial savings could be realized by both state and local governments in a full Federal takeover of LTC.

Opponents of the full Federal financing of LTC point out that state and local tax decreases are not necessarily synonymous with this proposal. Opponents contend that state and local taxes will not decrease even though state and local outlays for Medicaid will. However, the intended tax relief properties of this proposal are not designed to force tax relief, but only to make the potential for tax relief available at the state and local levels. Potentially,

under the proposal for full Federal financing of LTC, state and local governments could decrease sales tax and property tax and spur economic growth as well as ease taxpayer discontent. It is beyond the consideration of this analysis to propose any mechanism to interfere with the taxation powers of state and local governments. The impetus for tax relief will have to come from the constituencies of states and localities as did California's Proposition 13, a grassroots initiated voter referendum which mandated tax cuts.

Profit Motive

If the profit motive was ever a positive force in the development of the LTC industry, it is no longer. Many people today charge that the profit motive is inconsistent with good LTC and the values of American society. There also seems to be a strong belief in this country that those market mechanisms that some say are missing and are the cause of the high costs in the LTC sector should not be encouraged in the LTC sector because of the nature of the services offered and powerlessness of the recipients. In his discussion of general assumptions in public choice analysis Robert Bish states that "Goods and services desired by individuals possess diverse characteristics, including characteristics which make them difficult or impossible to provide through market or purely voluntary activity."[27]

Certainly LTC is one area in which normal market activity has been less than successful and has caused the eruption of myriad problems such as institutional scandals, patient abuse, and profiteering LTC operators.

Allegations that the profit motive is injurious to good LTC do not go unsubstantiated. In 1971 the Connecticut Department of Finance and Control, Budget Division, released a study that showed that the LTC industry had a rate on investments double that of the top 500 U.S. corporations.[28] In 1976 the Report of the New York State Moreland Commission on Nursing Homes and Residential

Facilities released findings that strongly associated poor LTC and high profit margins.[29] In March 1977 the Executive Council of the AFL-CIO issued a statement recommending that Federal funds be limited to non-profit LTC facilities because of the windfall profits and poor care in for-profit facilities.[30]

Political Feasibility

Full Federal financing of long term care would have a strong political impact and there are political factors which must be considered. First, there is the creation and elimination of jobs brought about by the implementation of the full Federal financing of LTC proposal; second, the issue of special interest group pressure and its impact on the Federal level vs. the state/local level; and last, the loss of control over the LTC field by state and local governments.

The political feasibility of this proposal is predicated, in part, upon its impact on the job market. It is almost certain that this proposal for financing LTC will eliminate certain state and local government positions that deal with the regulation, administration, and reimbursement of LTC. Conversely, there would be a need for manpower to staff the newly formed Federal program. To circumvent almost certain union and local political actions, the Federal government could give state and local government employees who were left jobless because of the implementation of this proposal top priority in hiring for the Federal positions. Another approach to this problem would be to make available Federal subsidies to state and local governments to keep these employees on until they can be placed in the respective state or local government office.

Special interest group pressure is also an issue related to the political feasibility of the full Federal financing of LTC. State and local decision-making on issues relative to LTC is plagued with intervention from self-serving special interest groups. A 1976 New York State Moreland Act Commission on

Nursing Homes and Residential Facilities substantiated this special interest group pressure in reporting that "Private nursing home interests were able to obtain and employ political influence to achieve their ends on an impressive scale."[31] The finds of the Moreland Commission typify the extent of special interest pressure that is exerted at the state and local level. Under the proposed LTC program, special interest pressure at the state and local level would be useless because policy decisions would be made at the Federal level where special interests from a state or locality yield considerably less leverage.

The loss of state and local control, and issue which is often brought up in national health insurance discussions, would have minimal impact on this proposal. Full Federal financing of LTC would control only that part of the health field that provides LTC. The remaining Medicaid program would still be subject to local control. Since relatively little control over health care would be relinquished by state or local governments, and substantial savings could be realized by state and local governments, this factor should not detract from the political feasibility of the proposal.

Conclusion

The future of LTC is far from resolved. As the elderly population increases and resources remain finite or even decrease, difficult decisions will have to be made. Unless American society de-emphasizes institutionalized care, or positive changes in life-style prolong life and influence the quality of life, restrictive action in the health field will have to be taken. Either more of the gross national product will have to be spent on health care, (meaning less spent elsewhere), or health services and/or eligibility requirements will have to be restricted. The harsh realities of any health policy were summed up best by British politician, J. Enoch Powell, who ran his country's National

Health Service in the early 1960's. Mr. Powell noted that "Whatever the expenditures on health care, demand is likely to rise to meet and exceed it. To believe that one can satisfy the demand for health care if illusory."[32]

This is not to imply that there is no chance of an efficient and responsive LTC plan. But LTC must be controlled if future demands are to be met rationally and equitably. The above-mentioned proposal for financing LTC has the systemic ability to control and monitor the LTC field on a nation-wide basis, which is sorely needed at this point in time if future demands are to be adequately met by the system.

THE CASE FOR CONTINUED STATE FUNDING OF LONG TERM CARE

The case for continued state funding is based upon the concept of states bearing at least part of the fiscal burden for services over which they maintain some control. If some state control over the quantity and quality of long term care is desirable, then so is state funding because it enhances the likelihood that states act responsibly. In this section we will briefly examine the present relationship between the states and the Federal government and between the states and service providers (i.e., nursing homes). The problems associated with these relationships will be explored and then recommendations designed to decrease the effect of these problems but still maintain the basic fiscal framework of Medicaid reimbursement for long term care will be proposed.

According to Title XIX of the Social Security Act which became effective January 1, 1966, the Medicaid program was established;

> For the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disable individuals, whose income and resources are insufficient to meet the cost of necessary medical

services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care (SEC 1901).

The population eligible under the Medicaid program consists of two categories: persons whose eligibility is mandatory, and persons whose coverage is optional. Mandatory eligibility, generally referred to as the categorically needy, is comprised of all individuals who receive aid or assistance under Title I, X, XIV, or part of Title IV and those receiving supplmental security income under Title XVI of the Social Security Act. Persons whose coverage is optional, generally referred to as medically needy, are individuals who fit into one of the categories of people covered by cash welfare programs, individuals who have enough income to pay for their basic living expenses (and so are not recipients of welfare) but not enough to pay for their medical care.[33]

Medicaid services are divided into two categories: mandatory services and optional services. There are seven mandatory services: inpatient hospital care; outpatient hospital services; other laboratory x-ray services; skilled nursing facility services and home health services for individuals 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; and physicians services. The law provides for 17 optional medical services including clinic services, prescribed drugs, dental services, prosthetic devices, eyeglasses, private duty nursing, physical therapy, services of optometrists, podiatrists, and chiropractors, skilled nursing facility services for patients under 21, emergency hospital services, care for patients over 65 and institutions for mental disorders and for tuberculosis, care for patients under 21 in psychiatric hospitals, institutional services in intermediate care facilities and other diagnostic, screening, preventative and rehabilitative services.

States have the option to provide non-mandatory services to both categorically and medically needy persons. Illinois, New York, Minnesota, Washington,

and Wisconsin are the only states which provide all 17 of the optional services under their Medicaid programs.

State expenditures eligible for Federal reimbursement are determined by state plans submitted to HEW for approval. The amount of the Federal share is determined by a formula which provides a matching percentage equal to the difference between 100 percent and 45 percent of the ratio of the squared per capita income of a given state to the squared per capita income of the United States. No state, however, may have a Federal Medical Assistance percentage of less than 50 percent and more than 83 percent. In addition, seven relatively small expenditure categories pertaining to administration are subject to fixed percentage Federal Payments. Per capita personal income incorporated into various grant need formuals is an attempt to redistribute funds from higher to lower recipient areas.

Perceived Problems in the Federal Medicaid Structure

Martha Derthick, the author of Uncontrollable Spending for Social Services Grants, points to significant problems related to the open-ended categorical grant model. Derthick states:

> Spending for social services grants soared from $354 million in 1969 to 1.69 billion in 1972. The President's budget estimate of $937 million for social service grants in 1972 was too low by nearly $1 billion. Social services were "uncontrollable" primarily because they were open-ended. This was changed in the form of legislation in 1974 when Title XX was created and a ceiling of $2.5 billion on federal spending was set.[34]

The same dramatic increase in expenditures is currently evident in the Medicaid program. As was noted earlier, Medicaid expenditures are estimated to increase 66 percent from FY 1975 to FY 1978.

The Current Reimbursement Structure for Long-Term Care: State Level

At the present, the individual states have the responsibility of managing the Medicaid program. States reimburse monies to providers, set standards of care, assure that facilities meet standards, audit, license, certify service providers, and tax their constituents to meet the Federal match. The primary area of emphasis in this section shall be the means by which states reimburse long-term care providers. The states of Ohio, Connecticut, and New York have been pursuing new alternatives in this area and for this reason, have been selected as the primary states to be critiqued.

In Ohio, nursing homes are reimbursed on what the state terms as a prospective basis. A per diem rate to be paid in the future is calculated for each home based on past cost. Costs reported for the six months ending December 31, 1975, were used to set rates for calendar year 1977. The nursing home's rate is then multiplied by the number of patient days at the home each month to determine the monthly reimbursement. In cases of misrepresentation of cost and/or services rendered or concealment of data which would indicate a lower rate than a home is receiving, the rate is not adjusted retroactively. The average per diem rate for Ohio nursing homes was $19.32 in June 1977.

In June 1977, 77 homes were participating in the Medicaid program and were paid about $1.1 million. Ohio requires that cost reports be filled out within 90 days after the end of the reporting period. Failure to file a timely cost report results in a nursing home being paid at their current standing rate. The rate is revised when the nursing home submits its cost report. If the report indicates the home was over-paid during the period for which it failed to file, Ohio reduces future payments until the overpayment is recouped. If the home can justify an increased rate, the increase is delayed by the number of months the required reports are late.

Since 1974, Ohio has calculated the reimbursement rate by comparing nursing home reported costs to establish line-item-cost ceilings and overall cost ceilings. Ohio used the lower of the reported costs or line-item-cost ceilings. Ohio compares the resulting costs per patient day to the overall cost ceiling and reduces to this ceiling if necessary.[36]

In Connecticut, the Department of Social Services (DSS) administers the Medicaid program together with other state welfare programs. Long-term care accounted for 53 percent of Connecticut Medicaid expenditures in FY 1976. Initially, Connecticut used a point system for reimbursement whereby a home could qualify for a higher classification and a higher reimbursement level by providing services beyond health code standards. This strategy resulted in general upgrading of institutions, but not necessarily care. A report developed by the Legislative Program Review and Investigations Committee entitled, Containing Medicaid Costs in Connecticut, states:

> There was no reational relationship between points for classification and costs. Homes had an incentive to provide "services"--sometimes unrelated to patient needs--and many of them did.[37]

In 1975, a temporary system was developed using interim rates to reimburse providers while the point ssystem was phased out and institution of a new cost-related system could be implemented. These rates were based on 1974 costs, plus 5 percent for inflation. The new cost-related system was slated to go into effect January 1, 1978.

The cost-related reimbursement system is based on a breakdown of costs and assets at each home as follows:

A. Controlled cost centers

1. Dietary
2. Nursing
3. Laundry
4. Housekeeping

B. Uncontrolled costs

1. Management services (reviewed for reasonableness)
2. Utilities
3. Accounting fees
4. Other

C. Asset Valuation

1. Building
2. Land
3. Appurtenances

Under the controlled cost centers category, dietary, laundry, housekeeping, and nursing expenditures will be contained. Nursing homes, profit and non-profit together, will be grouped by size and class, and rank ordered by cost in each of the controlled cost centers. Costs, up to the 80th percentile, for each size and class in each cost center will be fully reimbursed. The most expensive homes (top 20 percent) will be reimbursed at the rate of homes at the 80th percentile. The maximum annual cost increase which is reimbursable in any cost center, will be the previous years cost multiplied by the current gross national product (GNP) deflator.

The uncontrolled cost category, unlike nursing or dietary services, cannot be grouped across homes. The cost would include: utilities, employee benefits, self-employment taxes, and maintenance costs. These costs will be examined for their "reasonableness" and verified by field audit.

The asset valuation category bases the asset valuation in its proposed reimbursement system on the "Fair Rental Value System." Under this sytem, all homes are depreciated on a straight line basis with an average life of 40 years.

All long-term care facilities seeking Medicaid reimbursement will be required to submit to the Committee on state payments an annual report by December 31st of each year. Based on the detailed annual report, desk auditors will determine an interim rate for each facility. After independent field auditors verify the information provided, the interim rate, with adjustments if indicated, will become the actual rate for that year.

The Moreland Commission Report which reviewed the long-term care industry in New York State explains in detail the New York State rate setting system. The system developed by the state has been viewed by many observers as one of the several models that other states might follow in developing a "cost-related" approach to Medicaid reimbursement. In New York State, nursing home operators are required to submit to the state a detailed statement of operating costs for the preceeding year certified by public accountants. Following this the statements are desk audited by the Division of Health Economics. Total allowable costs are divided either by the actual number of patient or resident days of care rendered in the year for which costs have been reported or by that number of patient days which would have been rendered had the facility experienced an average occupany rate of 90 percent. Whichever number is greater is employed. Nursing homes are then grouped by the division in accordance with bed size, location within the state, and sponsorship. There exist five bed size ranges, seven regional divisions, and three sponsorship classifications (proprietary, voluntary, and government). For each such group, weighted average per diem amounts of two kinds are calculated. The first is an average combined per diem cost of administrative, dietary, and housekeeping services. The second is the overall average per diem cost, excluding property costs, cost of therapy drugs, and return-on-equity. Per diem costs 15 percent above such group averages also would be disallowed. A "role factor" is applied to per diem costs. The "role factor" consists of the set of projections of inflation and the prices of various components of facility costs, i.e., wage rates, food prices, fuel, drugs, etc. When applied to base year per diem costs, the role factor fixes a "prospective" rate which would provide reimbursement to a facility sufficient to maintain its base year pattern of expenditures, despite changes in prices anticipated from the base year to the rate year. Should actual costs in the rate year be below those anticipated by the prospective rate, through the achieve-

ment of efficiencies of one form or another, a facility would earn a profit from operations.[38]

Perceived Problems in the State Reimbursement of Long-Term Care

A problem commonly perceived by states is providing nursing homes with incentives related to cost containment. In Connecticut, under their new reimbursement system, efficient management will be rewarded by allowing a facility to keep 10 percent of the difference between its actual costs and ceilings set for each cost center, when the difference is $1,000 or more. In New York State, a fixed percentage of the difference between a home's actual costs and reimbursement ceilings are used as an incentive.

A second problem, one focused on by the Moreland Commission concerns Medicaid reimbursement of nursing home property costs. The report states:

> There has existed every temptation for owners to misrepresent costs of constructions or interest charges on morgage loans and to misstate a variety of other real property costs in order to obtain higher reimbursement....Clear incentives have existed for establishing "fictitious" costs based upon transactions among unrelated parties.

In response to the Moreland Commission Report, New York State has adopted the "Fair Rental System." The Fair Rental System does not permit reimbursement to vary, depending on whether a facility is leased or operated directly by an owner and does not change because of sales from one entrepreneur to another. This system mandates that all homes are depreciated based on an average life of 40 years. It is anticipated that the system shall end the practice of rapid turnover, inflated prices and lease-back arrangements. Thus, we have a valid example of a state able to rectify its errors and incorporate into its system a cost containing instrument which is responsive to its own needs.

States have also become increasingly aware of the negative impact of inappropriate placement of indivudals in LTC and differing level of care within the

industry. The Comptroller General's report on the Ohio Medicaid program concludes that:

> Ohio is wasting millions of dollars annually because the SNF benefit is not being effectively used as an alternative for high cost hospitalization.[39]

The report goes on to predict that the cost of care for 10,000 intermediate care patients incorrectly classified as SNF (skilled nursing facility) patients could create an overpayment of $73 million per year if skilled and intermediate care facility rates are $45 and $25 per day respectively.

