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NURSING HOMES AND THE CONGRESS: A BRIEF
HISTORY OF DEVELOPMENTS AND ISSUES

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NURSING HOMES AND THE CONGRESS: A BRIEF HISTORY OF DEVELOPMENTS AND ISSUES

Introduction

It is the purpose of this report to briefly examine some of the historical and current legislative developments and issues which have confronted and still face the Congress regarding the provision of and payment for health and related institutional services provided to older Americans by the Nation's public and private nursing home industry.

Prior to 1965, some Congressional study of problems in the nursing home field had been made, but legislation affecting nursing homes was only infrequently adopted. Federal matching funds were available to the States to enable them to purchase nursing home care for certain aged welfare recipients. Other laws provided some capital and other forms of financial assistance for the construction and modernization of public and private facilities. Except for this financial involvement, however, only limited attention was devoted by Congress to problems in the long-term health care field.

In 1965, Congress added the Medicare and Medicaid titles to the Social Security Act. This legislation greatly expanded the Government's previous role and importance as a purchaser of nursing home care for

the aged and the poor in the United States. With the expanding Federal financial responsibility in the nursing home field has come a new concern on the part of Congress in such non-financial matters as the standards established for homes, the quality and levels of skilled care provided in them, and the utilization of nursing facilities as an alternative to more costly forms of institutional health care. This report examines some of these developments.

1. Origins of the Nursing Home and Early Legislative Developments

At the turn of the 20th Century, nursing homes as such were virtually unknown in the United States. There was little demand for a specialized type of institution designed solely to serve the particular needs of older people. As a matter of fact, "aging," as a social problem in America, had not yet even appeared on the scene. Only about one out of every 25 Americans in 1900 was reaching or passing a 65th birthday. Reaching 65 didn't mean a great deal in those days either. Few older people experienced any important changes in life styles or living arrangements merely because another birthday had passed by. Most workers continued to pursue their previous occupations without interruption regardless of age until disability or death halted their usual activities. Concepts such as retirement from the work force at 65 and expanded leisure in old age were still undeveloped ideas in American history at this juncture in time.

Sick or disabled older Americans in 1900 usually could count on the family or close friends to provide them with personal needs and assistance. It was customary for most aged persons to live out their lives amid the same surroundings and among the same people with whom they had always done so. Numerous religious and charitable organizations also stood ready to aid the family in helping the older person meet many of his personal assistance requirements. Only the most destitute older American created a demand for institutional care as a public ward. This person usually became the resident of the almshouse or county poorfarm.

Events over the next 30 years, however, radically altered many of these conditions. To begin with, the number of persons reaching old age began to increase dramatically. More and more families faced the prospects of caring for and supporting a dependent older relative or friend in their homes. During this period, however, other influences were at work that began to make it increasingly difficult for some families to meet all of the traditional responsibilities for the care of dependent older members. Industrialization, growing mobility in the population, and other economic and social changes were combining in such a way as to impair the ability of many sons and daughters to help and assist their aged relatives. As a result, the numbers of dependent older Americans without any private means of assistance also began to rise.

Critics argued that the 19th Century poorhouse system represented a totally unworkable and undesirable solution to the growing problems of aged dependency in the United States. Charges were made that the almshouse and other similar types of public institutions were inhumane, inadequate, and unnecessarily costly for society to maintain.^{1/} Other answers to the problems of dependency had to be formulated.

One of the new approaches adopted by some of the States during this time was the creation of programs to provide cash assistance payments for needy older people who had no personal means of support and no financially competent relatives to help out. By the middle of 1931, 18 of the States had established various programs of "old-age assistance," "old-age pensions," "old-age relief," or "old-age security" for the increasing numbers of dependent aged population within their boundaries.^{2/}

The growth of these State-financed and administered public assistance (welfare) programs for the elderly proceeded rather slowly until the Depression when their expansion stopped altogether. With the collapse of the economy, the numbers of older people seeking public aid suddenly increased. State funds needed to support the assistance programs, on

^{1/} See, for example, The American Poorfarm and Its Inmates, Harry C. Evans, 1926.

^{2/} Social Security in America: The Factual Background of the Social Security Act, as summarized from Staff Reports to the Committee on Economic Security, 1937.

the other hand, began to diminish as the sources of State tax revenue dried up. The States turned to the Federal Government for financial relief.

In 1935, Congress responded by enacting the Social Security Act. Among other things, the legislation made it possible for the States to receive Federal matching funds for the purpose of making non-institutional cash assistance grants to various categories of needy people. Title I of the Act established a program of Old-Age Assistance (or OAA) which authorized the Government to match (up to certain limits) funds raised by States to help the needy elderly population.

Included in the Title I program was one provision of some importance in determining the future course of the nursing home system in the United States. The provision prohibited the Federal Government from making any matching funds available to the States for assistance payments to persons residing in "public institutions." The purpose of the prohibition was to discourage the States from using the poorhouse system as a means for dealing with the problems of aged dependency:^{3/}

The Social Security Act of 1935, which made public assistance payments to those aged 65 and over and living in their own homes or in private homes, but not in public homes, expressed our distaste for the poorhouse as a means of caring for the needy aged, and resulted in part in the present complexion of nursing homes and homes for the aged.

^{3/}

The Aged and Aging in the United States: A National Problem, Summary and Recommendations, Senate Committee on Labor and Public Welfare, 86th Congress, 2d Session, p. 145.

Undoubtedly, some privately-owned residential facilities and boarding homes existed before passage of the Social Security Act. But the prohibition against payments to persons in public institutions gave a new impetus to the idea of using private facilities as special institutions for the elderly:^{4/}

Expediency led to the widespread use of existing family structures, not otherwise fully occupied, with the homeowner or lessee often having an applicable interest such as nursing and an interest in such activity as a source of income. Here then was an opportunity for small proprietary ventures.

Even homes that had begun only as boarding houses soon underwent changes in their purpose, as residents continued to advance in age and as the incidence of chronic illness and disease rose as well:^{5/}

Some actually started as nursing homes. Some started as boarding homes for elderly people. But in historical background, even as in contemporary operations, the line between homes which offered nursing care and those which provided domiciliary services was not sharply drawn. With the passage of time, homes which had begun as room-and-board enterprises gradually, and sometimes imperceptibly, assumed responsibility for meeting the personal and nursing needs as these areas arose among their aging residents. Thus, many of today's nursing homes are yesterday's small private boarding homes for older people...

^{4/}
Ibid, p. 135.

^{5/}
Ibid:

2. Early Problems Relating to the Financing of Nursing Home Care

One, if not the principal, purpose of the cash assistance programs for the needy aged was to make it possible for the older person to care for himself. The assistance payments, along with whatever resources the recipient might have, would enable the otherwise dependent person to purchase such necessities as food, shelter, clothing and medical care. It was suggested that if the standards of need and the assistance payments were adequate, there would be no need for the poorhouse system of the past.

The 1935 Social Security legislation assigned to each State the responsibility for establishing its own needs standards and for basing its assistance payments on these standards. Almost immediately controversy arose as to whether the standards and payment levels adopted by the States were adequate or not to meet the needs of the aged poor and the other categories of recipients provided for in the new Federal law. Some of the States were accused of establishing wholly inadequate standards of need, resulting in payments far too small to be of much help. Other States were credited with setting realistic need standards, but were criticized for failing to make payment levels consistent with such standards.

To some extent, the levels of assistance payments actually made by the States depended on a limitation imposed in the Federal legislation. Under the law, the Government would not match any portion of a monthly assistance grant to a recipient that exceeded \$30. Individual States were free to go beyond this monthly dollar amount, but only if they assumed all of the financial burden for the additional costs involved. During the Depression years in particular, few of the States seemed able or willing to finance monthly grants much in excess of the dollar limits contained in the Federal matching formula.

Because of the prohibition against payments to persons living in public institutions, most of the placements of aged recipients who required a sheltered or institutional environment, other than hospitalization, were made in the numerous proprietary homes that were now beginning to appear throughout the United States. In turn, the level of old-age assistance payments often determined where these placements would be made. Welfare officials would subsequently indicate to the Congress that the choices frequently involved less than desirable homes.

Nevertheless, the demand for the services provided by the homes not only persisted, it intensified. During the Thirties, the number of elderly persons living in institutions primarily for the aged had declined by about 10 percent, due largely to the emptying of public almshouses. During

the Forties, however, the size of the older population in the United States rose appreciably and the number of elderly people in nursing homes and homes for the aged rose by about 38 percent.^{6/}

Inadequacies in the quality of care being provided in many of the small proprietary homes was first brought to the attention of Congress in 1945, when welfare officials appeared to testify on proposed hospital construction legislation:^{7/}

There is a growing conviction among public welfare and public health officials that the level of medical and nursing care provided by most private boarding homes is wholly inadequate either from a health or welfare point of view. Moreover, despite mushroom growth of such commercial homes, there are still large numbers of chronically ill persons requiring institutional care for whom there is no available facility...

The witnesses recommended that the proposed construction grant program be amended to include assistance for ⁴⁵hospital-affiliated nursing homes:^{8/}

It seems to us that there is an essential need for hospital-affiliated nursing homes and other facilities for the chronic sick which are something less than hospitals and something more than custodial care institutions.

^{6/}
Ibid., pp. 134-135.

^{7/}
"The Hospital Construction Act," Hearings before the Senate Committee on Education and Labor, 79th Congress, 1st Session; testimony by spokesman for the American Public Welfare Association; p. 364.

^{8/}
Ibid., pp. 364-365. In 1946, Congress enacted hospital construction legislation, popularly known as the Hill-Burton program. The APWA's nursing home recommendations were not included in the law.

In 1946, Congress was asked to examine certain changes in the old-age assistance program and their potential impact on the capacity of the needy aged to obtain adequate long-term care. One recommendation involved raising or eliminating altogether the dollar maximums imposed by law on the amount of monthly assistance payments to individuals for which Federal matching funds were available:^{9/}

A maximum payment of \$40 per month will not meet the minimum needs of all aged persons. Such a payment is too low for recipients who live in large cities where rents are high, unless they have other income. It is difficult anywhere to get care in boarding or nursing homes for \$40 a month, and in many communities it is impossible.

Welfare officials testifying in Congress also again urged reconsideration of the ban on payments to persons living in public institutions. They recommended modification of the prohibition to permit payments to individuals in public medical institutions. The ban would continue for persons residing in facilities that were largely domiciliary in character:^{10/}

This would allow us to utilize our present county homes as infirmaries, convalescent homes, or institutions for the chronically ill.... Care provided in county homes could, with the addition of a few medical and nursing facilities, be vastly superior to most care that is now available...

9/

"Issues in Social Security," Report to the Committee on Ways and Means by the Committee's Social Security Technical Staff; January 17, 1946;
p. 276.

10/

"Amendments to the Social Security Act," Hearings before the House Committee on Ways and Means: Part 7: 79th Congress. 2d Session. 1946: p. 1131.

Repeal or modification of the ban on payments to persons in public institutions was also sought on grounds that such action would expand existing long-term care bed capacity and, thereby, meet part of the intensifying demand for more institutional facilities:^{11/}

...such public institutions may represent the only available facility for the type of care needed and provide care at standards comparable to, if not better than, facilities which do not classify as "public institutions."

1946 Amendments to the Social Security Act liberalized somewhat the Federal matching formula with respect to OAA payments though an overall monthly maximum ceiling of \$45 was retained in the Act.^{12/} However, no action was taken to revise the ban on payments to persons in public institutions.

In 1948, the Advisory Council on Social Security reported to Congress that private nursing facilities charging rates within the reach of assistance recipients were becoming much too crowded to meet the increasing demand for institutional care. The Council agreed that the prohibition on payments to persons in public institutions should be changed:^{13/}

In some communities, public medical institutions could care for these aged persons, if the Federal Government were to bear a share of the cost. Moreover, if Federal funds were available for this purpose, communities would be stimulated to improve the quality of care in such facilities.

^{11/}
Ibid., p. 1107.

^{12/}
Liberalizations in the Federal matching formula for old-age assistance were again made in 1948 and in 1950.

^{13/}
"Recommendations for Social Security Legislation," Senate Document No. 208, 80th Congress, 2d Session; June 19, 1948.

The Council also expressed concern about the quality of care in nursing facilities generally and recommended that matching be made available to persons in any medical institutions, public or private, only if States established standards for their medical facilities and nursing homes:^{14/}

At present the Social Security Act does not require States giving assistance to persons living in private institutions or nursing homes to establish any standards for the operation of such facilities. Some of the private institutions and nursing homes in which recipients are living offer a very poor quality of care and do not properly protect the health and safety of recipients. We believe that, as a condition of eligibility for Federal funds, a State aiding needy aged persons in public and private medical institutions and commercial nursing homes should be required to have an authority or authorities that would establish and maintain adequate minimum standards for institutional facilities, and for the care of aged persons living in such facilities.

The Truman Administration agreed with both of these recommendations of the Advisory Council and in 1949 sent to Congress legislation to change the public institution prohibition contained in the law and to require States to establish standard-setting agencies.^{15/} Both provisions were included by the Congress in the 1950 Amendments to the Social Security Act:^{16/}

Under present law, the Federal Government participates in the cost of assistance payments to persons residing in private, but not in public institutions. Under the bill, the Federal Government would share in the costs of payments to old-age assistance recipients living in

^{14/}
Ibid., p. 116.

^{15/}
"Social Security Amendments of 1949," Hearings before the House Committee on Ways and Means on H.R. 2892: Part 1; 81st Congress, 1st Session.

^{16/}
"Social Security Amendments of 1949," House Report No. 1300; 81st Congress 1st Session; August 22, 1949; p. 42.

public medical institutions other than those for mental disease and tuberculosis.... Private institutions with charges within the financial reach of these recipients do not have sufficient capacity to provide this care. Your committee is of the opinion that aged persons should be able to receive State-Federal assistance payments while voluntarily residing in public medical institutions, including nursing and convalescent homes. In some communities, existing public facilities would then be enabled to admit old-age assistance recipients in need of long-term care who are now denied admission because of the financial burden that would be imposed on the local unit of government. Moreover, if State-Federal old-age assistance is payable to aged persons residing in public medical institutions, it is possible that many communities will develop additional facilities for chronically ill persons, and thereby assist in meeting the increasing need for such facilities by the aged population.

The Committee rationale for the standards requirement revealed some of the growing Congressional concern for the well-being and safety of patients in long-term care facilities:^{17/}

Tragic instances of failure to maintain adequate protection against hazards threatening the health and safety of residents in institutions emphasize the importance of this [standard-setting] function of State government.... Persons who live in institutions, including nursing and convalescent homes, should be assured a reasonable standard of care and be protected against fire hazards, unsanitary conditions, and overcrowding.

1950. 1930 S S I
Public
1965 XVIII 27X.

17/

Ibid., p. 43.

Two other recommendations of the 1948 Advisory Council were also considered by Congress at this time. Under the original Social Security Act, the public assistance titles (including the OAA title) limited Federal financial participation in State assistance programs only to help provided to recipients in the form of cash money payments. This meant that, if the costs of medical care furnished to recipients were met by a State or local welfare agency directly through payments to the providers of medical services, such expenditures had to be borne entirely by State or local government. No Federal matching funds were available for direct payments of this sort. The Advisory Council proposed that the law be changed to permit States to make vendor payments to providers on behalf of the recipients in need of health care.^{18/}

The Council also noted in its report that the medical needs of recipients created special financial problems for the States under the limitations contained in the Federal matching formula. The Council proposed that the Federal Government make additional matching money available (within certain limits) to pay for one-half of the medical care costs incurred by the States for the needy over and above the regular cash assistance maximums contained in existing law.^{19/}

^{18/} See pp. 112-114 of source cited in Footnote #13.

^{19/} Ibid.

In 1950, Congress agreed to the idea of making vendor payments on behalf of the needy, but at that time the Council did not adopt recommendations for additional matching funds for medical assistance purposes:^{20/}

Certain provisions of the Social Security Act have limited the effectiveness of the public assistance programs in assisting needy individuals to meet their medical needs. One of these provisions is the definition of assistance which limits Federal participation to money payments made to the needy individual. Some assistance agencies consider it preferable to pay the medical practitioner or institution that supplies the medical care directly.... The bill provides that Federal funds under old-age assistance may be used to match payments directly to medical practitioners and other suppliers of medical services in behalf of needy aged individuals which, when added to any money paid to the individual, does not exceed a monthly amount of \$50.