The problem of appropriate placement in relation to cost containment is discusssed in the report prepared by the Connecticut Legislative Review and Investigations Committee studying containing Medicaid costs. It states:

> While the number of Medicaid recipients has only doubled from about 90,000 in 1967 to about 180,000 in 1976, Medicaid expenditures were six times higher in 1976 (188 million) than in 1967 (32 million). A major cause of Medicaid cost increases in Connecticut is the imbalance in levels of care provided by the nursing home industry. Connecticut spends nearly half of its Medicaid budget on expensive skilled nursing care, while other states average only 20 percent. Conversely, other states average about 16 percent of Medicaid budgets for lower cost intermediate care, while Connecticut spends only 4 percent.[40]

The Moreland Commission Report in New York State also suggests that significant inappropriate placement is impacting on cost containment activities since little, if any, variation in cost "can be explained by the assumption that higher cost homes are treating patients in need of more intensive care."[41] The report goes on to state:

> Undermining many regulatory efforts is the near total lack of monitoring or control over decisions affecting the placement of individuals in homes. State regulatory agencies have failed to define explicit rules and to implement effective procedures to determine which patients or residents might require the most expensive "skilled nursing" level of care, which might require "health related" care, and which can be successfully cared for in domicillary facilities.[42]

Recommended Structural Changes in the Current Long-Term Care Reimbursement System

Thus far, this paper has explained existing structures related to long-term care reimbursement and illustrated perceived problems within the structures. The paper will now focus on recommendations applicable to long-term care funding.

It is recommended that the Federal and state roles in the financing of long-term care remain essentially as they are. That is, the Federal government should continue to provide matching moneys and states should continue to manage the long-term care industry. Further, states should continue to bear a fiscal tax burden for the provision of service to their constituents in their respective localities.

Recommendation #1

That the current "Medicaid" categorical grant-in-aid Federal program be altered to establish a separate Federal categorical grant-in-aid program exclusively for long-term care funding. It is further recommended that the categorical grant would have considerable impact on containing the rapid expansion of Medicaid costs. By splitting the current Medicaid categorical grant approximately in half, it may be possible to place ceilings on both the medical assistance and long-term care Federal allocations. Further, such a step should promulgate a similar separation of long-term care administration on the state level. This would service to heighten the amount of attention paid to the unique problems related to long-term care services. Utilizing the close-ended approach would promote sounder fiscal planning on the Federal and state level. The ceiling or "CAP" would force states to develop prospective expnediture estimates in order to assure federal reimbursement under the "CAP".

Recommendation #2

That the current formula used to determine the state-federal match be altered. Application of the CAP concept currently used in the provision of Federal entitlement grants may have significant merit over the current use of the per capita

income formula element. The CAP concept is primarily related to the states capacity to financially support efforts in relationship to its need for service weighted against other states. Further, adjustments for differences in costs of medical care from one state to another could be included in the formula. Examples of how these formula features may impact on individual states has been prepared by the Center for Governmental Research, working paper #3: The Medicaid Formula. The paper primarily addresses distributional and equalization effects of the Medicaid formula and Medicaid formula alternatives. These findings should be carefully considered on the Federal level as a means by which distributional objectives can be more equitably met.

Recommendation #3

That states create a separate office of Long-Term Care Administration. This state office should have the legislative power to license and certify facilities, enforce regulations, set rate structures, and determine long-term care needs. The office should develop a yearly prospective state plan which estimates total state expenditures for provision of long-term care. The state plan would be submitted to HEW where the long-term care categorical grant-in-aid formula would set the Federal match share of the requested state plan. The office should also have the power to rule on the appropriateness of any new facility or expansion of long-term care facilities as it relates to the prospective state plan developed.

Recommendation #4

That the state office of Long-Term Care Administration decentralize management functions by the creation of Regional Management Offices. The regional offices would be held accountable for region-wide coordination of long-term care planning, rate setting, auditing, and coordination with the central state office of regulatory oversight. Each region would be responsible for preparing a prospective yearly regional expenditure plan and need estimate. The regional office would be expected to coordinate its efforts with regional and local planners

to best determine where gaps in service occur. The regional management office need not be a purely state function. The state central office could contract with a regional not-for-profit management association comprised of providers, state and local officials, and citizens of the region. This independent association comprised of providers, state and local officials, and citizens of the region. This independent association would hire appropriate staff to carry out the mandated functions of the state office. Such a scheme might be more politically feasible in areas where a high degree of leadership has produced superior long-term care services. This approach may work well in regions that are less densely populated. In rural regions Incorporated Provider Councils could exercise the regional management responsibility. The state central office would provide the regulatory enforcement and possibly the audit function. Only providers with superior facilities and proven administrative expertise should be selected. Being recognized as the "experts" in their region should enhance the acceptance of a closer state monitoring role. In congested urban areas it is recommended that the state central office provide a direct management function.

This continuum of options available to the state office of Long-Term Care Administration should produce an effective means by which the characteristics of individual regions within the state are recognized. It will also provide the state with significant flexibility in achieving its long-term care goals within the context of the regional perspective.

Recommendation #5

It is recommended that states adopt a prospective rate setting capability. Specifically, a scheme should be devised for dividing total per diem operating costs into cost categories, such as the Connecticut breakdown of controlled cost centers, uncontrolled costs, and asset valuation. Variation among homes in per diem costs for each of the categories selected should be explained by use of multiple regression technqiues, such as the Moreland Commission applied in its

study of 1970 nursing home costs. From this analysis, statistically typical costs can be determined. Adjustments could then be made relative to size, class, wage rates, and patient mix. This implies a "group average" outcome. The Moreland Commission report suggests: "Efficient care standards would be defined by determining the percentage that actual costs of standard setting homes are of the calculated statistically typical costs for these homes." Thus, a standard setting home in dietary service may have actual costs which are 95 percent of its regression estimated (that is a statistically typical) dietary cost. Efficient care standards for each home would be caluclated by applying this percentage figure to each home's regression estimated cost. The goal of this approach is to set standards by which nursing homes will be reimbursed. It is further recommended that rates set using this scheme be set on a regional basis and be used as the basic determinant of the Regional Fiscal Plan submitted to the state office for inclusion in the total state plan. In setting rates, states should apply the extent to which individual providers are meeting acceptable care standards. States should not reward providers for achieving superior ratings in care standard review audits. This will only proulgate the increased development of "lavish facilities." The goal should be to equalize the quality of care provided in all state facilities.

Incentives should be given to proprietors who have demonstrated cost effectiveness and achieved acceptable ratings relative to care provision. It is recommended that states permit facilities to retain as profit a percent of unspent moneys for each cost category.

Recommendation #6

It is recommended that states adopt a property reimbursement cost system similar to the New York State "Fair Rental System." As was stated earlier, this system does not permit reimbursement to vary depending on whether a facility is leased or operated directly by an owner and does not change because of sales

from one entrepreneur to another. All homes are depreciated based on an average life of 40 years. This bold approach to eliminating nursing home abuses should be viewed with interest by every state. One criticism of the "Fair Rental System" is that it may hamper proprietors with sound track records in receiving a fair return on their investment. It is recommended that this feature be changed either through the use of a review process or point system which would award proprietors who have deomonstrated "good faith" in the provision of service some measure of flexibility in receiving current asset valuations for the sale of properties.

CONCLUSION

The intent of this exercise has been to describe the current structure of finance applied to the long-term care industry. An effort was made to analyze various problems occurring within the structures and recommend corrective procedures. The recommendations provided do not alter the essential responsibilities currently existing within the Federal and state governmental structures. Rather, they suggest steps which will strengthen the system which currently exists.

The rapid growth and development of the long-term care industry coupled with the "skyrocketing" costs of the Medicaid program mandate a thorough re-examination on the Federal and state level of each governmental unit's commitment to long-term care. This can be best accomplished through a "partnership" effort between the Federal government and various states.

FOOTNOTES

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FEDERALIZING THE ADMINISTRATION OF MEDICAID

This chapter presents an argument for the federal domination of Medicaid Administration. Unlike the other chapters, this one includes no counterpoint, no position paper exploring state control of Medicaid Administration due to one participant's inability to sufficiently research the area. While we consider the omission a serious one, there are a few mitigating circumstances. First, the state control perspective is essentially an argument for the status quo which suggests that little which is fresh or innovative would be included. Second, the system of state control for large federally-funded programs that provide local services has been extant in this country for the past decade. Two notable examples, the Comprehensive Employment and Training Act (CETA) and Community Development Block Grants, have long provided us with state control management models.

This chapter starts with a brief account of the role played by the states in the administration of Medicaid. The remainder of the chapter, devoted to building a case for a federally-administered program, investigates thoroughly such areas as ability to respond to the needs of long-term care clients, efficiency, and cost containment under federal control.

States as Administrators

Robert Derzon, former head of the Health Care Financing Administration, told a conference of state administrators, "The job of designing and managing a state Medicaid program is extremely complicated--far more so than practically any other state activity you supervise or operate".[1] There are arguments which suggest that many states cannot in fact operate such a complicated program well.

It is because states have been considered to be weak administratively

that the federal government has attempted to aid state administrative functioning through the grant system. Michael Reagan, an authority on American Federalism, describes eight purposes of federal grants,[2] of which five relate to the administrative function:

(1) Achievement of minimal standards in programs which exist in states at widely differing levels.

(2) Achievement of a critical mass in a given area and avoidance of wasteful state duplication. (i.e., regionalization and economies of scale.)

(3) Improvement of substantive adequacy of state programs through professional technical assistance, because only a few states are able to compete with the national government in attracting outstanding talent.

(4) The stimulation of experimentation for programs and methods which can then be applied nationally to better achieve program goals. (Reagan notes that most such experiments did not well up from the local level. They were, instead,, mandated by the federal government. Sometimes experimentation can only be started at the local level if directed from above, owing to the status quo orientation of local elites.)[3]

(5) The improvement of state and local administrative structure and operation. Since the 1930's, federal grants have been important in inducing grant-receiving governments to professionalize their organizational structure and practices. Reagan suggests that "While a few states have always been the equal of the national government....the majority of states have been laggard in adopting modern management knowledge".[4]

State administrative capability may be divided into three areas of consideration: administrative capacity and technological capacity, political capacity, and degree of domination by special interest groups.

(1) Administrative capacity refers to staffing patterns and presence of

sufficient staff to do the job while technological capacity is concerned with the use of a computer or other system which promotes economies of scale in larger operations. Poor administrative and technological capacity can undermine the success of a Federal grant system. Jeffery Pressman, writing on the political implications of the New Federalism, cites a growing skepticism over the success of revenue sharing resulting from a perceived lack of capacity among states in the areas of planning, personnel, and management.[5] The Advisory Commission on Intergovernmental Relations (ACIR) evidences a similar skepticism concerning the efficacy of federal social intervention grants, for successful implementation at the state and local levels depends on the political leadership and the management strength of the localities.[6]

These suspicions are not unfounded. In the area of administrative capacity, for example, the Ohio State Budget for 1976-77 listed only 70 people employed in the entire AFDC (welfare) program.[7] Even New York State, still wealthy by any standards, and long considered a leader among state administrations, has its problems. In a recent interview, an official in the New York State office handling hospitals and nursing homes stated that administrative costs in the state were not only not high, but in fact the managerial staffing pattern had long since been cut as "thin" as possible. The relevant question is, at what point does a reduction in manpower cost more in inefficiency and ineffectiveness than the salaries it saves?

There is also inefficiency in the area of technological capacity. Currently, even with the prospect of ninety percent federal financing for capital installation of high technology data processing systems, and seventy-five percent reimbursement for their operation, not all states have taken steps to initiate such data systems. The Department of Health, Education and Welfare has created a model Medicaid Management Information System (MMIS) for state data

systems to follow. After six years of the program, only 15 states have an MMIS in full operation, and 32 MMIS programs are planned. A full six states have no plans for an MMIS at this time.[8] (Total includes territories.)

(2) The second division of administrative capability, "Political capacity" refers to the existence of a well-developed political system, formal and informal, which can effectively foster programs and monitor their implementation, particularly in the case of new or changed programs. In this area, too, there are problems which contribute to less than optimum operation at the state level. Reagan charges that many state legislatures are characterized by low pay, too frequent turnover, and a tendency to hamstring their Governor.[9] In fact, one-third of our state legislatures do not meet in regular sessions every year.

(3) The third area of admininistrative capability, the question of the domination of states by special interest groups, (SIGs) has two aspects. First, such groups may consist of organizations lobbying for a particular cause. These types of interest groups are positive or negative depending on the perspective of the observer, but, it can be agreed that no one group should have excessive influence over a legislative body. In general, observers seems to believe that special interest groups are stronger in states than in Washington. For example, it has been charged that currently, many state legislatures are dominated by insurance interests,[10] certainly of relevance if any further legislation concerning government-financed health insurance is considered.

State governments have also been accused of domination by interest groups in the second sense of that term, that is, as the existing informal economic power structure of the community. It is to this latter sense which Pressman refers when he summarizes several studies which are critical of state government. He reports that states were found to be "unresponsive, institutionally weak, of

low visibility, and dominated by narrow economic interest groups".[11]

A specific example of what can happen under such local control is evidenced in the Comprehensive Employment and Training Act of 1973 (CETA), a revenue-sharing grant. CETA replaced earlier categorical programs in manpower training and it was hoped that creative planning would take place through the required "manpower plans". Instead, an interim evaluation of CETA[12] showed that manpower programs were being politicized, that "planning" tended to follow rather than lead the action stage, and that the responsibilities of administration were clearly straining the capabilities of local governments. Over 40 percent of the units submitting plans were intially assessed as performing marginally. In addition to these problems within localities, there were responses in the larger system. Congress began to return to categorical funding in certain sub-areas of manpower, such as youth, because of the need it perceived to address them as "national problems." The analogy to health is clear in the conflict between local administrative control and achievement of national purpose, even under conditions of full and adequate financing.

Although the states are weak in administrative capability and are thus unable to operate a complicated program such as Medicaid, the states themselves often lay blame at the feet of the federal government. They complain of a nightmare of excessive paperwork, overly-detailed, repetitive, rigid and incomplete regulations as well as excessive concern with proofs of compliance over actual service activities. Yet, the states themselves are frequently guilty of the same thing. For example, block grants were instituted to aid localities with a minimum of federal intervention. In the case of the Safe Streets Act of 1968, "four-fifths of the states have adopted policies that

exclude certain activities from funding and encourage others, with the result of reducing local flexibility".[13] Although approvals of amendments to the state plan can be obtained, "the amount of time and paperwork involved...often leaves local officials believing that block grant...decisions are, at best, a ritual".[14]

The "red tape" the states complain of is misleading, at least insofar as it happens that many of the admittedly difficult regulations are not about program requirements per se. They are often about important new national objectives in fields related chiefly through the administrative function, such as environmental protection and equal employment.[15]

Federal Administration in Health is Required to Achieve Cost Containment

The concept of natural area was first put forth by James Fesler. Basing his arguments on economics and geography, he proposed that the country could be divided in any number of different ways, depending on the category or factor selected; for example, rainfall, or the density of the elderly population. The natural or obvious division lines for one factor would not necessarily match the divisions laid down for another. If problems in society, then, can reveal their own natural regions for handling, we should not be surprised if "The legal areas of particular governments seldom coincide with or wholly embrace the natural areas defined by the problems with which society must deal."[16] We may extend his ideas to suggest that our familiar political subdivisions can actually obscure our vision of the"natural area" of a problem, since we simply assume that it will coincide with the boundaries of those subdivisions. In health, they are presently the states.

Fesler himself was thinking mainly of two models for "natural areas" beyond the state and local levels: the ad hoc organization of the Tennessee Valley Authority, and the federal government. Although he did not uniformly advocate federalization of programs, he clearly recognized the value of the

central government.

Health is a problem whose natural area has indeed become national. We have seen that providing access to health care is becoming a national priority. It would appear that if we wish to guarantee access to minimum levels of health care to all our citizens, we will have to be willing to pay the bill from the federal treasury. But would it be sufficient to finance health insurance as a grant at a rate of 90 or even 100 percent to effectively induce more uniform state participation? Such financing would be insufficient, because in the absence of state control, the necesssary other half of a federal health care system would suffer: cost containment.

Cost containment, in terms of expenditures of public funds, necessitates rational planning and controls to obtain maximal value for the taxpayers' dollars. We may wish to limit the amount of these dollars spent, or we may collectively decide to spend more if we like what we are getting for our money. Cost containment means more, however, in terms of the health care system as a whole. It means resource containment: health care is like any market, in that demand is always potentially infinite. Resources, no matter how abundant, are scarce in the face of potential demand. No society can have all the health care it can possibly consume.

Currently, health resources are allocated in part by some states' relative unwillingness to finance access to health resources for all of their people. If the federal government steps in to increase their access by adopting the proposed medical insurance plan, or takes an even broader step to guarantee that financial access to all of us through national health insurance, we will quickly face the dilemma long ago anticipated by the Committee on the Costs of Medical Care. First, demand may increase beyond the supply capacity of our present health systems, resulting in rationing by

queues or lack of access to some individuals for arbitrary reasons. Second, the system may expand to meet the demand, but for a price in public expenditures which would be far in excess of our willingness to pay. In sum, government financing will create demand pressures which will require vigorous measures to contain.