3. The Need for More Nursing Homes

A number of those who testified before legislative committees during the 1940's warned Congress that the growing demand for the services of long-term care institutions, including nursing homes, was rapidly outstripping the available supply of qualified facilities. There was already some evidence that the private homes were becoming overcrowded and unable to meet demand requirements. The public institutions were often underutilized due to such factors as the ban in the Social Security Act against payments to or on behalf of residents living in public facilities.

^{20/}

See pp. 41-42 of source cited in Footnote #16. A separate matching program for medical care was enacted in 1956; see Section 4 of this report.

Private and public sources of capital for new construction or for the expansion of existing institutions were at this time virtually nonexistent. Private lending institutions were usually unwilling or, at best, reluctant to make available financing for the construction of "single-purpose" type facilities, such as nursing homes. Only the small proprietors were venturing risk capital in the nursing home field and their resources were, of course, very limited. No public program to expand nursing home capacity existed either. Congress had been asked during the deliberations on the Hill-Burton legislation to include construction grant assistance for nursing homes and other long-term care facilities, but no such action was taken.

One of the first major studies to document the need for more skilled nursing homes was undertaken in 1953-54 in a joint project sponsored by the U.S. Public Health Service and the Commission on Chronic Illness.^{21/} The project involved a survey of the long-term care facility situation in slightly more than a dozen States. For the purpose of the survey, nursing homes were defined as those establishments which provided "skilled nursing home care" as their primary function. Using this definition, the project surveyors discovered that 72 percent of the homes studied could not fit such a classification. Obviously, there was a serious shortage in the number of truly skilled care facilities in the country.

21/

"Nursing Homes, Their Patients and Their Care," Public Health Service Publication No. 503, Government Printing Office, Washington, D.C., 1957.

Welfare officials, who had testified in 1945 in favor of a construction grant program for nursing homes, recommended that such assistance be limited to institutions which were "hospital-affiliated." It was suggested that such affiliation could promote better coordination and closer cooperation between the acute and long-term care segments of the health community. An even stronger proposal regarding the relationship of hospitals and nursing homes was made in 1952 by President Truman's Commission on the Health Needs of the Nation. This Commission recommended that the existing small, independent (and largely proprietary) nursing homes in the country be replaced by "larger homes" located near hospitals and supervised and operated by these hospitals.^{22/} Control over the future course of nursing home care in America thus began to emerge as a new issue for legislators to consider.

In 1954, the Eisenhower Administration proposed to amend the Hill-Burton program to provide construction assistance for long-term care institutions, including nursing homes. The legislative package submitted to Congress, however, included aid to only public and non-profit facilities and not proprietary institutions. In presenting its case before Congress, the Administration noted that a construction program in the long-term care field was needed in order to alleviate some of the growing pressure on the country's short-term general hospitals to accept and care for the chronically ill. As part of a program to relieve this pressure, the Administration requested \$10 million annually to help in the construction of skilled homes.

^{22/}

"Building America's Health," A Report to the President by the Commission on The Health Needs of the Nation, December 18, 1952.

Anticipating opposition to the legislation from the proprietary elements in the industry, the Secretary of HEW explained why the Administration's proposal limited aid only to public and non-profit institutions:^{23/}

That the bill is confined to nonprofit nursing homes does not mean that nursing homes of this type are the only necessary or desirable ones. We are well aware that there are over 9,000 proprietary nursing homes now in existence. Nor can there be any doubt as to the need for additional high quality nursing homes of this type. But here, as in the case of all other facilities covered by the provisions of H.R. 7341, it seems appropriate to limit eligibility for Federal construction grants to those which are sponsored by public or other non-profit agencies or associations.

In cross examination, the Secretary was asked whether the Government shouldn't also establish a program to aid proprietary facilities. A program only for public and non-profit institutions, it was suggested, could have a serious adverse effect in an industry so overwhelmingly proprietary in its character. The Secretary responded by indicating that no Administration position had yet been developed regarding assistance to private nursing homes. As for the matter of competition from Federally-subsidized nonprofit homes, she commented:^{24/}

...as you know, the need for nursing homes and nursing home beds is so great that I cannot conceive that if this program were authorized, it would be competition with the present proprietary homes....

^{23/}
"Public Health Service Act, Hospital Survey and Construction Amendments of 1954," Hearings before the Committee on Interstate and Foreign Commerce on H.R. 7341, 83rd Congress, 2d Session, 1954; p. 19.

^{24/}
Ibid., p. 45-46.

As expected, witnesses for the nursing home industry did not agree with the Secretary on this point and flatly rejected the Administration's proposed program of assistance to non-profit homes:^{25/}

The American Nursing Home Association is opposed to H.R. 7341 principally for the reason that the administration seems to be attempting to place federally sponsored nursing homes in competition with the estimated 20,000 nursing homes that for years have cared for the indigent, the aged and the chronically ill without aid or favor from either county, State or Federal Governments.

Instead of the Administration's plan, the industry witnesses suggested that Congress earmark some of the loan money allocated to the Federal Housing Administration (FHA) and the Small Business Administration (SBA) for the construction of nursing facilities. The witnesses observed that private capital resources for construction or improvement purposes simply were inadequate and that the granting of Government money to non-profit institutions in light of this consideration would be grossly unfair:^{26/}

...with the FHA type of guaranteed loan for nursing homes, we could make available facilities for the treatment of chronic illness heretofore unknown in these United States, and we could pledge this to the American people, that we would keep abreast of the growing needs of our aging population, rendering to them services in small units at a community level...

^{25/}

Ibid., pp. 97.

^{26/}

Ibid., pp. 101.

The private operators also addressed themselves to some of the questions regarding the quality of care available in existing homes. The problems that existed were directly tied to the inadequate mechanisms used to pay for the costs of nursing home care:^{27/}

There are many things we do not know, but of this we are certain, that if we are to operate better, more efficient nursing homes and give more extensive treatments in our nursing homes, we must have made available to us the encouragement of private financing and the establishment of higher rates from the Departments of Public Welfare and Old-Age Assistance.... Be assured that our statistics show that the old-age assistance grants paid do not provide sufficient funds for 24-hour care in our nursing homes. The burden falls squarely on the private patients. The acid test is to examine your own conscience and ask yourself, "Would I expect for \$25 a week to have one dear to me, who is senile, confused, and in need of bed care 24 hours a day, in need of 3 substantial meals and clean linen, sanitary conditions, professional nursing care day and night, could I really expect these things for less than \$4 a day.... Yet our medical social workers expect miracles from the nursing homes.

Despite the industry's strong opposition to the Administration's plan, Congress later in the year adopted amendments to the Hill-Burton law to provide Federal financial support for the construction of non-profit nursing homes and other types of non-proprietary long-term care institutions.^{28/} Only those facilities capable of providing "skilled nursing care" were to be eligible for Federal financial assistance under the new program. Such care was defined to include "nursing services and procedures employed in caring for the sick which require technical skill beyond that which an untrained persons possesses." The law also required

^{27/}
Ibid., pp. 99.

^{28/}
68 Stat. 461.

that any Federally-aided home be operated "in connection with a hospital" and that the nursing care and other medical services be "prescribed by, or...performed under the general direction of, persons licensed to practice medicine or surgery in the State." The term "nursing home" was defined as a "facility for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require skilled nursing care and related medical services...." These represent one of the first attempts on the part of Congress to define the institutions and the "level of care" provided in such facilities for which Federal financial aid would be available.

The 1954 Hill-Burton legislation also contained a requirement directing the Government to conduct a truly Nationwide survey of the country's chronic care institutions, including nursing home facilities. Instead of inventorying homes in accordance with some of the more traditional designations used in the field -- nursing home, home for the aged, convalescent home, etc. -- institutions were classified according to the primary "level of care" offered by the facility.^{29/} The survey indicated that there were about 25,000 homes of various kinds in the United States, nearly 83 percent of which were proprietary in their ownership. About 7,000 of these homes (accounting for 180,000 beds) could be classified as "skilled nursing homes." An additional 2,000 facilities were designated as personal care homes that offered some skilled nursing care. Of the remaining number of homes, 7,000 were classified as personal care homes without skilled nursing care and 9,000 as sheltered care institutions.

^{29/}

"Inventory of Nursing Homes and Related Facilities," Public Health Reports, Vol. 69, December 1954; pp. 1121-1132.

4. Legislative Developments between 1956-1959

In 1956, the Senate's Committee on Labor and Public Welfare published several reports on problems of the aged and of aging in the United States. One of the reports, prepared by the Commission on Chronic Illness, observed that the quality of care afforded older people in many of the Nation's nursing homes was continuing to deteriorate.^{30/} The cause of such deterioration, the report noted, was inadequate financing. The Commission found a reluctance on the part of the public, public agencies, and insuring organizations to make adequate payments for nursing home care, since much of the care provided was either substandard in quality or custodial in character. This reluctance posed a serious dilemma for policymakers attempting to resolve problems in the nursing home field. On the one hand, it seemed that adequate financing for nursing home care would not materialize unless and until considerable improvement in the level and quality of such care occurred. On the other hand, much of the needed improvement sought after could occur only if adequate financing was forthcoming. The Commission urged Congress to strengthen the programs available to pay for nursing care, particularly the public assistance programs:^{31/}

^{30/} "Recommendations of the Commission on Chronic Illness on the Care of the Long-Term Patient," Studies of the Aged and Aging, compiled by the Senate Committee on Labor and Public Welfare; November 1956.

^{31/} Ibid.

Financing is probably the most neglected and unresolved area in improving care in the bulk of the nonhospital institutions. The efforts of licensing authorities and nursing home operators to apply new knowledge and otherwise raise standards can succeed only if better financial support is forthcoming for these institutions, particularly the ones that are financed through public assistance.

As noted elsewhere, Congress had already made several changes in the public assistance programs which were important for the indigent person in need of long-term institutional care. In the original Old-Age Assistance program, for example, the Government matched monthly cash assistance payments on a dollar-for-dollar basis up to a maximum of \$30. Amendments to the Social Security Act in 1939, 1946, 1948 and 1952 produced changes both in the matching formula itself and in the maximum monthly payment ceiling. Changes in the formula increased the Federal share of assistance costs from the original 50% to slightly more than 60%. The monthly payment ceiling had been raised from \$30 to \$55. The original Act had also prohibited the use of matching funds for making payments to persons living in public institutions. The Government was also barred from sharing in any assistance costs made in the form of direct payments to vendors of medical care. Both of these restrictions were modified by the Amendments of 1950.

In 1956, Congress again legislated in the public assistance
32/
area. The Old-Age Assistance formula (and the formulas in the

other assistance titles) was revised to permit the Government to match four-fifths of the first \$30 of cash assistance, plus one-half of the balance up to a monthly maximum of \$60. More important, however, the 1956 Amendments created a new matching arrangement to help States meet the assistance costs of medical care provided to recipients, including the costs of nursing home care. The States were now authorized to average medical assistance expenses and to receive Federal matching on a 50-50 basis within certain maximums. The Government's share of medical expenditures in the adult assistance categories was to be determined by multiplying \$6 a month by the number of recipients. In other words, the matching funds available for medical assistance no longer would be limited by the monthly dollar ceiling amounts per individual recipient applicable in the matching formula for cash assistance payments to recipients.

In 1957, the financing of nursing home care was discussed in an entirely new legislative context. Representative Aime Forand of Rhode Island, second-ranking Member of the House Committee on Ways and Means, introduced legislation to create a new program of hospitalization and surgical insurance for the aged under social security. Among other things, the Forand bill provided for payments for up to 120 days of nursing home services.^{33/} Nursing home services were defined in the bill as:³⁴

^{33/} H.R. 9467, 85th Congress.

^{34/} Ibid.

...skilled nursing care, related to medical and personal services and accompanying bed and board furnished by a facility which is equipped to provide such services, and (A) which is operated in connection with a hospital, or (B) in which such skilled nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State.

Such a definition was virtually identical with the definition of skilled care provided by facilities deemed eligible for construction grant assistance under the Hill-Burton amendments enacted by the Congress in 1954. The Forand bill prescribed no Federal standards for nursing homes that would participate in the program. Instead, any institution could enter into an agreement with the Government to receive payments for nursing home services, if the facility were licensed as a nursing home "pursuant to the law of the State in which it is located."

Hearings on the Forand bill and other proposed amendments to the Social Security Act were held in 1958.^{35/} In testimony before the Committee on Ways and Means, the Eisenhower Administration and most health care provider groups expressed strong opposition to Congressman Forand's proposal for a health insurance plan for the aged. Witnesses for the American Nursing Home Association, who also

35/ "Social Security Legislation," Hearings before the Committee on Ways and Means on All Titles of the Social Security Act; 85th Congress, 2d Session, June 1958.

opposed the bill, recommended that the Federal Government limit its role to assisting the poor and the "medically indigent."^{36/} The proper legislative course for Congress to follow, Association officials suggested, would be to strengthen the existing State-administered medical assistance programs:^{37/}

...our Association supports the principle of increasing Federal participation in providing funds for medical care through a percentage ratio of participation on the part of State governments. We are opposed to the Federal Government contracting directly for the medical, hospital, and nursing home care of OASI beneficiaries... We do believe that the economic status of the individual should be the basis of determining need. That free choice of facility within the framework of our licensing laws and within the category of need should be assured, that determination of care should be on the State rather than national level, that the manner in which such funds are dispersed should be left to the discretion of the States, and that some sort of participation on the part of States would be desirable for the proper administration of such a program for the medically indigent.

Amendments to the Social Security Act were enacted by Congress in 1958, though the amendments did not include a program of hospital or health insurance for the aged.^{38/} One of the Committee reports on the legislation, however, directed the Government to study the need for and implications of such a program:^{39/}

^{36/} Persons whose incomes and resources are large enough to cover daily living expenses, but not large enough to pay for needed medical care.

^{37/} See p. 177 of source cited in Footnote #35.

^{38/} P.L. 85-840, August 28, 1958. Among other things, the amendments further liberalized the Federal matching formula with regard to cash and medical assistance payments.

^{39/} "Social Security Amendments of 1958," House Report No. 2288; 85th Congress, 2nd Session; July 28, 1958; pp. 6-7.

Your committee is very much aware of the problems faced by the aged in paying for hospital services and nursing home services. A number of bills introduced in the 85th Congress would broaden the old-age, survivors, and disability insurance program to provide for payment of the cost of hospitalization and nursing home services for beneficiaries under this program... Your committee believes, however, that more information on the practicability and the costs of providing this kind of protection through various methods should be made available before it entertains any recommendation for legislation on the subject... Your committee has asked the Secretary of Health, Education and Welfare to conduct such a study and report the results on or before February 1, 1959. With the results of such a study available, the Congress will be in a better position to decide what legislative measures, if any, should be taken to meet the problem.

In April 1959, the Government study on hospitalization insurance for the aged was published. The comments in the report on nursing home care revealed a lack of information about conditions in such facilities: ^{40/}

There is much less information with regard to the extent of utilization of nursing homes and other types of medical facilities by aged persons. Most population surveys relate primarily, if not exclusively, to persons who are not living in institutions. Surveys of the institutional population have been infrequent and have provided little information as to rates of admission, length of stay, or similar factors.

The report noted that there were a wide-range of services and many different levels of care provided by the many and various institutions known as "nursing homes." This diversity made it virtually

40/ "Hospitalization Insurance for OASDI Beneficiaries," Report to the Committee on Ways and Means by the Secretary of Health, Education and Welfare; April 3, 1959.

impossible to assess either the costs or the consequences of including a nursing home benefit in a program of health insurance for the aged. If such a benefit were to be included, the report recommended, a single set of program participation standards for nursing homes should be prescribed:^{41/}

There is no national accrediting agency [for nursing homes]. If nursing home benefits were provided, therefore, the insurance system might, at least at the outset, have to establish its own standards as to the care for which it would pay.