A national program to plan the distribution of resources and to ensure the careful use of available health resources is thus necessary for the success of federal financing of health for the poor and elderly. The need for rational health planning has been foreseen and acted upon by Congress in one guise, the creation of Health Systems Agencies (HSAs), independent regional agencies acting under federal authority to study and plan for local health needs. Other cost control measures are essentially administrative in nature. Ensuring efficient delivery of services, overseeing appropriateness of utilization, and setting fair but not excess wage rates are but a few examples. Finally, the systems of health financing and administrative controls must be effectively linked with the planning by the HSAs, and it is likely that federal administrators would be the more motivated to work cooperatively with the federally-sponsored HSAs.

Why can we not leave states to initiate vigorous cost control measures on their own? The record shows that states are variable in every respect, and for the reasons outlined in previous sections, will be variable in their response to cost containment as well. If some states participated in control efforts, there would be improvement, but the result will be far less than it should be from the number or strength of the states involved. The energetic efforts of the states which move forward in financing, planning, or controlling health care will be drained off by those which do not. This is because health is an action area characterized by significant economic externalities--that is, health policies in one state have significant fiscal impacts on other states.

Externalities occur when the action taken by an individual decision-making unit imposes unavoidable (and usually unplanned) benefits or costs on others, and no feasible method of compensation in return can be arranged. Fuchs gives the example of vaccinations. Not only do they protect the recipients again a communicable disease, they also collectively reduce the chances of an epidemic and thus the chances of unimmunized persons getting the disease.[17] Conversely, consider the impact on a pregnant woman living near the border of a state which did not provide a preschool rubella immunization program.

Externalities take place equally in cost containment and in provision of care. Physicians in particular may well migrate to obtain higher status and salaries where individual states institute measures to limit their fee schedules or induce them to work in cooperative arrangments such as HMO's. While members of the middle class population would not be expected to migrate merely to obtain covered medical services in their younger years, they already do migrate at retirement age to more amenable climates and may well begin to do so if faced with the possibility of needing extended care in time to plan for it. Taxpayers, too, can migrate.[18]

In contrast, under federal administration such migration could be a positive event. For instance, at this time, persons with arthritis and certain lung disorders consume expensive hospital and SNF care, but many are unable to take the simple expedient of moving to a state with a more therapeutic climate, such as Arizona. Under federal administration, they could move and be confident of retaining their eligibility for care.

Ernest Saward lists four general types of economic regulations, all of which have been used in the health care field: (1) subsidization of individuals

or groups, as in Medicare and Hill-Burton; (2) quality control, as in accreditations and PSRO's: (3) entry restrictions, as in licensure and more recently the certificate-of-need programs; and (4) rate or price regulation, as in Medicaid's fee schedules or Maxicap proposals.[19] It is clear that all of the regulations would be useless if all that need be done to avoid them was to leave the area.

In testimony to a House subcommittee, a spokesman for Rhode Island argued that the nation needed to go beyond health policy to national financing because of the external blocks his state had encountered in establishing universal health coverage. Since so many of Rhode Island's citizens work for out-of-state employers, the state was stymied in regulating the employers' health insurance rates and benefits.[20] Karen Davis supports the principle of regionalization along the natural market areas for health as marked out by the HSAs; she believes that strong roles for state governments in a program of national health insurance could interfere with this type of regional organization. For example, residents of eastern Arkansas may turn to Memphis for specialized health services, rather than Little Rock.[21] A federally-run program would be best able to handle both these problems, because it would be freer to set guidelines within state or HSA boundaries, or to transcend them when justified. Because states compete, the federal government is now prone to overvalue equality (treating everyone the same, making no exceptions) at the expense of equity (making individual adjustments to achieve fairness).

Finally, while it is true that if all states were to willingly act in concert, we would have a better chance of a successful cost containment program, it is unfortunately also true that most states cannot be relied on to implement creative cost containment measures on their own. Special interest groups, as discussed above, are more active at the state than the federal level. The record shows that virtually every major cost control mechanism

has found its impetus, and often its inception, at the federal level. Outstanding are Health Maintenance Organizations (HMO's) or pre-paid group practice; the Regional Medical Programs which preceded the HSAs, experimental reimbursement systems, Professional Standards Review Organizations (PSROs); and the National Health Service Corps to attract physicians to medically underserved areas.

In contrast, the state record on cost containment is spotty. Loebs describes the situation of utilization review through PSROs, intended to monitor both quality of care delivered and cost containment through utilization review of services to Medicaid clients. According to Loebs, "Despite the potential savings to the states through the implementation of a utilization review system, about half of the states had no functioning utilization review system before the local PSROs were organized.[22] In 1974, planning legislation instituted the Certificate of Need program, under which a facility must demonstrate a real service need in its area for its projected establishment or expansion. Prior to the legislation, most states took little action to control the needless and expensive proliferation of facilities which was going on. [23]

In summary, the evidence suggests that federal administrative control is the best mechanism for achieving the essential nationwide standards for policies in cost containment.

A Federal Administration Would Be Efficient And Responsive

Consider some of the findings on Medicaid reported to the House Subcommittee on Oversight and Investigations:

1. Information (pertaining to surgical rates) as reported by states was "so inconsistent as to preclude any detailed

analysis." The Subcommittee could not determine, for example, if a rate decrease was an actual effect or due to differences in reporting.

2. Data indicated a 16-fold difference in surgical rates between two states; also the rates for Medicaid as a whole are above the rates for the rest of the population.[24]

3. States were unable to justify the necessity of the procedures.

4. The Subcommittee viewed as particularly disturbing, the inability of many states to be accurate and consistent _or to report at all_. (Italics theirs.)[25]

Although the Subcommittee faulted the Department of Health Education and Welfare (DHEW) for failing to require the states to submit the needed data, the principal blame for deficiencies in administration of the program was placed in the system itself:

> There is too great a division of labor and responsibility in the Medicaid program. This fosters a lack of accountability. The Federal Government helps finance and monitors the States" efforts. The states monitor their fiscal agents, whatever State agencies are responsible for health and welfare. And, finally, the state agency often subcontracts with a private company for the actual administration of the program. Apart from but related to this chain of responsibility, the Professional Standards Review Organizations (PSROs) are supposed to determine the necessity of elective procedures. To whom they are responsible remains unclear.[26]

Since the Subcommittee must deal with the system as it is presently structured, that is as a federal-state partnership, it recommended that DHEW develop and require use of uniform categories of reporting; that Congress tie funds to such reporting, and so on: a typical move toward

more control by mandate. Thus, in our system, if the federal government is dissatisfied with state performance, it has no choice but to create ever tighter restrictions in the use of its funds, combined with expensive systems for monitoring compliance, and threats of grant withdrawal as the motivating force. Such threats, it would seem, are likely to turn a partnership into a duel. Actually withholding funds is a serious decision which federal administrators do not like to make because they are aware of the dependence of state budgets on federal dollars. More importantly, the real victims of the "punishment" may be intended clients of the program, in this case, Medicaid eligibles in need of hospital, medical, or long-term care. Might it not be time, then, to streamline the handling and the accountability of the program in the fullest sense possible, that is, to allow the federal government to operate the program?

The Director of the Indianapolis Urban League asserted to a House Subcommittee that no amount of tinkering with the federal, state, and private system can obscure the need for a single national health system trust fund operated by the federal government with input from general revenues, contributory taxes, or a special surtax.[27] One model suggested was proposed by the Committee for Economic Development. They advocated a tripartite national health insurance system using the existing employer funds and Medicare, with the rest being subsumed under Medicaid, and paid for by a special trust fund overseen by Medicare.[28]

There is much to suggest the effectiveness of the federal government as administrator. It has experience in the provision of good quality acute and long-term care in the Veteran's Administration system. The VA has been providing care to thousands of veterans--often the most indigent of veterans--for fifty years, compiling, in those years, a relative absence of complaints.

The VA also has experience in the purchase of care for veterans in community nursing homes.

In the insurance industry, economists have found that Medicare is operated very inexpensively. Estimates are as low as 2-3 percent of overall operating expenses.[29] There is agreement that administrative costs may not be comparable to private industry because of differences in populations served and in role requirements: private companies pay taxes and advertising, but Medicare has more extensive record-keeping. Also, estimates of efficiency would be expected to vary depending on whether costs are compared to number of benefits paid, total cost of benefits paid, and so forth. Nevertheless, even those who contend non-comparability means the public sector is not definitely more efficient admit that it means the private sector is not so, either.[30] Two economists who sought to carefully investigate insurance expenses by studying a variety of cost breakdowns determined that there are economies of scale in health insurance.[31]

A historical survey of legislation shows that Congress has classically been interested in good management. Five particular achievements will express the point. The first general legislation was the Civil Service Reform or Pendleton Act of 1883, considered to have formed the basis for American personnel administration. In 1912 came the "Report of the Commission on Economy and Efficiency: The Need for a National Budget", which led to the Budget and Accounting Act of 1921, creating the Budget Bureau, now the Office of Management and Budget. The New Deal passed legislation to create administrative structures for the control of government-run businesses following a report submitted by Brownlow's Commission on Administrative Management. A significant legislation in 1946 called the Administrative Procedures Act addressed the need for more standardized procedures in the writing of bureau-

cratic regulations which implement laws. Finally, the Hoover Commission in 1949 made a study, with recommendations, of the organization of the Executive branch of government which was subsequently adopted by the states as well as the federal government.[32]

Today the federal government collectively displays an almost overwhelming array of knowledge and skills, much of it directly concerning health care or the art of administration.

--DHEW now has five separate offices concerned with some aspect of long-term care or the aging, such as policy recommendations or maintenance of quality standards in nursing homes.

The Monthly Catalog of U.S. government publications listed 17 titles relating to principles of good management, from January, 1978 to May, 1979.

--The Health Care Financing Administration is merging its Medicaid and Medicare Bureaus in 1979 to strengthen the programs now, and, in view of the interest in the issue, to develop preparedness in the event of a "universal" health insurance program in the future.[33]

Since we can only project what Medicaid might be like under full federal financing and administration, similar to Medicare's, it may be most fruitful to contrast the state experience in Medicaid with the federal experience in Medicare.

Under Medicare, payments are made through selected private insurance companies, such as the Blue Cross plans, called intermediaries for Part A (Hospital), and carriers for Part B (Medical). Payments are prompt, made within four to six weeks, and are rarely reduced from the amount requested. Payment may be made either to the individual or directly to the provider. Eligibility is established by federal employees stationed in Social Security offices.

Under Medicaid, payments are made by state or local jurisdictions in health or social services, or by a private company under contract with a state agency. Eligibility is determined by state or local employees. Payment must be made directly to the provider, who does not have the option of "topping off" the fee as set by the state. In a study of physicians' reactions to the Medicaid program in California, it was found a wait for payment can easily be one full year. Likewise, California physicians report high rates of unilateral and unexplained reductions in payment from the amounts requested.[34] The government obviously retains the right to reduce the level of payment from the amount requested by the provider as a means of correcting bills submitted in error. However, reduction rates which exceed tolerance limits needlessly alienate providers and bespeak an administrative machinery in need of improvement. California is, in fact, experiencing high rates of provider dropout.

While Medicare shows excellence in its handling of providers, Medicaid in some ways has a better track record of service to clients. Medicare's clients largely have status eligibility: one is either 65+ or not; furthermore, one may anticipate the arrival of one's eligibility threshold, the 65th birthday. Consequently, Medicare takes advantage of this and achieves some of its administrative cost-effectiveness by placing greater demands on the resources of the applicant clients. With Medicare, any person seeking coverage is advised to apply three months in advance of her 65th birthday. However, the Medicaid population is chiefly characterized by a shifting, situational eligibility: the applicant may be a recently laid-off mother, a teenager who finds herself with an unwanted pregnancy, or a middle-income worker with a chronically-ill child needing extensive, but irregular and unpredictable, care.

Some of the permanently poor retain eligibility on an income basis but are careless about "re-certifying" their eligibility until a felt need for medical care arises. Not all of Medicaid is like this, of course. Many people of long-standing poverty are quite careful about meeting expectations; the nursing home resident who first spends down her resources to become eligible, has then virtually a status eligibility, if she is not expected to be able to return to independent functioning. Nevertheless, Medicaid administration has been arranged such that a disorganized client who waits until the last minute to apply for coverage can still be at the doctor's office in a matter of days.

Under a federally-run combined system, we would anticipate Medicaid's service to providers to be improved to the standards being maintained in Medicare. We would expect the present difficulties caused by the interactions between the two programs to be eliminated, and we would look for the program to demonstrate the responsiveness to clients presently shown by Medicare.

An example of a problematic interaction between Medicaid and Medicare is the latter's 100 days' coverage in a nursing home. This 100 days often leads to administrative difficulties for government bureaucrats, nursing home operators and patients alike in cases of dual eligibility, as state and federal administrators variously interpret the law regarding which level of government should take precedence for financial responsibility. If the structural tendency to competition to avoid the obligation were eliminated, the problem would disappear. A second administrative twist between the two programs is the states' option to "buy-in" to Medicare for the Medicare-eligible Medicaid clients. These clients cannot afford to pay Medicare's cost for

themselves, and it would appear to be worthwhile to the states to pay their fees. Yet many states choose not to, even though the buy-in is not expensive. It may be that the administrative costs of the buy-in program are high enough to cause states to judge the potential gain to be insufficient.

Finally, can a federally-run system adapt to meet the needs of a changing service population, as in the challenge of Medicaid? We would not expect such a program to be as inexpensively run as Medicare is now, but it will still be a step forward from the tangled mess of eligibility, accountability, reimbursement, appeals, audits, reporting and reviews which goes on at every intersection between two negotiating parties in the present Medicaid system.

FOOTNOTES

[1]Robert Derzon, "Improving Health Care Financing--A Constructive Approach," Journal for Medicaid Management 1 (Summer 1977):2.

[2]Michael Reagan, The New Federalism (New York: Oxford University Press, 1972), pp. 70-71.

[3]Ibid, p. 70.

[4]Ibid., p. 71.

[5]Jeffrey Pressman, "Political Implications of the New Federalism," in Financing the New Federalism, ed. Wallace Oates (Baltimore: John Hopkins Univ. Press, 1975), p. 37.

[6]Advisory Commission on Intergovernmental Relations, Categorical Grants: Their Role and Design (Washington, D.C.: Government Printing Office, 1977), No. A-54, p. 41. (Hereafter referred to as ACIR, Categorical Grants).

[7]Ohio, Ohio State Budget, 1976-1977.

[8]U.S., DHEW, Data, p. 97.

[9]Reagan, The New Federalism, p. 111.

[10]U.S. Congress, House, Hearings on a Bill for Health Policy, p. 615.

[11]Pressman, "Political Implications," p. 34.

[12]William Mirengoff and Lester Rindler, The Comprehensive Employment and Training Act: Impact on People, Places, Programs (Washington, D.C.: National Academy of Sciences, 1976), pp. 9-18, 88.

[13]Advisory Commission on Intergovernmental Relations, Block Grants: A Comparative Analysis (Washington, D.C.: Government Printing Office, October, 1977), No. A-60, pp. 20.

[14]Ibid, p. 26.

[15]ACIR, Categorical Grants, pp. 39-40.

[16]Ibid., p. 11.

[17]Victor Fuchs, Who Shall Live? (New York: Basic Books, 1974), p. 130.

[18]ACIR, Categorical Grants, p. 41.

[19]Ernest Saward, Regionalization of Personal Health Care, Proceedings of a Milbank Memorial Fund Roundtable (New York: Prodist, 1976), p. 81.

[20]U.S., Congress, House, Hearings on a Bill for Health Policy, p. 615.

[21]Karen Davis, "Regionalization and National Health Insurance," in Regionalization and Health Policy, ed. Eli Ginzberg (Washington, D.C.: DHEW, Public Health Service, Health Resources Administration, April, 1977), No. (HRA) 77-623, p. 178.

[22]Loebs, "A Survey of Issues and Indicators," p. 19.

[23]Eli Ginzberg, "The Many Meanings of Regionalization in Health," in Regionalization and Health Policy, ed. Eli Ginzberg (Washington, D.C.: DHEW, Public Health Service, Health Resources Administration, April, 1977), No. (HRA) 77-623, p. 5.

[24]These data illustrate how poor administration leades to violation of both goals of the Medicaid program. The poor may not be receiving quality health care, if they are being subjected to large amounts of excess surgery, and the taxpayer does not see his money used efficiently, as overutilization is probably the major source of waste in the Medicaid program.