Three months after this report was published, the Committee on Ways and Means held public hearings on the new Forand bill (H.R. 4700), which had been introduced during the 1st Session of the 86th Congress.^{42/} Once again, the Administration and most of the health care provider groups, including the nursing home association, opposed the legislation. There were, however, also those who favored enactment of some sort of program and who commented on the nursing home benefit provisions of the Forand bill. Witnesses from the Physicians Forum, for example, were concerned about the single facility participation requirement contained in the proposal. The requirement only that participating institutions be licensed by the State in which they were located was thought to be much too broad:^{43/}

^{41/} Ibid., p. 71.

^{42/} "Hospital, Nursing Home and Surgical benefits for OASI Beneficiaries," Hearings before the Committee on Ways and Means on H.R. 4700; 86th Congress, 1st Session.

^{43/} Ibid., p. 177.

Unfortunately, there are many nursing homes which have little or no concern for the welfare of their patients and which function principally to exploit the financial resources of aged and chronically ill individuals... The criterion for acceptance of a nursing home in this new program must assure a high quality of nursing home care even though this would mean the establishment of a suitable set of standards by the Federal Government.

The American Nurses' Association agreed that reliance upon State law to assure the quality of care provided in nursing homes might ^{44/} not be enough:

At this time, we wish to call attention to the poor conditions prevalent in nursing homes throughout the country. To provide a means of payment for nursing home care through social insurance will not be enough... We note that in H.R. 4700, a nursing home to be eligible for payment under OASDI, must be licensed according to the law of the State in which it is located. Unfortunately, in many cases, such State regulation is not adequate to insure safe nursing care in the homes licensed... To protect both the insurance system and the beneficiaries, provisions for payment for nursing home services should clearly define the type of service to be covered. Every precaution should be taken to prevent the financing of substandard institutions through social insurance.

The spokesman for the American Public Welfare Association, Mr. Wilbur Cohen (later a Secretary of Health, Education and Welfare in the Johnson Administration), recommended that the law itself prescribe standards for homes wishing to participate in a program of health insurance for the aged: ^{45/}

44/ Ibid., p. 362.

45/ Ibid., p. 317.

In our opinion there are very few nursing homes that would presently meet the requirement of providing truly skilled nursing home service. But there is a great need for skilled nursing home service and the legislation should encourage the establishment and expansion of adequate skilled services in this area. We urge that the legislation specifically enumerate the basic standards for such homes to qualify for payments and that such homes be connected with or under the supervision of hospitals, or other appropriate medical direction.

While the House tax committee was considering some of the problems of paying for nursing home care for the aged, another committee of Congress was looking into some of the conditions in nursing facilities alluded to in the statements quoted above. In February 1959, the Senate had authorized an expenditure of \$85,000 by the Committee on Labor and Public Welfare to study problems facing older people in the United States.^{46/} A special Subcommittee on problems of the Aged and Aging, chaired by Senator Pat McNamara of Michigan, was formed to conduct the investigation.

The reports subsequently published by the Subcommittee and its staff were critical of nearly every facet of the nursing home care system in the country.^{47/} There were some outstanding, high-quality

^{46/} "Study of Problems of the Aged," Senate Report No. 47; 86th Congress, 1st Session, February 4, 1959.

^{47/} The Subcommittee report on nursing homes appears in Part VII, "The Aged and Aging in the United States: A National Problem," Report by the Subcommittee on Problems of the Aged and Aging of the Committee on Labor and Public Welfare, January 1960. A separate staff study appears in "The Condition of American Nursing Homes," A Study by the Subcommittee on Problems of the Aged and Aging; 86th Congress, 2d Session.

nursing facilities in operation in certain locales, but many homes and equipment in them were altogether outmoded and substandard. The list of deficiencies was lengthy. Nursing home administrators and operators did not possess the qualifications or training needed to assure proper provision of patient care. Many facilities lacked the numbers of skilled nursing personnel necessary to provide professional care. The range and kinds of services available in most homes were exceedingly limited, especially in the restorative care area. Routine physician attendance and organized medical supervision was less than ideal.

The Subcommittee also found that the nursing home licensing programs of many States were not working. Standards were often very low and inadequately enforced. Inspection programs were underfunded, understaffed, and, in some areas, virtually non-existent:^{48/}

Because of the shortage of nursing home beds, many States have not fully enforced existing regulations, the failure to do so reflecting the policy of the States to give ample time to the nursing home owners and operators to bring the facilities up to standards. Many States report that strict enforcement of regulations would close the majority of the homes. Too often, however, the failure to enforce the regulations has been the consequence of inadequate enforcement staff. Some 20 percent of the homes in one State, for example, failed to meet the standards for staff, facilities, and equipment 18 years after the licensure and regulation legislation was enacted--largely because of inadequate enforcement.

^{48/} See p. 20 of the staff study cited in Footnote #47.

The Subcommittee reports not only documented inadequacies regarding the quality of care in facilities, they also pointed out that conditions in some homes were actually hazardous to the very safety and health of the patients living in them: ^{49/}

...about two out of five persons in nursing homes coming under the Hill-Burton Act occupy "non-acceptable" beds as classified by Hill-Burton standards and reported by the States... "Non-acceptable" is a Hill-Burton Hospital Construction Act classification reported by the States on the basis of fire and health hazards. This classification does not include, for example, beds nonacceptable in terms of inadequate staff or failure to provide rehabilitation and restorative services, recreational facilities, and pleasant living conditions.

The Subcommittee blamed inadequate financing generally, and inadequate public assistance financing in particular, as the principal cause of most of the problems uncovered during the investigation of conditions in American nursing homes: ^{50/}

...the standard of a nursing home in all its facets is primarily governed by its income which in turn is primarily governed by the rate paid for public-aided patients. Nursing homes are caught between two fires: one, the desire of everyone in and out of Government to demand the best possible care of the elderly; and two, the lack of desire to pay for it... Few, if any, nursing homes will be able to give adequate care for much less than \$200 per month, even if the factors of taxes, depreciation, and profits are wholly disregarded. Where people are paying less they are getting less... The quality of care offered the infirm aged is, in the great majority of nursing and old-age homes, determined

^{49/} Ibid., pp. 7-8.

^{50/} See pp. 140-41 of Subcommittee report cited in Footnote #47.

by the level of public assistance payments to their patients. It should be noted that testimony before the subcommittee indicated that even in those States which exceed substantially the \$65 per month Federal ceiling for matching old-age assistance payments, the average monthly old-age assistance payment does not approach this \$200 figure.

The Subcommittee recommended that Congress take steps to improve and expand the physical plant of American nursing homes and that minimum standards be prescribed for the facilities serving public assistance recipients:^{51/}

These minimum standards should be considered as a "floor" for State standards in their supervision of nursing homes, public and private, which care for patients receiving Federal public assistance grants.

During 1959, Congress did take steps to expand the capacity of the nursing home industry to meet the steadily growing demand for more skilled care facilities. It may be recalled that, despite industry opposition, a construction assistance grant program for public and non-profit nursing homes had been enacted in 1954 as part of the Hill-Burton Act amendments.^{52/} In testimony on that legislation, witnesses for the American Nursing Home Association pointed out that private, as well as public, sources of construction and improvement capital for nursing homes were virtually non-existent. The Association called on Congress for assistance in obtaining capital through the programs administered by the Small Business Administration and the Federal Housing Administration.

^{51/} See p. 27 of staff study cited in Footnote #47

^{52/} See Section 3 of this report.

In 1956, under its general loan authority regarding small business, the Small Business Administration inaugurated a loan program for proprietary nursing homes.^{53/} Commercial loans could be made to convalescent and nursing homes for new construction, expansion, equipment and supplies, and for working capital. To be eligible for loan assistance, the home had to qualify as a "small business," meaning that its annual volume of receipts could not exceed \$1 million. Different loan arrangements were possible, including direct loans in circumstances where private lenders could not or would not join in the SBA's regular loan participation program. The maximum amount of a loan could not exceed \$350,000 and carried a maximum interest rate of 5-1/2 percent over a term of 10 years.^{54/}

The 10-year term on loans from the SBA was, in the judgment of many nursing home officials, far too brief a period to be of much help to most proprietary operators. As a result, the industry continued to work for the enactment of a loan assistance program similar to those

^{53/} "Long-Term Institutional Care for the Aged," Hearings before the Joint Subcommittee on Long-Term Care of the Senate Special Committee on Aging, December 18, 1963; pp. 71-72.

^{54/} For a discussion of the requirements for loan assistance, see CRS Multilith Report 70-119 ED, "Federal Financial Support for the Construction of Nursing Homes," May 11, 1970.

administered by the Federal Housing Administration. In testimony on the proposed Housing Act of 1959, spokesmen for the nursing home industry presented the following case:^{55/}

The Hill-Burton benefits are restricted to non-profit and tax-supported institutions which care for only 29 percent of the people in nursing homes. The [existing] FHA program does not contain adequate provision for nursing care on a continuing basis and was not designed to support nursing homes per se. The Small Business Administration loan policy, in keeping with its general policy, is far too short a loan period and far too low a Federal participation. This prevents the great majority of the proprietary nursing-home owners from obtaining such loans and makes it difficult for them to compete with the nonprofit homes supported by finance programs existing within the Government.

Congress agreed with this assessment and established a mortgage insurance program in Sec. 232 of the Housing Act of 1959.^{56/} Under the original program administered by the FHA, mortgage principal could not exceed \$12,500,000 or 75 percent of the estimated value of the property or project to be financed. The maximum interest rate was set at 6 percent of the outstanding principal balance (exclusive of the premium charges for mortgage insurance). The term of a loan was established for a period not to exceed 20 years.

^{55/} "Housing Act of 1959," Hearings before the Senate Committee on Banking and Currency; 86th Congress, 1st Session; January 22-28, 1959; p. 359.

^{56/} Public Law 86-372.

5. Medicare and Medicaid Legislation: 1960-1965

The Forand health insurance program for the aged was defeated in committee in March of 1960 by a voting margin of 2-to-1.^{57/} In June, however, the Committee on Ways and Means reported out a measure which, among other things, resulted in important changes in the medical care programs for older people financed through the public assistance titles of the Social Security Act.^{58/}

One part of the legislation made available to the States more favorable Federal matching arrangements, if the States undertook to make significant improvements in their medical payment programs for old-age assistance recipients. The legislation also included an entirely new matching program, known as Medical Assistance for the Aged or MAA. Under this program, States could receive Federal funds on a matching basis to help meet the medical expenses of the "medically indigent" or "medically needy." This group included persons over 65 whose incomes and resources were such that they were not entitled to cash assistance payments, but whose income and resources were inadequate to meet their medical expenses.

The House-passed version of the 1960 Social Security Amendments listed and defined the services that could be included in a medical

57/

"The Evolution of Medicare -- From Idea to Law," Research Report No. 29, U.S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, 1969; p. 84

58/

"Social Security Amendments of 1960," House Report No. 1799, 86th Congress, 2d Session, June 13, 1960. The amendments are popularly known as the Kerr-Mills amendments after the principal authors of the legislation.

assistance program, including definitions, for the first time, of terms such as "skilled nursing-home services" and "nursing home." "Skilled nursing-home services" in the House bill meant skilled care provided by a registered nurse or licensed practical nurse, if performed under the general direction of or prescribed by a physician, and if furnished to an individual as an inpatient of a nursing home. The definition also included the medical and other services related to the provision of skilled care and the bed and board required by inpatients. The term "nursing home" was defined to mean those facilities licensed by the States as nursing homes which (1) were operated in connection with a hospital or which (2) had medical policies governing the provision of care established by one or more physicians responsible for supervising the executions of such policies.

The Senate-passed version of the legislation also listed the various kinds of services that States might include in a medical assistance program. The Senate bill, however, contained no legislative definitions of these services or of the facilities or persons that could provide them. The conference committee formed to resolve the differences in the two bills eventually adopted a compromise which retained the list of services without definition along the lines of the Senate-passed legislation. As a result, the problems of defining nursing home care and nursing homes in the Social Security Act were temporarily set aside.

In 1961, the newly-elected Kennedy Administration indicated its intention to push for enactment of a program of hospital insurance for

the aged financed through the social security payroll tax system. In testimony before the Committee on Ways and Means in July, the new Secretary of Health, Education and Welfare outlined a program which, among other things, would pay for "followup skilled nursing-home services provided to a patient after his transfer from a hospital..."^{59/} Under the plan, insurance benefits would be paid on behalf of insured beneficiaries to providers of health services which satisfied certain "conditions of participation" required by the program. Such conditions, according to the Secretary, would assure that aged beneficiaries would receive quality health care from institutions qualified to provide it:^{60/}

...the inclusion of these conditions is a precautionary measure designed to prevent the program from having the effect of undercutting the efforts of various professional accrediting organizations...to improve the quality of care in hospitals and nursing homes. To provide payments to institutions for services of a quality lower than are now generally acceptable might provide an incentive to create low quality institutions as well as an inducement for existing facilities to strive less hard to meet the requirements of other programs.

The provider of skilled nursing services in the Administration's proposal would be a "skilled nursing facility." Such a facility was defined in terms of compliance with the following requirements for program participation: (1) primarily provides skilled nursing care for patients requiring planned medical or nursing care, or restorative services,

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"Health Services for the Aged under the Social Security Insurance System," Hearings before the Committee on Ways and Means on H.R. 4222, 87th Congress, 1st Session, July 24, 1961; p. 34

^{60/}

Ibid., p. 132.

(2) has medical policies established by a professional group (including physicians) with a requirement that each patient be under a physician's care, (3) is a facility supervised by a physician or registered professional nurse, (4) maintains adequate medical records, (5) provides 24-hour nursing services, (6) operates under a nursing facility utilization plan, and (7) is licensed under applicable State law. In addition, participating facilities would have to meet such other conditions relating to health and safety as might be prescribed by the Secretary of Health, Education and Welfare:^{61/}

...because it would be inappropriate and unnecessary to include in a Federal law all of the precautions against fire hazards, contagion, etc., which should be required of institutions to make them safe. According to reports of State agencies, about 10 percent of the hospital beds and about 40 percent of the skilled nursing home beds are unacceptable because of "fire and health hazards." Payment for services in such institutions could seriously undermine efforts of State health departments and professional groups to eliminate dangerous conditions in health care institutions.

The Administration's bill also would have permitted States to establish conditions higher than those prescribed as National minimums for participating providers:^{62/}

The conditions could also be varied for different areas and classes of institutions and could, at the request of a State, be higher for institutions in that State than for those in other States. There would be uniform national

^{61/}
Ibid., p. 132.

^{62/}
Ibid., p. 133.

minimum requirements. But in addition, in States where requirements are higher than the prescribed minimum, the program would at the request of a State follow the higher State requirements. If a State decided, for example, that all nursing homes within its jurisdiction should provide high health and safety standards and requested that the requirements under the program with respect to institutions within its boundaries conform to this level, the Secretary could cooperate to the full extent of his authority. This flexibility in the Federal program would give further support to the various States in their efforts to improve conditions in institutions.

Except for the public hearings, no further action was taken during the 1st Session of the 87th Congress on the Kennedy Administration's hospital insurance plan. In July 1962, Senator Clinton Anderson of New Mexico, speaking for himself and other Senators, announced that he would offer the Administration insurance program as a Senate floor amendment to pending welfare legislation.^{63/}

Among other things, the Anderson amendment contained a new and even more restrictive definition of the kinds of facilities that would be permitted to participate in the program as providers of skilled nursing home care. Only those institutions which were "affiliated" with, or under the common control of, hospitals would be qualified to provide such care:^{64/}

Even more significant is the need for quality protection in the case of nursing homes. It would be regrettable if poor quality care in nursing homes were to be sponsored by paying for health care in institutions whose environment is truly a threat to the lives of their patients. Our amendment would strengthen the assurance that nursing

^{63/}

Congressional Record -- Senate; July 3, 1962.

^{64/}

Ibid.

home services covered by the proposal are of high quality. It would do this by requiring that nursing facilities may participate in the program only if they are affiliated with hospitals.