[25]U.S. Congress, House, Committee on Interstate and Foreign Commerce, Inadequacies of Medicaid Management: Report by the Subcommittee on Oversight and Investigations, 95th Cong, 2nd session, December, 1978, pp. 1-4.

[26]Ibid.

[27]U.S. Congress, House, Hearings on a Bill for Health Policy, p. 367.

[28]Ibid, p. 967.

[29]J. Krizay, "Does the Social Security Administration Really Run Medicare on 2% of Income?", 7 June 1973, Congressional Record 18607.

[30]Ibid.

[31]U.S., Department of Health Education and Welfare, Social Security Administration, Office of Research and Statistics, Health Insurance Administrative Costs, By Ronald J. Vogel and Roger Blair, No. (SSA) 76-11865, p. 7.

[32]See Frederick C. Mosher, Basic Documents of American Public Administration: 1776-1950 (New York: Holmes and Meier Publishers, Inc.).

[33]Robert Derzon, "Improving Health Care Financing," p. 1.

[34]Michael Jones and Bette Hamburger, "A Survey of Physician Participation in and Dissatifaction with the Medi-Cal Program," in The Medicaid Experience, ed. Allen Spiegel (Germantown: Aspen Systems Corporation, 1978), pp. 277-289.

ETHICS: THE QUALITY OF LIFE

The quality of life for the elderly is something we all wish to improve; yet, there is wide disagreement on how this is to be done. In this chapter, the contributing authors address themselves to this question, and although they differ as to the means, there is an implied consensus on the end sought. Broadly speaking, the authors indicate that a qualtiy life is one in which the individual considers himself and is considered by others to have not only a past but a meaningful future over which he has control. Furthermore, it is a life in which the individual is able to retain, wherever applicable and whenever possible, his connection to the activities of the family, the community and the work force. However agreement on goals does not extend to agreement on strategy. This chapter presents two views, two possibilities for an improved system of long term care for the elderly. First, there is an examination of long term care delivery under federal control and then a consideration of delivery under a state controlled system.

ETHICS AND FEDERAL CONTROL OF THE QUALITY OF LIFE

Aging is not an end, it is the beginning of another segment, another passage in our lives. We must begin to realize that the elderly have a right to live this last segment to its fullest. The Federal Government must guarantee this right. Ethically and morally it is the only choice we can make. No part of life should be feared: life should be held, turned over, examined and enjoyed to the fullest. The elderly deserve this choice. Sharon R. Curtin, in her book, Nobody Ever Died of Old Age, states, "If we could change the picture we have of old people and view life as more of a continuous circle...perhaps we could learn to view old people as human beings with a future as well as a past."[1]

The present system of Medicaid fails, in many states, to cover those services which are necessary to improve the quality of life for the elderly.

Under the present medicaid system, states may decide eligibility requirements and what levels and types of services to provide. Stephen Loebs in an article on Medicaid states that presently, "dominant political ideology and attitudes... held by legislators and governmental bureaucrats were the chief determinants of the responses to the optional choices in the medicaid program."[2] What has developed is a separate Medicaid program in each individual state that is often not sensitive to the needs of the elderly.

Long Term Care, one aspect of Medicaid, seems to have become synonomous with institutional care, whether in hospitals or in nursing homes. The very nature of institutionalization often is in direct conflict with quality life; by fostering dependence, it removes dignity and the need to feel wanted and needed from the lives of the elderly at a time when it is most important.

The following analysis was written to examine the prejudicial status that our fears of aging and dying have incorporated into the treatment of the elderly, and to show the lack of dignity allowed the elderly even in their dying. There are alternatives to the present long term care situation but they demand that first we redefine the very term. For purposes of this analysis, long term care will be defined as those medical services which, when guaranteed to all Americans 65 and over, will maximize their opportunities for independent quality living. The states have not accomplished this and under the pressures of rising costs, there is very little proof that the condition will improve in the future. The Federal Government must intervene if an equitable and satisfactory system of medical care for the elderly is to be established. The 1976 Moreland Commission report concluded that the fragmentation of the present Medicaid system was due to the lack of a comprehensive government program. More important, it stated that what is required "is a new federal program which would help guard all forms of institutional long-term care and....would concentrate on financing more informal and non-institutional means of meeting the

needs of elderly persons."[3]

Old Age -- The Feared Frontier

Americans are notorious for their hatred of age. They compulsively buy new things, erect new structures, construct newness into their lives. We are bombarded in every aspect of our lives with advertisements promising happiness through age retarding, youth perpetuating methods -- the face lifts, wrinkle creams, hair dyes, energy tonics. America has become a society which worships the image of youth, attempts to deny age, and refuses to accept death. It is no wonder that this notion surrounds our treatment of the elderly. They have become a flaw, a financially burdensome blemish on our youth cult, and we hide them away in nursing homes, hospitals and domicilary facilities where we can comfortably ignore their existence -- a reminder of our own mortality. We find them slow, old fashion, over-the-hill, senile, and in so many ways, irritating. And underlying our irritation is the fearful fact that they will one day move over and allow us, the young, to take their places. How dare they get older! How dare they die! For in their aging and eventual death, each of us is pushed closer to the front of the line. And so we ignore, deny, and resent. In fact, as author Robert Butler points out, "we are so preoccupied with defending ourselves from the reality of death that we ignore the fact that human beings are alive until they are actually dead. At best the living old are treated as if they are already dead."[4]

The lengthening of life expectancy and the growth in our over 65 population has largely been due to advancements in our medical technology. Estimates place the over 65 population at 25% of the American population by the year 2000.[5] America's technological progress has created a segment of the population for which we are unprepared; "for whom survival is possible but satisfaction in living elusive."[6] It is true that 81% of those over 65 remain independent,

95% live in the community and at any one time only 5% are in institutional care.[7] However, these figures appear to be radically changing as more of the elderly begin to find it financially, meidcally, or mentally impossible to maintain their independence. Their choice, often reluctantly, is a nursing home. A 1966 study of the characteristics of one home for the aged showed that 45% entered because of their own mental or physical impairment, 23% because of the death or impairment of a spouse, 7% because of poor neighborhoods, loneliness or relationship problems, and 23% because of the death or severe illness of their adult child.[8] This is substantiated by a 1971 study done by Brandeis University's Levinson Gerontological Policy Institute of 100 patients in nursing homes. Of these, 37 needed full time skilled nursing care, 26 needed minimal supervised living, 23 could get along at home with periodic home visits by nurses and 14 needed nothing.[9] Sixty-three per cent of these 100 patients could technically survive without the confines of a nursing home. The Brandis researchers concluded from their study that "large numbers of disabled are forced into nursing homes...simply because public programs could not give attention to alternative ways of meeting their needs outside of institutions."[10]

Much of this "forcing" is done because of the following attitudes which perpetuate unfair myths about old age.

- The Myth of Disengagement which holds that the elderly prefer to live alone or perhaps only with their peers.
- The Myth of Senility which often lumps anxiety and depression into the category of senility and holds that all old people grow forgetful, confused, and have reduced attention spans.
- The Myth of Unproductivity which perpetrates the belief that age and unproductivity and synonomous.[11]

It is these attitudes which perpetuate the belief that the elderly cannot adequately care for themselves that often leads them or their families to choose

dependence over independence -- the "old age home" over their own. Edith Stern wrote in her article "Buried Alive", that "Unlike some primitive tribes, we do not kill off our aged and infirm. We bury them alive in institutions."[12]

The Loss of Quality Life

All humans get old; in effect, we are all sentenced to die. We have a beginning and an end with death the final point in the continuum. The old cliché that reads that it is not whether we win or lose, but how we play the game that is important. The manner in which we allow the elderly to play out the "game of life" becomes important. Existing data indicate that the opportunities for quality life for the elderly has declined significantly:

- In 1971 over 10 million elderly live on less than $75 per week.
- Thirty per cent of the elderly live in substandard housing.
- Social Security penalizes the old by reducing their income checks as soon as they earn more than $2,400 a year.
- 3.4 million elderly persons live in poverty with an annual household income of less than $3,500.[13]

Yet, in spite of these conditions, we expect the elderly to maintain both their physical and mental health. The World Health Organization's Charter states that health is a state of complete physical, mental, and social well-being and not merely the absence of disease or informity. Robert Butler wrote in Why Survive that health meant the "capacity to thrive rather than simply survive."[14]

As Americans, we need to establish as a priority the personal right to quality life which is far more important than biological survival. In order to prioritize, we must dispell one of the most distorting mythos of old age -- the myth of senility. We must begin to relize that the elderly as they exist today are plagued by enormous stress that leads to depression, anxiety,

psychosomatic illnesses, and irritability. That grief for the many losses that the elderly suffer -- loss of friends and relatives and ultimately the loss of one's own life -- bring apathy and emptiness. Often alone, the elderly find themselves unable to survive independently. They become dependent pawns, handing their lives over to death or institutionalization. Twenty-five per cent of all known suicides occur in the 65 and over population; until recently, 25% of annual state hospital admissions were 65 and over; and 5% of the elderly are confined to nursing homes, hospitals, or other institutional care.[15]

Misuse of Hospitals

Are hospitals and nursing homes able to provide quality life to the elderly? Hospitals historically were organized as centers for healing, curing, and restoring individuals to health; they were not organized around dying. Hospital staff are trained in restorative care, not in the care of the aged or dying. A 1973-74 survey of over 100 medical schools in the United States shows that 87% offered no geriatric speciality and did not plan on adding one; 74% lacked apprenticeship in nursing homes; and 53% offered no opportunity for contact with nursing home patients.[16]

Deaths in a hospital are often viewed as a failure and a cause for anxiety for the staff. As a result, dying patients often become "targets of super human, futile efforts at resuscitation and maintenance (as in the Quinlan case) or shunted off into the farthest room and ignored as much as possible."[17] In Miami not long ago, two elderly men -- critically ill, homeless, penniless -- were put into wheelchairs to sit in a jammed aisle of a hospital until nursing home space could be found for them. Both men died in those chairs, and it was hours before anyone even noticed they were dead. One man had been sitting in his chair for three days and the other for two.[18] Section I of the "Principles of Medical Ethics" drawn up in 1973 by the American Medical Association reads

that "The Principal objective of the medical profession is to render service to humanity with full respect for the dignity of man." One need not ask if death in a wheelchair is dignifying or if using hospitals as "holding tanks" is providing quality life.

Nursing Homes -- The Human Warehouses

In spite of the movement to improve the quality of care provided by nursing homes, they will remain in the eyes of the elderly often nothing more than "warehouses". To the old, they are the last stop before death and viewed with a mixture of fear and hostility. "All old people -- without exception -- believe that the move to an institution is the prelude to death....a decisive change in living arrangements, the last change he will experience before he dies."[19]

Beyond this, nursing homes often fail to provide the most necessary ingredient, comprehensive medical care. Although Federally required, many states do not effectively enforce the use of a principal physician or medical director. Often, attending physicians' visits involve very little other than glancing at charts, thereby denying the patients quality care. The Moreland Report cited that "a common complaint which the Commission has heard....is that physician visits are often perfunctory."[20]

The most fearful aspect of nursing homes is that they rob the elderly of every last shred of independence. They are reduced to the status of infants, totally dependent, at first involuntarily and then, finally, voluntarily. In Nobody Ever Died of Old Age, Curtin describes the treatment she encountered in various nursing homes. She found that the attendants often treated the elderly "as if they were infants, unhearing, uncaring, unable to speak or communicate in any way. The patients were uniformly called honey or dearie or sweetie -- or sometimes naughty girl if they soiled their beds -- just as one tends to

call children by pet names.... The bodies were kept clean, fed, powdered, combed, and clothed. They were as infants, without modesty or sex or privacy."[21]

Death, the Untouchable State

Growing old, and all that aging entails is terribly lonely. The elderly are talked to and visited and tolerated partly out of guilt, partly out of a sense of responsibility. Perhaps the greatest loneliness comes from the elderly having to fear and grieve for their own death alone. There are very few people that will sit and listen to talk of dying. It is still a taboo; a macabre topic to be avoided. In our need to deny death's existence, we attempt to remove ourselves from its presence. On one hand, we react to death by "abandonment of the dying -- for they symbolize what we want to avoid. To abandon is to isolate. To isolate is to degrade, dehumanize. The final result -- an excruciating loneliness at the end of life."[22] On the other hand, we use every technological method to postpone death through heroic means, methods used to sustain life when there is no hope of restoring the life to a health state. Our technology can often hide the actual time of death by continuing life through machines. The cost of postponing death not only is costly monetarily, but also it denies the dying the right to a dignified death -- the final phase in a quality life. We overlook the basic fact that the quality of life rather than the quantity of living should be the priority.

Passive euthanasia, unlike mercy killing, is the act of allowing a patient to die naturally rather than using heroic means of sustaining life. There are those who would say that any form of euthanasia is unethical. But it is fear of failure and guilt that often prompts doctors and families to continue heroic measures thus convincing themselves that everything humanly possible was attempted. Isn't it much more unethical to allow an individual to die alone and isolated, to rob him in the end of the familiar human companionship

of family and friends?

Hospices and Home Care -- Acceptable Alternatives

In an attempt to deal with death, the concept of hospices was developed. A hospice is an inpatient facility designed specifically to make dying as confortable an experience as possible and the hospices idea has begun to take hold in the United States. Along with the hospice has come a new emphasis on home care and the right of the individual to know when he is dying thereby giving him control over the last segment of his life. The emphasis on home care is the result of studies that indicate that people prefer to die at home.

Besides helping the terminally ill to die in dignity and understanding. indications are that the hospice concept can eventually lead to cost containment. Lower rates exist because of low overhead resulting from a reduced range of services, empahsis on home care and less emphasis on technology and hardware. A 1972 study by Cardinal Ritter Institute in St. Louis compared home care costs for 140 terminally ill patients for a four month period against the estimated costs of alternative methods of care. The results showed:

Home Care	$ 94,000
Hospital	1,758,000
Nursing Home	350,000
Home with last two weeks in hospital	162,000[23]

Quality Through Opportunities

When planning for the aging, especially in the area of health, we need to maximize the rights to freedom of choice for the elderly while emphasizing quality life. In order to do this, we need to recognize the needs of the elderly. It is not the government's responsibility, whether local, state, or

federal to guarantee health but rather to guarantee that the opportunities for a healthy, quality life is available. The elderly, who must exist on fixed incomes without the hope of increasing those incomes through additional work, must be guaranteed needed services which will enable them to continue their independence in a dignified way. As Lyndon B. Johnson once states, "A basic goal of an enlightened society must be to provide opportunities which enable older people to keep and strengthen their independence and dignity."

Under the present medicaid system, the states maintain flexibility in determining who is eligible, the types and levels of medical services for which financing is available, and the levels of reimbursement for providers of medical services. Under this system, it is estimated that as many as 8,000,000 people below the poverty line are not eligible for Medicaid.[24] Since as previously stated, 3.4 million elderly persons live in poverty, one may assume that a large portion of the elderly are not receiving adequate care. Although states are required to include many services, certain services such as drugs, eyeglasses and dental services are left to the discretion of individual states.

Aging, by its very nature, means that there are certain biological changes in the body. Basically, the body degenerates. The states have been negligent in providing services needed by the elderly, and it is the duty of the Federal Government to provide these services. Since these services cannot be considered luxuries but necessities, they should be completely funded by the Federal Government. Under this definition of a Federal takeover of the medicaid system for long term health care of the elderly, care of the elderly would be a component separated from health care services for those not elderly. For purposes of this paper, the program will be called Medicel or Medical Care for the Elderly. Under a Medicel system there would be two funding components.

Component 1: Medical Services -- 100% Federal Funding:

These services are those which are preventive in nature and are necessary for the elderly to (1) maintain independence, (2) obtain and retain quality living and (3) enable the elderly to remain in their own homes or the homes of family members. These services would include:

1. Diagnostic and clinical screening (i.e. for glaucoma or diabetes)
2. Lab tests
3. Daytime non-residential care at geriatric hospitals
4. Rental of hospital equipment such as beds, wheelchairs, walkers, etc.
5. Physical rehabilitation therapy, non-residential
6. Homemaker, friendly visitor, home delivered meals, and other home services
7. Counseling services in mental heatlh and family needs including psychiatric out-patient services
8. Immunizations
9. All forms of dental services
10. Prescribed drugs
11. Prosthetic devices
12. Eyeglasses and optometrist services
13. Podiatrist services
14. Hearing aids and audiologist services
15. General doctor visits
16. Home hospice care
17. Emergency room hospital services

Component 2: Medical Services under 70% Federal Funding/30% State Funding:

These services would be the most costly services but would not include heroic measures.