This provision in the Anderson amendment sparked considerable controversy during the Senate floor debate. Senator Robert Kerr of Oklahoma, for example, charged that the affiliation restriction made a mockery of the nursing home benefits contained in the Anderson amendment.^{65/} The Senator estimated that, under such a definition, only about 500 homes could qualify as providers of service. Most older people, therefore, would be denied access to such benefits. At several points in the debate, the "affiliation" requirement was again criticized. Finally, Senator Anderson agreed to modify the requirement along lines proposed by Senator Edmund Muskie of Maine. The Muskie amendment would have allowed participation in the program on the part of non-hospital affiliated homes, if the Secretary of HEW determined on the basis of full and complete study that such homes were equipped to provide quality care and that such participation would not produce any imbalances in the trust funds raised to finance the Administration plan.^{66/} On July 17, 1962, the Anderson hospital insurance amendment was defeated on the Senate floor by a vote of 52-48.

^{65/} Ibid., July 16, 1962.

^{66/} Ibid., July 17, 1962.

In November of 1963, the House Committee on Ways and Means reopened hearings on a revised Administration proposal for a program of hospital insurance for the aged. The revised legislation (King-Anderson bill) included the nursing home-hospital affiliation requirement contained in previous Administration plans, but as modified by the Muskie amendment discussed in the Senate in 1962:^{67/}

The requirement of hospital affiliation--intended to provide assurance that payment would be made only to skilled nursing facilities having adequate medical supervision--will serve to encourage facilities to enter into arrangements which many experts in health care believe will have (and where attempted have had) success in improving the quality of their services. A facility would be deemed to be affiliated with a hospital if, by reason of a written agreement, (a) the facility operates under standards, with respect to its skilled nursing services, clinical records and use of drugs, which are jointly established by the hospital and the facility, (b) arrangements exist for timely transfer of patients, and (c) the hospital's utilization review plan applies in all respects to the services furnished by the facility. The Secretary is required to study, after consultation with appropriate professional organizations, ways of increasing the availability of skilled nursing facility care. On the basis of such study, the Secretary may authorize the participation of facilities which, though not affiliated with hospitals, operate under conditions assuring the provision of a good quality of care, provided such action does not create (or increase) an actuarial imbalance in the trust fund.

67/

"Medical Care for the Aged", Hearings before the Committee on Ways and Means on H.R. 3920, Part 1, 88th Congress, 1st Session, November 18, 1963, pp. 45-46.

Although the American Hospital Association did not support the King-Anderson bill in the hearings, Association witnesses did express support for the hospital-nursing home affiliation provision contained in the legislation:^{68/}

- Mr. King. As you know, the bill limits participation of nursing facilities to those facilities which are affiliated with hospitals. Does the AHA consider such an affiliation arrangement between a hospital and a nursing facility a device which would help to improve the quality of nursing facility care which is now often poor?
- Dr. Wilson. We would say that that affiliation would certainly promote good care.
- Mr. King. Would you recommend any changes in the affiliation provisions?
- Mr. Williamson. I think that the present affiliation agreement proposed in the bill indicates, and it was hoped at the time that the bill was written, that accredited programs with nursing homes would be more widespread than they are. Accreditation hasn't advanced the way we hoped it would through the Joint Commission on Accreditation. However, that is still being worked upon. We have gone ahead with a program of what we call registration, the American Hospital Association itself, which is attended with a good set of

principles to qualify nursing homes as being desirable institutions. One requirement in this set of principles is that nursing homes have affiliation relationships with general hospitals; the formal document provides for various details which we believe will substantially improve the quality of care in nursing homes and facilitate the transfer of patients and in other ways, economically and otherwise, benefit long-term care patients.

The American Nursing Home Association, on the other hand, vigorously opposed any affiliation requirement:^{69/}

The bill discriminates against a vast majority of nursing homes which are not hospital affiliated. Many of these homes have, however, provided many years of care to a large segment of the chronically ill and aged when others were ignoring the problem. There are many of these homes that would be eliminated from the care program simply because an area hospital would not be willing to sign an agreement with the Department of Health, Education and Welfare and/or the nursing home. The number of formal affiliation agreements between hospitals and nursing homes is insignificant. Probably less than 2 percent of America's nursing homes have such agreements.

^{69/} "Social Security; Medical Care for the Aged", Hearings before the Committee on Finance on H.R. 11865; 88th Congress, 2nd Session; August 14, 1964; p. 715. Comparable testimony was presented by the Association in testimony before the House Ways and Means Committee on January 23, 1964.

Association witnesses again expressed general opposition to any program of Federal health insurance for the aged financed under social security. However, the industry would support needed improvements in the State-administered medical assistance programs for the poor and medically needy aged. In particular, the nursing home officials noted, steps should be taken to improve the level of financing available in States for the purchase of quality skilled nursing care: 70/

The facts are that despite all our efforts to upgrade nursing home care--and the change in the nursing home picture during the last few years has been phenomenal--there will continue to be substandard nursing homes providing minimal care as long as public officials are unwilling to provide more than 40 to 50 percent of the cost of what we in the industry feel is necessary to pay for good nursing home care.

Some of those testifying before the Committee, however, were convinced that better financing alone would not be enough to guarantee improvements in the quality of nursing care available to the public. Coordination between the hospital system and nursing homes would be essential and affiliations among the institutions could achieve this objective: 71/

70/ See Part 4, p. 1866 of the source cited in Footnote #67.

71/ See Part 3, p. 1340 of the source cited in Footnote #67.

...it should be recognized that with respect to hospital care, standard setting by a voluntary professional agency, the Joint Commission on Hospital Accreditation, is well established, generally accepted and notably successful. With respect to nursing home care, however, no comparable pattern of standard setting has yet been developed and widely applied... This important consideration, along with the objective...of meeting needs for the aged for inpatient care to the extent medically appropriate through provision for skilled nursing home services, provides strong grounds for including the attainment of effective functional relationships between skilled nursing homes and hospitals... Progressive development of affiliations to achieve this goal is deemed to be important not only in facilitating timely transfer of patients but is seen to have significant bearing upon the improvement of the quality of care for aged patients... By bringing the skilled nursing facility increasingly under the influence of the hospital, it can be expected that the capabilities of the skilled nursing facilities in providing post-hospital care would be enhanced and that continuity of care would be promoted.

While the House tax committee was looking into the affiliation question, another Congressional committee was investigating the standards for homes used in the State medical assistance programs. In testimony before the Senate Special Committee on Aging in December 1963, the Federal Commissioner of Welfare noted that 34 percent of all public assistance money used to purchase medical care was for nursing home care and that recipients utilized about 60 percent of all available nursing home beds. ^{72/}

^{72/} See p. 4 of source cited in Footnote #53.

The Commissioner candidly admitted that the quality of the care purchased was often substandard:^{73/}

There should be no spending of public assistance funds for care which does not meet the health needs of recipients or does not reflect a reasonably good quality of care. Unfortunately, today, we are paying for second- or third-rate nursing home care for many public assistance recipients. The term "nursing home" is used widely and indiscriminately. This need not and should not be.

The Commissioner observed that inadequate levels of financing accounted for many of the problems in the nursing home area, but she also noted that the Federal Government lacked the authority needed to prescribe or enforce minimum nursing home standards. The Commissioner was questioned on this point:

Senator Moss.

I was wondering if you feel that there ought to be some power extended to your Department to require compliance with standards of safety and health care since the Federal Government is supplying a good part of the money that is being expended?

Dr. Winston.

I think you are getting at the point here, sir, as to whether or not there should be some minimum Federal standards.

73/ See p. 6 of source cited in Footnote #53.

Senator Moss. Yes.

Dr. Winston. Which should be adhered to and for which we should have ways of checking compliance if Federal funds go into this type of program. I would say, sir, I think this is not a determination for an administrative agency because this would be determined by whether or not there was Federal legislation which permitted the establishment of standards. We, of course, can work with and encourage guides or standards but there is no basis for requiring that those standards be met.

Senator Moss. You would need additional legislative authority if you were to have the power to insist on compliance with the minimum standards.

Dr. Winston. I would judge so.

In July 1964, the Committee on Ways and Means reported out and the House of Representatives passed an omnibus bill to amend the Social Security Act. The bill, however, did not contain a program of hospital insurance for the aged, or "medicare", as the proposal was now being named in the press. In August, the Committee on Finance sent the legislation to the floor of the Senate, also without medicare amendments. However, on September 2, 1964, the Administration's plan was offered as a floor amendment to the bill and adopted by a vote of 49-44. A month later, the Chairman of the Committee on Ways and Means reported that the

House-Senate conference committee on the bill was completely deadlocked over the hospital insurance amendment. Congress adjourned without final action on the proposed Social Security Amendments of 1964.