1. Private duty nursing care
2. Nursing home care
3. Mental institutional care

4. Residential hospital care
5. Residential hospice care

Under the Medicel system the elderly would be guaranteed medical services emphasizing home care. Besides being a cost containment system, it is aimed at increasing the quality life of the elderly by increasing the amount of income they will be able to spend on services other than health care. Congressman Edward Koch of New York once estimated that keeping a person on home care would cost $2,000 to $6,500 as opposed to $15,000 to $20,000 in a nursing home.[25] It is essential that the elderly be guaranteed the opportunity to remain at home because "Many elderly persons even if chronically ill want to remain at home (but) need assistance in....homemaker home health aid."[26]

Conclusion

The challenge that must be faced in providing an equitable medical program for the elderly is to guarantee maximum necessary services while not financially incapacitating the states or the Federal Government. The proposed Medicel system does this. It guarantees services through Component I while continuing some state flexibility under Component 2. The emphasis of the program is on quality living at home. Since most sources speak of the elderly as the 65 and over population, this would be the soul eligibility requirement. Regardless of race, creed or color, all persons over 65 would have the opportunity to obtain necessary medical care. The states, because of their varying ideologies have been unable to guarantee this. As previously shown, this has caused a large segment of our population to exist in poverty, riddled with fear and anxiety. The elderly have a right to live a healthy, dignified, and independent life. The Federal Government has the responsibility to guarantee opportunities to do so. Zorba the Greek once said that "death is not the trouble, life is the trouble."[27] The elderly must have access to a life with as few troubles as possible.

STATE CONTROL OF THE QUALITY OF LIFE

Who shall take care of me in 2020? It is in the ethical issues concerning Medicaid-funded long term care (LTC) that the force and even pathos of this question is most apparent. Ethics, by definition, deals with what is good and bad and with moral duty and obligation. Many of the contributers to this book are just beginning to have their lives directly affected by ethical questions relating to Medicaid-funded LTC.

Do we place our parents in nursing homes? Do we acknowledge the wish of terminally ill parents or spouses that no heroic measures be used to prevent death? Can we guarantee the aged a quality life and still retain the quality of our own lives? Is there such a thing as freedom of choice when it comes to health care?

Perhaps the best way to understand the implications of the problem for the year 2020 is to look at the facts in the year 1979:

- Sixty percent of those people receiving Medicaid are either elderly or physically disabled.
- Current projections indicate that Medicaid will cost $22.3 billion dollars by 1980.
- The fastest growing poulation in the U.S. is the over 75 group.
- Three-forths of all older people have a chronic illness.
- Forty-seven percent of older people have some limitation in activities of daily life.
- Thirty-eight percent of older people have some significant impairment in their ability to function.
- Chronic brain syndrome or senile dementia which has a prevalence of three percent during the age space of 60 through 69 increases by more than sixfold to age 90, where it reaches a prevalence rate of

approximately twenty percent.

- Estimates for mental and emotional disorders among the aged run from a low of fifteen to a high of approximately thirty percent in the 65+ age group.
- Nursing home bed utilization doubles with every decade of life past the 60's.[28]

The facts point to an increasing population of older people who will continue to drain resources. As the situation worsens, we will be forced to address a growing number of ethical concerns and decide what are the most humane solutions to our problems.

The ethical problems surrounding Medicaid funded LTC are complex and subject to great regional variation. In order to rationally recognize the problem and come up with solutions, the states must retain the ability to make policy and differently interpret the ethical problems faced by its citizens. The goal of this paper is to examine how state initiated and controlled policies will promote the quality of life of those in LTC in a manner that is superior to all other alternatives.

In order to accomplish this goal, the paper shall look at the importance of state diversity specifically concerning ethical issues: why states are in a better position to obtain community input and convert these inputs into a policy that will be supported by its citizens and why states are in a better position with regard to humane policy innovation which will insure the quality of life of its citizens.

Two issues which reflect the problems of Medicaid-funded LTC shall be discussed within the context of the status quo argument. These are the right to a quality life and the right to freedom of choice, specifically in relation to the euthanasia question.

What is a Federal Takeover?

In this chapter, it has been noted that a federal takeover of Medicaid-funded LTC would be composed of three elements: 1) 100 percent federal funding of those services which are preventative in Nature and necessary for the elderly to maintain independence and quality living while remaining in the homes; 2) no federal funding of heroic measures, and 3) 70 percent federal funding/30 percent state funding of nursing homes and hospitals.

The fallacies of this model center around the belief that the federal government can determine what the citizens of this country want in terms of LTC and then enforce these standards in a uniform way. The model also fails to address the question of the controversy over and complexity of such terms as "quality living" and "heroic measures". In addition, the federal takeover model neglects the history of the states in humane policy innovation in numerous social areas including medical care and treatment of the aged.

State Diversity

Daniel J. Elazar in American Federalism: A View From The States presents a picture of a diversified United States whose cultural, political and ethnic makeup varies from state to state and region to region. He divides the country into three cultural bases: moralist, individualist and traditionalist.

The moralist cultures, which are located primarily in the upper middle west and Oregon, welcome the initiation of new programs for the good of the community. "By virtue of its fundamental outlook, states Elazar, "the moralist political culture creates a greater commitment to active government intervention into the economic and social life of the community. At the same time, the strong commitment to communitarianism characteristic of that political culture tends to channel the interest in government intervention into highly localistic paths so that a willingness to encourage local government inter-

vention to set public standards does not necessarily reflect a commitment and willingness to allow outside governments equal opportunity to intervene."[29]

The individualist culture is strongest in the western states of Nevada and Wyoming and views bureaucracy as a potential fetter of private affairs. "Since the individualistic political culture emphasizes the centrality of private concerns, it places a premium on limiting community intervention -- whether governmental or nongovernmental -- into private activities to the minimum necessary to keep the marketplace in proper working order."[30]

Traditionalism, which is concentrated most heavily in the South, opposes all government interventions except those necessary to maintain the existing power structure and would accept new programs only if they were necessary for the maintenance of the status quo. "Good government in that political culture involves the maintenance and encouragement of traditional patterns and if necessary, their adjustment to chainging conditions with the least possible upset."[31]

It is interesting to compare the chart developed by Dr. Stephen Loebs of Ohio State University documenting the variation among states in the provision of Medicaid-funded services (Figure 1) to the map illustrating Elazar's findings (Figure 2). For example, the southern states, with a predominantly traditionalist culture, provide only federally mandated services to their populations. On the other hand, the moralist cultures of Kansas and Washington provide benefits to four out of the five categories. In general, those states with the greatest amount of traditionalist culture provide services to the least number of categories. Those with a moralist culture provide the greatest number of services.

There are several exceptions to this generalization. Hawaii, for instance, provides aid to the maximum number of categories yet has both an individualist and traditionalist culture. This may indicate the difficulty in making

Title XIX States Classified by Groups Eligible for Medical Vendor Payments
Under Medicaid, January 1, 1970

A		A B	A B C	A D	A B C D	A B C D E
Alabama	Nevada	Delaware	Connecticut	Missouri	Kansas	Hawaii
Arkansas	New Jersey	California	Massachusetts	S. Carolina	Washington	Maryland
Colorado	New Mexico	Kentucky	Michigan	W. Virginia		New York
Florida	Ohio	Illinois	Minnesota			Pennsylvania
Georgia	Oregon	Nebraska	Oklahoma			
Idaho	S. Dakota	N. Hampshire	Utah			
Indiana	Tennessee	N. Carolina	Vermont			
~~Iowa~~	Texas	N. Dakota	Wisconsin			
Louisiana	Wyoming	Rhode Island				
Maine		Virginia				
Mississippi						
Montana						

FIGURE 1

Key

I. Federal Cost Sharing in Medical Expenditures and Administrative Expenditures

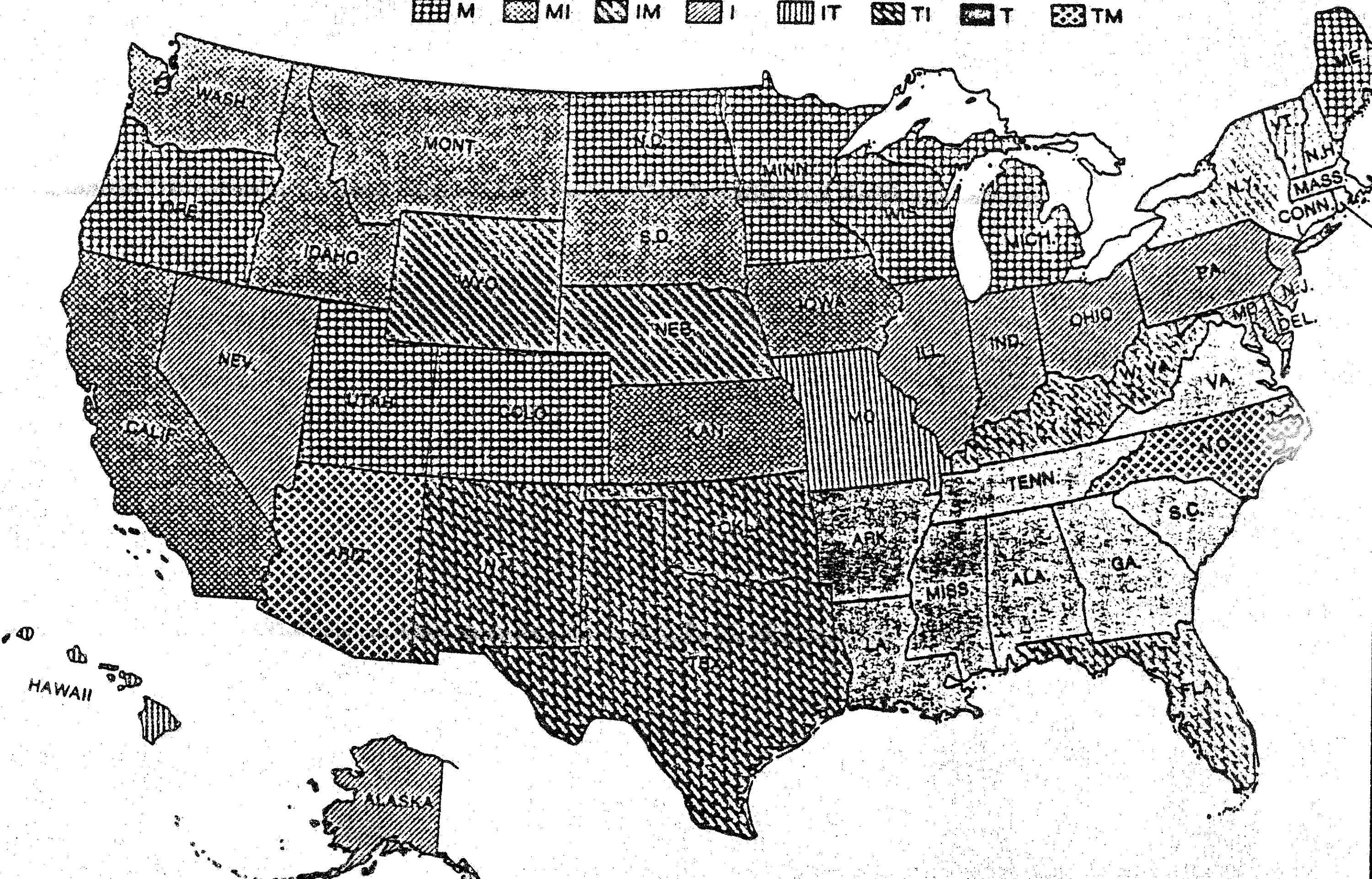
A = Categorically Related Needy
B = Categorically Related Medically Needy
C = Medically Needy Under 21 Years

II. No Federal Cost Sharing in Medical Expenditures (Cost Sharing in Administrative Expenditures)

D = General Assistance Recipients
E = Medically Needy Between 21 and 64 Years

Source: U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service; Assistance Payments Administration and Medical Services Administration, "Characteristics of State Medical Assistance Programs Under Title XIX of the Social Security Act", Public Assistance Series Number 49: 1970 Edition.

FIGURE 2



generalizations about the states, therefore, supporting the argument that a federal takeover is unrealistic because of state diversity and exceptions.

Research by other scholars supports Elazar's thesis that extensive variation exists among the states today. Sociologists Norval Glenn and J.S. Simmons conclude that regional differences are sharper than in the past in questions dealing with morals, political issues, international relations, and racial and ethnic minorities.[32] Political scientist Ira Shransky adds that "officials of leading states within each region are likely to generate their own innovations or take cues from leaders in other regions. The follow-the-regional leader communications network that prevails among most states helps to isolate their officials from direct national influence and permits the development of regional approaches to new programs -- even when such programs are sponsored and regulated by Federal Agencies."[33]

The Difficulty With Definitions

Even if the states had uniform political, cultural and ethical values, the problem of defning controversial and complex concepts exists to such a degree that a blanket federal policy at this time is unsuitable. For example, it is difficult to determine a definition for euthanasia which is specific enough to protect against misuse yet general enough to form a policy.

Theologian Paul Ramsey describes this difficulty in his analysis of the California Natural Death Act, the first state or federal law allowing for patients refusal of heroic measures:

> Any careful reader of the directive will see at once that it contains several quite ambiguous expressions. Among theses are "incurable", "terminal condition", "life-sustaining procedure", "artificially prolong the moment of death"; how these relate to "my death is imminent"; and the bearing of "whether or not life-sustaining procedures are utilized," whatever was the prognosis meant by those earlier expressions.[34]

Before any policy can be made on euthanasia whether by a state or national government, the concept must be digested by the public and understood by the individual. The technology which has brought this issue to the public eye is relatively new. There must be time for the implications of our new technology to be examined by both policy makers and the general public. Slowly, America's conception of death is changing. In the last ten years, there has been a distinct switch in philosophy from a life-at-all costs approach to a right-to-die ethic. As Ramsey notes, "We have come a long way in exploring what it means for individuals and groups to be responsible in making decisions regarding death and dying in the day of the biological revolution. There is much more openness in discussing the tragic decisions which sometimes must be made if individuals are to be responsible for their own life histories. In fact, 'death with dignity' has become something of a movement; the 'right to die' has become an almost faddish slogan."[35]

Scientists and moralists such as Ramsey caution against treading too hastily into these complex areas and making decisions by crisis. The moral and ethical consequences of euthanasia, especially in the cases of active killing of those presumed to be hopelessly ill or disabled, are far-reaching. Will active euthanasia, for example, become a method to reduce expenditures? Will governments use euthanasia as an excuse for genocide? What will happen to the moral framework of this country if we legislate killing? Are we on the verge of declaring war on the aged?

Leo Alexander's analysis of the medical practices and attitudes of German physicians before and after the reign of Nazism in Germany presents a chilling picture of what can happen when consequences are ignored and definitions are not distinct. He writes that the outlook of German physicians that lead to their cooperating in what became a policy of mass murders, "started with the acceptance of that attitude, basic in the euthanasia movement, that there is

such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to include the socially unproductive, the radically unwanted, and finally all non-Germans. But it is important to realize that the infinitely small wedged-like level from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick."[36]

At the present time, there are at least 49 death-with-dignity bills pending in 36 state legislatures. State governments, through the pressures placed upon them by their citizens, are beginning the slow process of determing policy for their areas. This decision-making process should remain at the state level.

The State As Policy Makers

As the issues involved with Medicaid-funded LTC grow increasingly complex and controversial, can the states answer the challenge? Historically, the answer has been "yes" with the states often responding to problems within their communities with innovativeness and sensibility.

Terry Sanford, ex-governor of North Carolina, describes the states as "laboratories of democracy." He quotes for support Supreme Court Justice Louis D. Brandeis who said, "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory and try novel social and economic experiments without risk to the rest of the country."

To cite just a few examples of state initiative in social issues:

- Mental Health. Kentucky's innovative training programs, Illinois' regional state-hospital clinics, and Maryland's community based programs have provided impetus for national programs.

- Education. States invented community colleges, pioneered in the use of instructional technology and pushed for universal education and consolidated high schools.[37]
- Abortion. 23 states considered changes in their abortion laws before the Federal courts took any decisive stand.[39]

State policy is often a reaction to the values considered important by its citizens. Oregon, for example, discourages economic development because its population has observed the problems caused by the influx of new settlers in its neighboring states of California and Washington. Minnesota protects itself against organized crime by a combination of strict legislation against betting, a vigilant judicial system and the attitude of its citizens.

The concept of citizen determination of state policy is important to remember before adopting a judgmental attitude about those states which provide benefits to only certain segments of their populations. Alabama, which provides services only to the categorically related needy, is often cited as an example of neglect in the social services and medical areas. In discussing what he describes as the "maligned states," Ira Sharansky concludes:

> "Alabama is another low-income state that shows unusual support for some public assistance....The state's economy is poor, and its population takes a conservative view toward the support of people who do not provide for their own needs.... However, the recipients of old age assistance do relatively well. The figures show payments to 'pensioners' -- as the old age recipients are labeled in Alabama -- rank closest to the national average....This class of the Alabama population receives the benefits of a program that is consciously mislabeled as a "pension progrm"; the rates and eligibility requirements are considerably more liberal than those applied to other welfare programs; and the state has responded quickly to new Federal grants in behalf of the elderly.[40]

(A discussion of what states are presently doing to provide better Medicaid funded LTC can be found in the "Levels of Care" and "Standards of Care" chapters of this book).

Is A Quality Life Possible?

A state's fiscal response to the needs of its aged is only one indicator of its concern for the quality of life of its elderly. It can be argued that no matter how generous the state and federal government are with medical benefits, quality life will always elude some of the aged because of their view of Medicaid as a "handout." If a major determinant of quality life is a feeling of self-respect and independence, the concept of Medicaid itself may work against the elderly. Alabama has been one of the few states to make a conscious effort to preserve the pride of the aged by deliberately naming its program "Old Age Pensioners," therefore removing the welfare onus from the recipients.[41]

The attitude of a community toward its aged may not be reflected in how much of its tax dollars support Medicaid. In some states, especially those with a traditionalist culture, the norm is for members of society to take care of their own. (See the section on non-whites and Medicaid-funded LTC for an examination of ethnic groups and their view on aging).

Sociologists John Lozier and Ronald Althouse document this occurence in rural West Virginia and conclude:

> What is required for successful old age is the continued existence of community or neighborhood systems which can recognize and store credit for the performance of an individual over a whole lifetime and which enforce the obligation of juniors to provide reciprocity. Without such a system, the help that is provided to an elder robs him of his dignity, for there is no recognition that this is his due, and not a form of charity.[42]

Just as it is important to destroy the myth of the aged as serene human beings going gently into the night, it is also important not to paint a picture of utter despair among the aged. In many parts of this country, the nuclear family does expand to include an elderly parent who needs LTC. The rise of the Grey Panthers and the extension of retirement age until 70 are indicators of a growing militancy in the elderly population which may result in increased political power. Attitudes toward aging, like attitudes toward death, are changing.

As the fabrie of our society changes, so must the individual change. L.F. Jarvile, in his investigation of aging suggests that, "It always comes as a surprise to younger people that many older adults experience life's high satisfactions. The finding of social science research reports that life satisfaction is not unduly low in the aged; and many older adults report greater satisfaction at their present late stage of living than do young adults. The evidence suggests that most older adults have not grown old, sick, poor, and lonely. Indeed, they are more concerned with opportunities for learning and experiencing life than the young are prepared to believe."[43]

Quality life for Medicaid funded LTC patients will increase when public pressure within the states comes to bear on the issue. Variation of the quality of life among states and communities will always remain, and this variation will provide the flexibility needed for an aging population to coexist with a young population.

The ethical problems concerning quality life are as difficult as those of euthanasia and need the same careful thought. Should we allocate our money to the study of aging or childhood diseases? What price do we want to pay to guarantee the aged quality life? Are we looking for something that money can not buy? If allocating resources is not the answer, how do we integrate the aged population into society in a way that promises a better life for all?

Conclusion

This paper has shown that we are faced with difficult and complex ethical problems in relation to Medicaid funded LTC. The solution to these problems is not waving the magic wand of a federal takeover, but rather in careful examination and innovative solutions at the individual, community and state level in cooperation with the federal government.

The United States is a country with a diverse population which has led to innovative ideas and programs. To superimpose a federal system upon the states in the area of health care for the aged would neither consider the different values within and among the states nor provide for the priorities set by taxpayers. The states would probably, if history can predict, synthesize a federal program for their own use, therefore both defeating the purpose of a federal takeover and voiding the responsibility of the community and the state to its people.

In addition, the changes that have occurred through the advent of new technology and social services need more examination before decisions can be made. The changing attitudes of Americans toward death and aging will bring about the most far-reaching improvements in LTC. When we finally learn to live with death and the aging process, we will have conquered most of our problems.

The challenge of today and the years until 2020 is to use diversity and flexibility as our strength.

FOOTNOTES

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[43]Jarvik, Aging Into the 21st Century, p. 553.

CONCLUDING COMMENTS

Each of us, at some time or another, is consoled by the belief that some centralized power, be it a person, group or institution, is ably directing the complex systems that serve our society, and thus freeing us from the strenuous task of understanding the vast complexities of our institutions. In a benign and superficial sense, this myth of the "super competence" is akin to Ernst Cassirer's myth of the state for it directly affects our approach to reality. In part it is beneficial because it helps people believe that society is serving them. But the myth has its costs; to the "super compentence" we willingly relinquish control. Occasionally, our faith is shaken and we become angry or frightened enough to do something. For example, the Three Mile Island nuclear power plant accident and the attendant efforts by many to comprehend the intricacies of nuclear power production have made us painfully aware that the mechanisms of control are not adequate. Although the multiple problems which exist in our health care system for the elderly do not have the dramatic impact of Three Mile Island, surely they present a comparable policy problem which must be solved to avoid increasing human misery.

The time to consider our futures, who will care for us when we are the sick and the aged, is now! Today, the answer to that question is often the skilled nursing facility, the most expensive way for society to bundle off the chronic health problems associated with aging. As the elderly increase as a portion of the population, the increase in payments for LTC will cause a massive redistribution of wealth, far outstripping inheritance taxes and other mechanisms for transferring wealth from one generation to another. It will eat away at our national savings and the domino effect it generates

may affect the housing industry, industrial investments and other forms of industry reliant upon a ready supply of capital.

Chapter I of the General Accounting Office report entitled, "Entering a Nursing Home - Costly Implications for Medicaid and the Elderly"[1] relates the dizzying evolution of Medicaid and its relationship to LTC. The chapter starts by pointing out that when Medicaid was enacted in 1965 it was felt that it would only give rise to modest increases in expenditure beyond the $1.3 billion cost of the vendor payment programs it replaced. Medicaid was activated in 1966; by 1968 the cost was $3.5 billion; by 1975 it was $12.5 billion; and by 1978 it was $18.6 billion. In 12 years Medicaid expenditures rose by 1330% above the 1966 base of $1.3 billion. Even accounting for inflation in the health area, the increase is in excess of 1100%.

There are several reasons for this growth in expenditure but the major one is the coverage of nursing home care. A full $7.6 billion, or 41% of the 1978 Medicaid expenditure is for LTC. The Institute for Medicaid Management projects that the Medicaid expenditure for LTC should reach $9.4 billion by 1984.[2] Given the track record for estimating future expenditures in this area, one might guess that even this figure represents a rather conservative guess.

If this expenditure trend continues, LTC will eventually become a burden our society will be unable to bear. By the early part of the 21st century, as the children of the post World War II baby boom move into the 70's, the level of expenditures will be so high that services may have to

[1] General Accounting Office, Entering a Nursing Home - Costly Implications for Medicaid and the Elderly, November 26, 1979, pp 1-15.

[2] Institute for Medicaid Management, Data on the Medicaid Program: Eligibility/Services/Expenditures, Fiscal Years 1966-78, DHEW, Washington, D.C., 1978.

undergo a forced reduction at the very time when consumer demand will be most intense. If we cannot control the LTC system within the next twenty years, the stage will be set for a significant decrease in the living standard for the elderly, the possibility of passive euthanasia as a programmatic necessity, and the probability of wide spread misery for our elderly.

Not only is LTC excessively expensive, but the system which has evolved to care for the sick and the aged is excessively complex. At the root of the problem of escalating costs and control is our health care policy process itself. Historically, the "Great American Policy Compromise" has involved giving the political liberals their pet programs and helping the conservatives lick their political wounds by letting distant state governments run many of the programs. Many "short circuit" devices have been tried to foil the great policy compromise. Lyndon Johnson's "creative" federalism sent aid directly to the distressed cities and even to community groups looking for innovation and effectiveness. Richard Nixon's "new" federalism gave local jurisdictions new freedom within the framework of bloc grants so that they might do what the idiosyncratic local political structure might want most. However, both left unchanged the policy compromise struck in 1965 with regard to health care. In this compromise, most of the health care power went to the states.

In response to the confusion and disarray caused by the federal/state compromise, the PMS has tackled the very basic questions of LTC - who shall administer, finance, structure services, regulate and allocate values for LTC? Our answer is not yet another "new" federalism or a return to the

halcyon days of state independence. Our conclusion is that we must reassess the LTC system in its entirety, considering all incentives and values.

As Sandra Caccamise has stated in her chapter on the administration of LTC, the present structure depends upon an unenthusastic "partnership" among federal, state and local units of government. In reality, LTC is rendered by governments, by the private non-profit sector and by the private sector. To the states go the tasks of partially funding, regulating, setting standards, and encouraging innovation for LTC. Although the federal government assumes the role of technical advisor for these functions, its real task is to provide dollars.

The next thirty years of LTC regulation will see the federal government breaking out of the pattern set by the "Great American Policy Compromise"; it will dramatically increase its authority and powers. While it is improbable that the diffuse LTC system could be federalized, some of the PMS seminar participants saw greater federal participation even to the extent of direct participation in administering a small percentage of special purpose and pilot long term care facilities. The federal role and span of control will increase, but so will that of the states. New York State is committed to the regulation of LTC perhaps to a greater extent than most states and will become a national model. The PMS seminar noted that the level of state intervention in long term care will escalate, especially as more and more legislatures struggle to understand and get control over their own Medicaid programs.

The increasingly important roles of the federal and state governments is merely part of the present trend. We hope to see other administrative

structures eventually replace both the state and the federal government in LTC because both represent illogical outposts from which to run LTC. Various levels of government inherited LTC by default, an uneasy partnership developed, growth was uncontrolled, costs zoomed - the system was out of whack primarily because no one was clearly in control. This situation leads us back to the all important question, "Who will take care of me in 2020?"

We ask you, the reader, to speculate upon the solutions presented here. Perhaps, the answer can be found in one of the ideas included in this paper. Perhaps these solutions can provide a starting point, a base upon which to build sound cost containment strategies, levels of care, central screening mechanisms, and reimbursement procedures. Perhaps we will have to find other solutions, not suggested herein. We feel we have fulfilled our responsibilities just by raising the question of our needs with regard to LTC. We propose no miracles in this modest little monograph, but we hope that when the bell tolls for the LTC of the post-war baby boom, it will not signal the bankruptcy of society also.

APPENDIX I

MEDICAID REIMBURSEMENT FOR LONG TERM CARE: PROBLEMS AND OPTIONS

Rick Hug
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SUNY Simulation
22 June 1979
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INTRODUCTION

We shall attempt in this paper to present some of the more important problems associated with Medicaid reimbursement for long term care (LTC) and pose some strategies for attacking those problesm. Since political values are important determinants of the way public policy problems are viewed, we shall begin our analysis by describing the values that have shaped the problem for us.

POLITICAL VALUES

Respect for Individual Rights

In our society, individual rights and freedoms have always been given special attention. Protecting the "inalienable" rights of those who cannot care for themselves is part of this tradition. "Respect for individual rights" requires that long term care be continued in the future and has implications for what can be considered acceptable care. Individual rights to privacy the pursuit of happiness, self-determination, and freedom must be safeguarded.

Private Sector Involvement and Accountability

It is appropriate, often, desirable, for the private sector to become involved in carrying out important public responsiblities. When this occurs, it is important that a chain of accountability be maintained. Providers of long term care must be accountable to elected officials, patients and their families, and local communities. They must be accountable not only for the accountable not only for the appropriate use of public funds but, more important, for the safety and well-being of patients and the protection of their individual rights.

Economy, Efficiency, Effectiveness, and Equity

Funds spent for public purposes should actually accomplish those purposes (effectiveness) in the most direct way (efficiency) with the least burden to the taxpayer (economy). Public programs should be fair (equity) to providers and consumers alike; allowing a reasonable profit for providers, with equal

access and consistent eligibility determination for consumers.

Although it is easy to address problems with respect to a single political value, it is hard to find procedures that yield improvements with respect to all values. For example, using the private sector to accomplish a public purpose is valued. The profit motive, however, tends to divert the providers' attention from serving the public purpose and lengthens the chain of accountability. Efforts to achieve economy and efficiency run headlong into the problem of assuring concern for human dignity. As it is not possible to obtain optional results with respect to a single value without sacrificing other values; stategies, structures and methods must balance gains with respect to one value against losses with respect to others.

PROBLEM - 1: Environmental Factors

The LTC sector of the health industry is a part of that industry; deficiencies in other areas, such as preventive medicine and ambulatory care, effect the resources needed to care for patients at the LTC level. Impoverished individuals without adequate access to lower levels of care will wind up at the higher levels of care. Individuals not receiving needed check ups are more liable to become incapacitated through detection of diseases at later, less treatable stages. At the LTC level, with its high per patient expense, Medicaid pays over 50% of the cost. Efforts, beyond the scope of this paper, are needed at the lower levels of care to effect long term reductions in LTC costs.

Changing demographic characteristics may lead to increased LTC costs. New York State estimates an 8% increase in the age group of 65 years and older and an 11.5% increase in the age group of 75 years and older between 1970 and

1980. Studies indicate that the prevalence of chronic diseases, impairments, and utilization of medical services increases with age. (Select Committees on Aging and Population, 1978: 124). The proportionate number of residents in LTC institutions increases with age (Select Committees on Aging and Population, 1978: 127).

The final environmental constraint mentioned here is the nature of the market as a whole. Cost containment is limited by insulation of consumers and providers from costs through third party reimbursements, patients are not knowledgable consumers of sophisticated care to limit unnecessary use, additional costs entailed by large third party coverage, and gaps in insurance and government coverage encourage inefficient use (Cahill, 1977: 26; CHIPS, 1978: 12; Davis, 1975: 3, 11).

These issues must be addressed at the national level for LTC cost containment and better, more efficient care.

PROBLEM 2: Mechanism for LTC Placement is inefficient, resulting in longer stays than necessary and misplacement in higher levels of care in the LTC system.

Early studies (GAO, 1971: 30; Spiegel, 1979: 16) indicated a 20% misplacement in a higher, more costly level of care than needed. At these higher levels, the patient is more restricted and has less freedom; the inefficient placement costs more as well. Since these early studies, a standardized rating form, the DMS-I, was instituted. Current levels of misplacement are between 5 to 8% for Skilled Nursing Facilities (SNFs) in Monroe County, and 25% for Health Related Facilities (HRF) (Monroe County LTC Program, Inc., 1977b: 2,6). This may be understated, as a 1978 study (CHIPS, 1978: 26) done at a state hospital indicated that of patients discharged to nursing facilities, of those with

similar ailments, 100% of those on public assistance were institutionalized compared with 30% of the remainder.

One reason for this misuse is lack of consideration of alternatives. The Select Committee on Aging (1977; 32) found that in Massachusetts fragmentation in the delivery system for Home Health Care (HHC) made placement easier in SNFs and HRFs. The HSA of NYC found a similar fragmenation in the HHC delivery system (1977: 500). It takes less time to arrange care with one agency than to arrange different services with several.

Multiple access points compound information gathering for planning purposes and placement decisions. In Onondaga county 30 planning, placing, and delivery agencies provide access to the LTC system (CHIPS, 1978: 31). Data was not given for Ames County. Multiple access points may also retard entry into the system by ignorance of available facilities, engendering delay in acute care facilities.

Lack of an organized placement system also hinders changes to other levels as patient conditions change (CHIPS, 1978: 3). Lack of knowledge of openings may result in inadequate or too much care.

PROBLEM 3: Restricted definitions of levels of care and limited reimbursement alternatives results in poorer care at higher cost.

The current defined levels of care uncer Medicaid are SNFs, HRF, Domiciliary Care Facility (DCF), and Home Health Care (HHC). Patients do not fit neatly into those categories. A study done at Upstate Medical Center showed DMS-I form scores above the state median. This was a factor in late discharge from acute care facilities. This indicated that another level of care was feasible (Mascherry, 1978: 9). A study cited by the HSA of NYC (1977: 457) indicated

25% of those surveyed in SNFs needed more care than they were reimbursed for or provided. 40% did not meet the SNF standard for level of care, but were above thelevel of care provided at HRFs.

Another study cited by the Monroe County LTC Program, Inc. (1977: 1) states that a constraint in HHC use is thelack of consistent definitions against which appropriate home care services could be applied.

Gaps in HHC coverage are cited by Senator Tarky Lombardi, Jr. (Lombardi, 1977b). The HSA of NYC projects a need for 50,000 to 70,000 persons to be serviced through HHC (1978: 233).

PROBLEM 4: Lengthy periods in determining eligibility, price ceilings set below the private rates, and reasonable cost reimbursement mechanism tied to a cost basis yields inequitable care disincentives for institutions to take Medicaid patients, and lack of ability to control cost.

The lengthy eligibility process cited in the simulation data hinders transferral of patients between levels of care. This results in unnecessary costs and does not enhance patient care. The SUNY study (Macsherry, 1978) states that 16.9% of those sampled were delayed from discharge from acute care facilities by lengthy eligibility assessment procedures.

The reasonable cost reimbursement formula leads to inflation and inefficiency by allowing more sophisticated equipment and those with higher costs to be paid more. (Cahill, 1977: 28) The Moreland commission found that cost variations in care were not related to the need for care.

Low ceiling rates are cited as detrimental to development of alternative care in two GAO studies (1977c: 41; 1974a: 35). Low rates combined with high admission standards force many of the highest need patients, and therefore the most costly to care for, away from voluntary facilities and into public ones.

This creates higher cost for the public institutions.

PROBLEM 5: There is a need for greater accountability in the reimbursement system. Greater financial accountability needs to be tied to better quality assessment to ensure abuses.

GAO investigation of New York State audits yielded additional undiscovered excess claims (1977a: 10, 34). Specific comments can be found in a 1979 study by GAO (1979b: 26,27).

The Finger Lakes HSA (1977: 106) found that help was not available or known to all. The infirmities of the patients, and that many of them are alone, restrict their ability to bring litigation.

Better coordination is needed amoung regulatory agencies. A GAO study found two cities where agencies were not notifying each other of results (1977a: 28). The Finger Lakes HSA (1977: 106) cites the need for quality measures of outputs (patient goals) rather than inputs alone.

PROBLEM 6: Limited federal participation in LTC places an undue burden on state finances.

Medicare copayments and deductables have to be picked up by Medicaid for joint eligible patients. Medicare coverage is limited to 100 days of care, and then only after hospitalization. There is a homebound requirement for eligibility for HHC. LTC costs should be shared more equitably.

PROBLEM 7: Patients remain in acute care beds longer than necessary.

This is a result of the problems above. The simulation indicates that there is a shortage of SNF beds; this is a cause for longer stays, but partially is a result of the other problems itself. Another cause for this problem is an excess of acute care beds in New York (Cahill, 1977: 202). Excess beds cost money to maintain, with no income to offset the cost. There is therefore an incentive to keep patients longer.

SOLUTIONS

The values chosen limit the range of alternatives to increase quality and cost effectiveness of the Medicaid LTC program. In addition, the problems listed under the first problem area act as constraints as well.

The solutions here are orientated to changes that can be made in the near future to give better care and greater freedom to individuals while increasing accountability and cost effectiveness.

A keystone in bettering the present system is the establishment of central administration units patterned after the ACCESS program in Monroe County. This pilot unit has the responsibility for prior approval of service use, level of care determination, case management, and placement in the LTC system. Units would serve as a focal point for collection of data on care needs vital for planning future construction and service systems, thereby helping to reduce future costly backlogs and ensure facility availability for various levels of care.

The agency would serve all prospective LTC patients, eighteen years or older, regardless of their funding source. A casework system- using a team of physicians, nurses, and social workers to determine placement considering psychological, social, and physical needs- would ensure optimal match between patient needs and the level of care. This would result in cost reductions by eliminating misplacement in higher levels of care, freeing beds for patients and thus reducing hospital backlog. Part of these savings would result from serving as a focal point for HHC services, thus having adequate information to provide a mix of services for a patient from the scattered HHC and existing community services.

Tailoring the right level of care would aid in maintaining the dignity of the patient by considering all his needs, not just the medical ones. Maximum use of home facilities and lower levels of care will help keep the patient in familiar surroundings longer, cutting down on future possible institutional placement. By serving as a referral source for the private patient, some cost containment could occur through more effective placement of private patients and awareness of private patient needs for planning purposes.

The Monroe County LTC Program, Inc. (1977b) estimated savings of $1 144 329 to Medicaid alone for the fiscal year 1978 as a result of diverting 7% of SNF and 25% of HRF patients to more appropriate levels of care. They also claim that ACCESS would totally reduce the acute care patient backlog waiting for placement in other levels of care. Whether this complete reduction and subsequent savings would occur in Ames County is uncertain.

Accountability would be enhanced through the case system, as it would allow a better assessment of the quality of care received in relation to patient goals set in the assessment and placement process.

This one structure thus deals with problems 2, 4, and 5 and perhaps comes closest to fitting all the political values affected by a solution.

We recommend expanded study of such alternatives as hospice care, respite care, and enriched housing as providing increased flexibility to the system. Those found to be of merit, we recommend a grant system similar to that in N.Y.S. Senate Bill 1107 to provide aid for expansion of facilities. This would allow a better match of patient and care level and remove some of the current financial bias toward institutions. Construction or expansion of facilities should be controlled through the Certificate of Need process in conjunction with existing HSAs and the new ACCESS units. Greater dignity

would result from receiving more tailored care at more appropriate levels. Better care level match would reduce inefficiency in the system, saving dollars. More levels would allow easier movement between levels, reducing waiting times and costs.

Hospice care is an example. The GAO study on hospice care (1979a) indicates that although hospices do not fit into any Medicaid LTC category, certain functions are covered. Hospice use of palliative care rather curative care for terminally ill patients would appear to cut down unnecessary suffering and costs occured from extreme life prolonging measure. The family and patient are treated as a unit and given services, such as death follow up and care for the family, that ease suffering. This type of treatment should be encouraged.

Where possible, expansion of alternative levels should be through conversion of existing facilities, such as excess acute care beds. This would provide a disincentive for extended acute stays engendered by need to fill excess beds. The Certificate of Need program should also be used to facilitate multi-level care institutions and agencies; this would facilitate interlevel transfers and spread high-care patient costs. Quotas for the high cost patients should be established to spread institutional costs for these patients amoung facilities and facilitate earlier placement.

We recommend increased coverage of alternate care level services as well. At present this could be accomplished through initiatives such as N.Y.S. Senate bill 6345, "Nursing Homes Without Wheels," which expands HHC coverage. Results as to whether cost reduction would occur are mixed. Increased eligibility might lead to increased use and no overall cost reduction (GAO, 1977: 22). Some studies cite cost savings through addition of homemaker services (GAO, 1977: 30). Increased coverage would allow those treated at higher levels to switch

to lower levels, increasing individuals covered for the same cost.

Federal regulations mandating the reasonable cost reimbursement system should be changed to allow a negotiated reimbursement system. Rates set below market prices, as in Ames County, lead to problems cited previously. Rate inflation is a problem of the health care industry in general, and in the long term can only be cured at the federal level. Negotiated rates would allow operators to receive an amount commensurate with market rates, while offering better containment. Governor Garrahy of Rhode Island attested to the effectiveness of this strategy (Select Committee on Aging, 1977: 21).

Federal attention should be directed to the LTC industry. Efforts to expand private coverage should be initiated. Further grants to promising alternatives to existing systems should be given. Medicare coverage should be expanded by reducing eligibility restrictions and adding services. Institutional care is next to the most expensive level of care as far as cost is concerned. Reducing gaps in Medicare would help ease the burden on states and provide more state money for other types of care.

An ombudsman position should be created with adequate staffing and funding to provide a better voice for infirm patients. Many Medicaid recipients lack funds to press abuse litigation; the mostlseverely disabled patients, particularly those without families or whose families are geographically distant, lack an adequate voice for stating their complaints. Giving them that voice would increase accountability of the institutions and assist current auditing efforts.

Pilot programs with performance auditing should be instituted, possibly in conjunction with Professional Standard Review Organizations (PSROs). In conjunction with the ACCESS case management system, this would help to tie fiscal inputs with patient outputs, helping to better reveal unnecessary costs.

SUMMARY

This text has examined some of the problems, causes, and solutions with the LTC health sector and Medicaid reimbursement. The solutions cited are in concurrence with the political values we have stated. Streamlining the pla placement system and expansion of alternatives would insure care more in keeping with the maintenance of freedom and dignity for the patient by allowing better use of less institutionalized facilities and more effective use of existing institutions. Costs could be better accounted for and more adequately restrained with a negotiated reimbursement system. Accountability would be enhanced through the ombudsman program and through greater orientation of the system to patient outcomes.

These actions will not cure all Medicaids ills, some of which are beyond State control, but do represent significant improvements and steps towards eliminating many of them.

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LONG-TERM CARE: MEDICAID REIMBURSEMENT

Does High Cost Yield High Quality?

Public Management Simulation Presented by:

Maria Muscarella
Jean Rosenthal
Garrett Sanders

"Society has the obligation to assist the poor and the aged. Among the ways it should help them, is by providing minimal levels of health care."

From

The Sociology of Health Care

Darryl Enos

INTRODUCTION

As the Albany State team began to look at the problem of Medicaid reimbursement, we ran into a mass of regulations, data, and literature that said confusing, and often conflicting things about government policy in this field. Since we are not experts on Medicaid, and because of the limited time of the simulation, we set out to put this sea of material together.

Our paper was written in adherence to three values:

1. Quality health care should be provided by the government for those who need it.
2. That care should be provided as inexpensively as possible.

and

3. Changes in the Medicaid System should not cause an increase in bureaucratic machinery.

We began our study by asking: Where do these three values fit into the Medicaid system? What is the purpose of Medicaid? The Federal government said in 1966 that its purpose was to provide and finance quality health care for anyone needing it. That purpose of Medicaid is still in effect today. Yet, many people (we focus on the elderly in Ames County) are sick. They are sick because they are too poor to afford quality health care. Somewhere there is a problem. At this point we asked: Is Medicaid meeting its stated objectives as effectively as possible?

Next we tried to search for the roots of this problem. We looked at items such as the Federal/State cost sharing equation and the issue of reimbursement policy itself and asked: Are these causes of the problem, or are they just symptoms of a more fundamental dilemma? We view the problems of reimbursement policy as indicative of ills with the total Medicaid system.

We concluded that the root of this problem lies in the structure of the Medicaid system itself. While the basic goal of Medicaid has not changed since its inception in 1966, the means of achieving this goal has. A "new" value, cost minimization, has entered the scene. In 1966, cost was no object to a Medicaid administrator. The duplication of facilities, bookwork, and the staff functions between Federal, State and County agencies administering Medicaid is an example of the spendthrift values that characterize the system.

Today, however, cost is an object. Cost containments is a critical factor that plagues the administration and delivery of all Social Services. The Medicaid Administrator today wants to provide quality health care, but he wants to do it as cheaply as possible.

After eyeballing the problem of providing quality care at minimal cost, we thought that the government may better implement the Medicaid program today by facing up to the austere realities of cost containment. The Medicaid system must adapt itself to fiscal constraints. If the government can become a better businessman, the altruistic objectives of Medicaid may be met more effectively. In other words, the government must learn to speak the language of proprietary nursing homes - the language of the "profit motive". The symbols of that language are dollars and cents; their configuration meaning either "incentive" or "sanction."

We believe that the government can "tune in" to the language, and improve the delivery of long-term health care services by:

1. Recognizing that cost containment is a critical factor in providing Medicaid.
2. Eliminating the waste and inefficient of Medicaid Administration.

and

3. Providing appropriate placement for Medicaid patients.

The remainder of this paper will address: 1) The related causes and problems of Medicaid reimbursement, and 2) Recommendations for alleviating or soothing the effects of those causes.

THE PROBLEM: HOW TO PROVIDE QUALITY CARE AT A MINIMAL COST

The most troublesome aspect of Medicaid is its high cost. Presently, over ten percent of the Ames County budget is allocated for payment of Medicaid bills.

There are several causes for the excessive cost of Medicaid. First, a major portion of Medicaid reimbursement costs is due to the overuse or inappropriate use of services by long-term patients. For example, many elderly patients are forced to wait in acute care facilities (i.e. hospitals) before they gain admittance to either Skilled Nursing Facilities (SNF's) or Health Related Facilities (HRF's). Since hospital stays can be as much as five times as expensive as most nursing homes, Medicaid must bear the unnecessary financial burden. This delay in placement is compounded with the inappropriate placement of long-term care patients in facilities which provide a greater level of care that the patients may actually require. Inappropriate placement of patients is widespread in Ames County as evidenced by the one-day census statistics comparing occupancy in HRF's with that of SNF's. The data show that there is a surplus of space in HRF's with a corresponding increase in the number of "Unoccupied, Unavailable beds" in SNF's. In other words, the wasted space in SNF's is wasting Medicaid money.

Why is there such inappropriate use of Medicaid services? One reason is that private nursing home owners are reluctant to take Medicaid patients into their facilities. This is because government regulations make it more profitable for a nursing home to care for a private patient rather than a Medicaid patient.

For example, Medicaid reimburses nursing homes at a much lower rate than that which can be received from private patients. Also, long delays in the determination of patient eligibility for Medicaid, and, lags in the actual reimbursement, make nursing home operators skeptical of accepting Medicaid patients. The nursing home operator hears that his facility will have to bear the cost caring for a patient declared ineligible for Medicaid. Another reason for the inappropriate use of Medicaid services is the lack of coordination and consistency among the regulations put forth by three governmental levels (i.e., Federal, State, and County). For example, the myriad of stipulation placed upon Medicaid regulations as they proceed from Federal to State and County governments causes a private nursing home owner to drown under bureaucratic "red tape".

A second reason for the high cost of Medicaid underlies the growth of "red tape" in this system. The prevailing attitude among those who administer Medicaid is that quality care is accurately measured by the amount of dollars spent by a facility in pursuit of that care. The problem is that standards of quality care differ per level of government. For example, Federal and State regulations require different numbers of professional staff per occupied bed, in a nursing home. The nursing home operator has no choice in situations such as this but to meet the most demanding (i.e., expensive)standard in order to please each governmental level. This appeasement is a major cause of costly Medicaid bills because the most expensive standard is not always the most effective.

The inadequacy of equating quality health care with dollars spent on achieving that care is reflected in the amount of "wasted" services that government regulations force nursing homes to provide. For example, the literature documents cases of long-term patients receiving unnecessary x-rays, drugs, and therapy because they were prescribed by government regulations. In other words, there is no guarantee that a high cost program will be of high quality.

The third reason for high Medicaid reimbursement costs is the amount of inefficient and fraudulent practices which occur throughout the system. The root of this problem lies in the lack of coordination among Federal, State and County regulations, regarding Medicaid. In addition, each level agency consistently failed to supervise and enforce regulations dealing with the fraudulent abuses of the system. In effect, each level of government added regulations instead of supervision thereby aggravating not relieving the problem. This lack of supervision gave individuals the opportunity to manipulate the regulations to their advantage.

This practice was exposed by the Moreland Commission's Report which discussed how several nursing home owners had consistently overestimated operational costs. Also, property costs estimates were inflated due to other fraudulent practices. In addition, insufficient funds were allocated to government auditing departments. This reduced government effectiveness in controlling Medicaid costs. However, some improvement has been noted in this area (as a result of the Commission Report) but continued efforts are essential if abuses are to be eliminated.

Finally, the Federal/State cost sharing equation results in high Medicaid reimbursement costs to Ames County and the State of New York. In effect, this equation discriminates against wealthy states because it uses median income as the indication of a state's ability to pay for Medicaid. The equation does not consider the amount of optional Medicaid services provided by a state (e.g., vision care) or the number of residents utilizing Medicaid services. In other words, this equation provides no incentive for states to expand Medicaid services for more people.

To summarize, there are four causes of high Medicaid reimbursement costs in Ames County, New York:

1. The inappropriate use of Medicaid facilities and services.
2. A disparity between costs and quality of health care.
3. Inefficiencies, loopholes and fraud.

and

4. The discrimination of the Federal/State cost-sharing equation against wealthy states, such as New York.

GENERAL RECOMMENDATIONS FOR THE ADMINISTRATION OF MEDICAID*

We have emphasized throughout this paper that government values regarding the provision of long-term health care have changed since the inception of the Medicaid Program in 1966. The "new" value is saving money. In the dim light of the present fiscal crunch, government administrators must pay close heed to cost containment and ways to exploit the profit motive.

Therefore, we believe that the government has a choice in determining the future of long-term health care:

1. The government can take over proprietary facilities and operate long-term health care without profit. This course of action, however, violates our third value which seeks to limit the scope of the government in this issue.

*Some of our recommendations have been adapted from the Moreland Commission Report.

OR

2. The government can develop mechanisms that use the profit motive toward the end of improving long-term health care. This can be done by putting an end to the reward of inefficiency and duplication in the delivery of Medicaid services. Also, the government should try to reduce the mandatory expenditures of nursing homes which show no relation to improved care (i.e., reject the "equation" between higher costs and greater health care). This is our first general recommendation.

Our second general recommendation refers to the fourth cause of high Medicaid costs (as outlined in the previous section), the discriminating Federal/State cost-sharing equation. We believe that provisions should be made in the equation to reflect - 1) the number of state residents utilizing Medicaid services, and 2) the quality of that state's service. The equation should be structured so that it rewards states that the most effective Medicaid Program.

A third general recommendation refers to our third cause of high Medicaid costs and calls for the reduction of paperwork, duplicated regulations, and administrative inefficiencies of the Medicaid program (it has been said that some nursing home administrators spend up to forty percent of their work day doing paperwork!). The three levels of government should strive for coordination of regulations so to facilitate the dispensing of long-term health care.

SPECIFIC RECOMMENDATIONS FOR THE AMES COUNTY SOCIAL SERVICES DEPARTMENT

I. Regarding the placement of long-term patients:

A. Clear, consise placement procedures should be developed by the Ames County administrators. Also hospitals, nursing homes, and social service agencies

should hire "Placement Officers" to be responsible for all placement activities.

B. Placement procedures outlined by the "Placement Officer" should go into effect as soon as the patient contacts the local social service agency OR has been admitted to a hospital for acute care.

C. Utilization Review Procedures (as suggested by the Moreland Commsion should be continued and expanded).

D. Limits should be set on the number of beds a SNF or HRF may classify as being "Unavailable if Unoccupied". Also, each SNF or HRF must accept a certain percentage of Medicaid patients. This, we hope, will eliminate some patients being turned away because they were labeled as "difficult cases".

E. Eligibility procedures should be simplified so that nursing homes will be able to avoid the absorption of costs due to the rejected patients.

II. Regarding the definition of "Quality Care":

A. A Quality Care rating system should be developed in which "quality" is determined by three factors:

1. Patient response to received care, and
2. The patient's relative response to care, and
3. Testimony of expert reviewers (e.g., Doctors)

Also, quality is to be measured by the actual care received by a patient - not by the technological, staff, and fiscal resources of the facility.

Also, the facilities receiving the <u>highest</u> quality ratings should receive the highest medical reimbursement (i.e., operationalize the "profit motive").

Also, the facilities receiving the <u>lowest</u> quality ratings should lose certification, and be

conditionally subject to legal suit in violation of the patient's right to quality health care.

B. Quality Ratings should be made public by:

1. Conspicuous posting in the facility
2. Distribution to the Supervisory Social Service Agency
3. Distribution to the Media (in extreme cases)

CONCLUSION

The above recommendations suggest a new focus for government policy in the providing of Medicaid services. To put it simply, the government needs to provide incentives (and sanctions) that make the business of caring for the elderly profitable to proprietary nursing home. Although "profit" and "quality care" are strange bedfellows, the government must adapt the Medicaid system to keeping them close (i.e., maintaining a positive relationship between profit and quality care).

There are lessons from this specific problem that can be applied to other problems in the financing and disbursement of social services. The policy issues of Welfare and Social Security, for example resemble those of Medicaid in that these social services face austere futures, cries for cost containment, and demands for effective programming. One lesson that may be of use in dealing with these issues is:

> The government might become more effective in providing social services if it shapes its regulations in terms of the special needs of the organization (or people) which dispenses (or utilizes) that service.

For example, some of the abuses of Welfare or Social Security might subside if it becomes unprofitable for recipients to try to "beat the system".

Another lesson is that coordination between the three levels of government is essential for the provision of cost/effective social services. In other words, the right hand must know what the left is doing in order for them to work together effectively. We think that the three government levels must plan together (i.e., seek feedback from one another) in the provision of social services so that inefficiency in the administration of those services lessen.

We think that this systems approach to the cost/effective provision of social services is essential for the survival of these services in America.

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THE LONG-TERM CARE MEDICAID REIMBURSEMENT PROBLEM

THE
AILING
HEALTH-
CARE
SYSTEM

PUBLIC POLICY ANALYSIS AND STRATEGY DEVELOPMENT

The SUNY BROCKPORT PUBLIC ADMINISTRATION TEAM:

Jean S. Doremus, Jeanne B. Hutchins, and Laura B. Volk

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INTRODUCTION

A growing public concern about the high cost of Medicaid reimbursement for Long Term Care (LTC) has created the need for careful analysis of the causes & consequences of past public policies and to develop strategies that provide solutions to identified problems.

Guiding the team through the assigned simulation, that reflects a serious public concern, were our stated political values serving to shape our policy proposals.

Using a systems approach, we analyzed current public policy and explored alternatives. We considered the forces that operate in the environment producing demands on the political system, pressing for allocation of resources toward desired objectives.

An integral part of the medical inflation picture, Medicaid reimbursement costs reflect the system's failure to create a cost-effective balance between supply and demand, government and the private sector, quality and price, provider and consumer, fexibility and control.

POLITICAL VALUES GUIDING THE SIMULATION

It needs to be remembered that government cannot do all things for all people. The mix of essential services ultimately provided involves, of necessity, the allocation of scare resources and its attendant decision-making process.

Three decades of government-stimulated construction of medical facilities, medical research, education and regulation have created greater demand for and use of health care. This advance comes at great and ever-escalating cost to society.

The question begins to loom: what can we afford as a nation and how should we allocate our resources? Can the enormously expensive Medicaid program, with its component of reimbursement for LTC be afforded? Given the unforseen costs involved, the inflationary bias and the changing demographic composition of our society, the question of such reimbursement necessitates a rethinking.

In order to determine a strategy for change, we must begin with a clear statement of the political values which will guide us in the analysis. They are as follows:

All individuals should have access to basic health care and related social services.

Government has an obligation to ensure reasonable access for all to LTC. In so doing, the government has the responsibility to regulate the quality, quantity and cost of such service.

The individual must take responsibility for maintaining his own good health. Preventive strategies will be emphasized.

Government should provide only those goods and services which the individual cannot provide for himself.

A LTC plan should include options to provide for freedom of choice, thus preserving the pluralistic nature of our private sector.

Free enterprise is essential to our democratic and economic order. It must be kept essentially intact in planning for the delivery of health services.

No single system for providing health care will satisfy everyone or prove to be regionally cost effective.

The lower the level of government responsible for administering a service, the more responsive to the needs of the people and efficient the service provided.

Fiscal responsibility and restraint must guide policy.

Health resources are scarce resources and do require difficult decisions on allocation.

Regulation, to be effective, should focus on cost and standards to guarantee the most appropriate utilization of available resources.

Government intervention is needed to ensure a fair and efficient allocation of resources. It must intervene to correct the lacking incentives normally provided by the market mechanism.

The cost of health care is a major contributing factor to inflation.

The role of the family unit in providing LTC is of primary importance. Home care with supportive services is desired over institutional care.

VALUES, PROBLEMS AND CAUSES

The problems connected with Medicaid reimbursement for LTC are numerous and interrelated. It is extremely difficult to see where one begins and another stops. The team has tried to identify and separate these problems into three problem sectors. They are as follows:

PROBLEM #1: HIGH COST . . . .

The implementation of the Medicaid reimbursement system has proven to be far more costly than originally envisioned and costs are continuing to escalate at an uncontrolled rate. Originally totaling $2.4B in 1967, projections for 1980 run to $22.3B. Interestingly enough, the annual increase in the cost of medical care first began to skyrocket the very year of Medicaid's inception, jumping from 2.9% in 1966 -- to 6.5% in 1967 -- to 12.5% in 1975. (See Appendices 1 & 2).

Two critical elements are missing which are needed to guide the Medicaid system: 1) a cost control component, 2) clearly delineated national spending priorities to keep spending in line and to assure the desired allocation of national resources.

HOW THE PROBLEM OF HIGH COST RELATES TO THE STATED POLITICAL VALUES .

Since national resources are scarce resources, unlimited spending for one commodity cannot be allowed. Fiscal restraint must be a guiding feature of national planning for the provision of social services as

well as others. What we opt to spend for LTC must be cut from somewhere else if spending is not kept within bounds. Given equally important and growing societal emphasis on education, welfare, and national defense, (to name but a few), our position must be that we cannot sustain the kind of growth that has occurred in the area of health care.

POSSIBLE CAUSES WHICH CONTRIBUTE TO THE HIGH COST OF LTC . . . .

> Administrative inefficiencies allow patients to be placed at inappropriate levels of care, encourage waste and reward inefficiency.
>
> Third-party reimbursement systems leave the patient (consumer) unaware of the high cost of treatment and serve as a disincentive for him to look for cheaper alternatives.
>
> The advance of new medical technology serves to raise expectations on the part of patients and stimulates its greater use and development.

PROBLEM 2: FAILURE OF THE MARKET MECHANISM . . . .

Medicaid has essentially brought about a condition in which the forces that create price equilibrium do not function in a normal way. Government intervention to assure the consumption of services for those needing LTC stimulates further demand for services. When there is no ceiling on the amount of resources made available, there is incentive for both supplier (physician) and consumer (patient) to generate as much consumption as possible. The Medicaid system of third-party payments leaves the consumer 1) unaware of the cost of service, and 2) with no incentive to cut back on the amount of medical services consumed. The result is overconsumption.

HOW THE PROBLEM RELATES TO THE STATED POLITICAL VALUES . . . .

In the case of Medicaid reimbursement for LTC, the health care industry holds an unfair advantage: the supplier controls the market and creates its own demand. Controls must be placed on the supplier

by the government. Health resources are scarce resources because the federal resources which finance LTC are finite. Some form of national priority-setting, decision-making and allocation needs to be implemented.

POSSIBLE CAUSES OF THE FAILURE OF THE MARKET MECHANISM . . . .

The allocation of the resources is regulated by the supplier (physician) who determines the nature, extent, and cost of the service the consumer (patient) must have.

The demand for services is inelastic; the patient wants treatment irrespective of cost.

There is a lack of competition among physicians as a result of under-supply due to restrictive medical school admission policies.

PROBLEM #3: FAULTY ALLOCATION AND DISTRIBUTION OF RESOURCES . . . . .

This is a major cause of substandard care for large segments of the population. Physicians, facilities and the greatest number of services are clustered in and around middle-class urban areas, leaving rural citizens and the inner-city poor underserved and their facilities underfunded.

HOW THE PROBLEM RELATES TO THE STATED POLITICAL VALUES . . . .

A basic level of LTC should be available for all. When over-consumption in some areas drains available resources and leaves other areas underserved, the government must then intervene to ensure a more fair and equitable allocation of health-care resources.

POSSIBLE CAUSES OF THE DISTRIBUTIONAL PROBLEM . . . .

The private market has not functioned to allocate equitably or to distribute evenly.

Not every individual has equal resources, therefore the distributional problem exists.

There is a lack of comprehensive planning to meet the needs to those needing LTC.

Some are consuming too much.

Adequate governmental control is lacking.

PROPOSALS FOR CHANGE

INTERIM SOLUTIONS . . . . Proposals for bringing about changes recommended as possible solutions for immediate implementation and are listed in Appendix 3. The proposals have been divided into three categories: government-based strategies for bringing about change in the Medicaid reimbursement system for LTC, facility-based strategies and physician-based strategies.

A brief synopsis of these proposals: they are aimed at eradicating some of the basic causes of the problems identified with reimbursement for LTC. They include fiscal and management strategies which set limits on spending, encourage efficient use of resources and ensure that standards for quality of patient care are maintained.

Furthermore, the interim strategies proposed are heavily dependent on greater concern for the "total patient" and his family. They advocate for maintenance in the least restrictive, and most economical, level of care. The proposed decentralization of services is in keeping with the most successful modern models for the delivery of LTC in other countries and is in line with our stated political values of advocating variety and responsiveness of local service options.

It must be realized, however, that coming to grips with the enormity of the problems brought about by the present reimbursement system for LTC, requires more than interim solutions. They are necessary for beginning to bring the system under control but are not adequate; they do not provide a comprehensive delivery system for the service and thus do not alleviate the stated problem of faulty allocation and distribution of resources. The question of converting the central political value of "access to basic benefits for all" into

a manageable arrangement of services, facilities and systems requires a comprehensive approach at the national level. We must look beyond the interim solutions to a comprehensive, single-agency provider for an integrated network of services for those in need of LTC... We call that system HEALTHPLAN.

HEALTHPLAN: A Single-Agency Solution

(See Appendices 4 & 5)

<u>POLITICAL VALUES GUIDE POLICY</u> . . . . Key values underlying HEALTHPLAN reflect those put forward at the beginning of this paper. Critical are issues of freedom of choice and self-sufficiency, which necessitate the development of more LTC alternatives and support options for patients and their families. All individuals will be provided, by means of comprehensive planning and program delivery, with access to basic health care. Costs will be shared by means of deductibles and co-payment systems as a way of equalizing the burden of LTC across society. The consumer of LTC services will be taking the responsibility for choosing and, in part, for financing the options taken. The government will provide incentives for the individual to choose the most cost-efficient LTC alternative which will meet his individual needs. The family unit will be encouraged to act as a support unit to those in need of LTC.

<u>WHAT IS HEALTHPLAN?</u> . . . . HEALTHPLAN is the framework for financing and delivering a comprehensive system for LTC. Primary beneficiaries are the elderly who become seriously ill. HEALTHPLAN applies the basic concept of insurance for acute care to cover LTC expenditures. The result is an insurance policy, owned by an

individual, representing a promise to pay if the individual is certified to be in need of LTC services and can meet eligibility criteria.

The system provides for active consumer choice and serves to encourage economical options by using deductibles and co-insurance policies. These options serve the desired goal of providing basic care for those who need it, while curbing spending for LTC, one of the stated political values.

<u>THE SYSTEMS APPROACH</u> . . . . Inputs to the HEALTHPLAN system reflect the patient and family needs as well as professional interests. Supports are rendered when individuals accept the single-agency system delivery of LTC and decide to participate in it. The main objective of the LTC system is to help the patient maintain maximum functional independence in the least restrictive environment. The community agency helps to coordinate resources available in the community and puts the patient in touch with the services available to meet his needs.

<u>RANGE OF SERVICES PROVIDED</u> . . . . HEALTHPLAN will focus on providing long-range support alternatives for individuals who cannot live independently without assistance. The range of services provided will include: 1) nursing-home care (SNF & HRF), 2) domociliary care, 3) congregate-living arrangements, 4) foster care, 5) day care, 6) housing for the elderly, 7) home-health care, 8) friendly visiting, 9)respite care, 10) meals-on-wheels and other home health-related services.

Again, the service emphasis would be to encourage patients and their families to opt for the least restrictive environment. Financial incentives will be provided to encourage home-health care with supportive services to participating families. Service at

different levels will be open, based on a patient's willingness to pay for such service, if desired above need certification for a standard level of care.

Such provision to provide for the purchase of service desired is in line with the stated political values describing the importance of freedom of choice and the free enterprise system, while shifting emphasis to the importance of the family unit in providing basic resources to support family members needing LTC for as long as possible.

FINANCING AND MANAGEMENT . . . . At the federal level, HEALTHPLAN will be financed from general revenues. Once a national MAXICAP is determined in dollar amounts for LTC expenditures, allocations will be made to states and localities by a formula similiar to that used for General Revenue Sharing. The state-level agency will be responsible for system management and operational functions. A central information management system will be an essential component. Operational management includes the service provision to ensure entitlements and benefits.

To assist in developing home and community-based options, the local community agency for LTC will perform patient assessment, offer options and arrange for service. It will also monitor quality to improve patient care. Patient management at the local level means matching the patient to the appropriate desired service.

Clients will be encouraged to opt for the least restrictive environment. The agency will require and receive waivers to pool Medicaid and Medicare funds for LTC.

Once an individual is certified for eligibility by a panel of professionals, he can choose among a wide range of services, after meeting a deductible. Because clients consume more than they would be

willing to pay for if they were participants in the reimbursement process, HEALTHPLAN embodies the co-payment concept. Reimbursement rates are set to pay for a standard intensity of care. Co-payment is required by the consumer in an an amount proportional to the covered cost of services provided. The result is an incentive for consumers to economize and thus save money and lower the numbers of patients opting for the higher and more expensive levels of care.

A ceiling payment for catastrophic illness or incapacity could be set on payments based on a sliding scale for different incomes. This would prohibit anyone paying more than 40% of their income on LTC deductibles of co-payment. States could participate by paying for <u>part</u> of the deductible for needy residents, thus preserving the cost-efficiency incentive built into HEALTHPLAN.