On January 1, 1965, the statutory Advisory Council on Social Security issued a report calling for enactment of a hospital insurance plan. Among other recommendations, the Council suggested that the proposed skilled nursing home benefits contained in the Administration's plan be renamed as benefits for "post-hospitalization extended-care" services:^{74/}

The services that would be covered would be those furnished to patients in extended-care facilities which are under the control of a hospital or affiliated with a hospital which are designed primarily to render convalescent and rehabilitative services... Services of this kind are essential to the overall treatment of many illnesses following their acute stage and prior to the time a person can return to his home or transfer, in some instances, to an essentially custodial institution... Since the proposed program is designed primarily to support efforts to cure and rehabilitate, and since "nursing home" care, in many cases, is oriented not to curing or rehabilitating the patient but to giving him custodial care, the Council does not propose the coverage of care in nursing homes generally... The Council

^{74/}

"The Status of the Social Security Program and Recommendations for Its Improvement," Report of the Advisory Council on Social Security, Washington, D.C., January 1, 1965; pp. 40-41.

recognizes that hospital affiliated facilities which provide post-acute convalescent care and rehabilitative care do not exist in many communities and that the services therefore may not be available immediately to many of the beneficiaries who might need them. The Council believes, however, that the coverage under the proposed program will encourage the development of such facilities and that, with the help of such extended care services can be made generally available within a reasonable time.

The Administration agreed with the Council regarding the change in the name of the skilled nursing care benefit in its program, but the affiliation requirement was deleted from the proposal altogether. In its place, the Administration proposed a new type of relationship between hospitals and nursing homes that would participate as providers of institutional services under medicare:^{75/}

The current bill, through the device of designating the care as "post-hospital extended care", would also more clearly differentiate the post-hospital skilled nursing and rehabilitative care that is intended to be covered from the long-term custodial care furnished in many nursing homes. The bill would make it easier for these facilities to participate in the program. It would do so by substituting for the requirement of affiliation with a hospital a new provision that would require only that the extended care facility have an agreement for the timely transfer of patients and medical information.

75/

"Medical Care for the Aged", Executive Hearings before the Committee on Ways and Means on H.R. 1 and Other Proposals for Medical Care for the Aged, 89th Congress, 1st Session; Part 1, January 27, 1965; pp. 4-5.

The then Assistant Secretary of HEW, Wilbur Cohen, also made it clear that the Administration's plan would not cover nursing home care generally:^{76/}

I think that there is still left open for decision how to finance both the construction and the cost of long-term care in skilled nursing home facilities. It may well be, in answer to your question, that if you passed this particular proposal which has a limited post-hospitalization convalescent care, or extended care, it might well be that someone would want to come along later and say this care should be covered for a longer period. Right now there is a serious limitation in the availability of quality facilities. But generally speaking I would say with this one exception I don't see a clear-cut basis for expansion of services in our proposal for the group 65 and over.

The representatives of the American Hospital Association appearing before the Committee on Ways and Means endorsed the requirement for formal agreements between participating hospitals and extended care facilities and the requirement for a spell of hospitalization prior to admission to such institutions.^{77/} Spokesmen for the American Nursing Home Association, however, continued to oppose both provisions and preferred to delete from the bill any references to agreements, contracts, or compulsory associations with the hospital community.^{78/} ANHA witnesses did express

^{76/} Ibid., p. 124.

^{77/} Ibid.; pp. 227-228.

^{78/} Ibid.; pp. 329-330.

satisfaction that the affiliation requirement was no longer part of the legislation:^{79/}

- The Chairman. Do you have any estimates, Mr. McDonald and Mr. Beaumont, of the number of nursing homes that would qualify under the definition of H.R. 1 when nursing home benefits would become available on January 1, 1967?
- Mr. Beaumont. Mr. Chairman, according to the latest published inventory by the Public Health Service there are 9,700 skilled nursing homes in the country. We are sure that this has varied somewhat and expect it is larger than that.
- The Chairman. Not all of those would qualify under this definition would they?
- Mr. Beaumont. What in particular did you have in mind that would prevent them from qualifying, Mr. Chairman?
- The Chairman. I am talking about hospital affiliation.
- Mr. Beaumont. Is that included in H.R. 1?
- Mr. Ball. (Commissioner of Social Security). Transfer.
- Mr. Cohen. Affiliation is out.
- The Chairman. That is right, the affiliation was in the bill last year.
- Mr. Cohen. That is correct, but not this time.
- The Chairman. That is out. What difference did that make?
- Mr. Beaumont. It increased the available facilities from about 400 up to 9,700, so we get a pretty good spread across the country.

The nursing home association also recommended a number of changes in the standards required of participating extended care facilities. For example, it proposed that institutions meet the accreditation requirements of the National Council for the Accreditation of Nursing Homes and that fire safety and nursing care standards be spelled out in the legislation.^{80/}

On March 29, 1965, the Committee on Ways and Means reported out amendments to the Social Security Act, including for the first time provisions for a program of health insurance for the aged.^{81/} Under the Committee bill, benefits would be provided for covered care in qualified extended care facilities where a patient was hospitalized for 3 or more consecutive days and had then transferred to the facility for continued care of the same illness within 14 days following hospital discharge. An extended care facility (or ECF) could be an institution, such as a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital or a section of a facility another part of which might serve as an old-age home. The bill waived this requirement where an ECF, in good faith, had attempted to arrange such an agreement with nearby hospitals and had failed. Participating facilities were required to meet the

^{80/} Ibid.; p. 323.

^{81/} "Social Security Amendments of 1965", House Report No. 213; 89th Congress, 1st Session; March 29, 1965; p. 27-29.

statutory conditions for participation set forth in the bill, along with such other conditions relating to patient health and safety which the Secretary might find necessary to prescribe. The bill also provided that, at the request of a State, such health and safety standards for that State could be higher than those applicable to other States, except in the case of hospitals where such standards could not exceed those prescribed by the Joint Commission on the Accreditation of Hospitals.^{82/} Neither the accreditation nor the fire and safety proposals, recommended by the American Nursing Home Association were incorporated into the House-passed measure.

In testimony before the Committee on Finance, witnesses for the nursing home industry again asked for many of the same changes in the bill that had been sought before the Committee on Ways and Means. In particular, the Association asked that any facility, which was accredited by the National Council for the Accreditation of Nursing Homes, be presumed to meet all of the statutory conditions of participation (except for the utilization review requirement), as was the case for hospitals meeting the

82/

A floor amendment sponsored by Senator Robert Kennedy of New York deleted the JCAH limitation imposed on the Secretary. Instead, the Secretary of HEW was required to impose health and safety standards for institutions in a State higher than those of the Joint Commission, if that State (or a subdivision of it) imposed such higher requirements as a condition of the purchase of services in such institutions under a State medical assistance plan. This provision is discussed elsewhere in this report.

standards of the Joint Commission on the Accreditation of Hospitals.^{83/}
 The Finance Committee, however, left the requirements for ECF's found
 in the House bill unchanged. The Committee made changes only with
 respect to the number of covered days of post-hospital extended care
 that the program would pay for.^{84/}

During the Senate floor debate on the 1965 Amendments, several
 Senators offered amendments relating to extended care benefits as pro-
 vided for in the hospital insurance portion of the bill. Senator
 Clifford Case of New Jersey, for example, offered an amendment requiring
 the Advisory Council on Social Security to undertake immediately a
 detailed study of the nursing home field in light of the extended care
 provisions in the bill. The Senator noted that the substitution of
 the "transfer agreement" provision for the "affiliation" requirement
 would help to expand the availability of extended care benefits to the
 aged, but he still wondered whether the provision in the bill might
 make extended care a "hollow" benefit for many older people. Senator
 Case was especially concerned about the requirement that ECF's have in
 their employ a full-time registered nurse:^{85/}

^{83/} "Social Security," Hearings before the Committee on Finance on H.R. 6675; Part 1, 89th Congress, 1st Session; May 7, 1965; p. 455.

^{84/} "Social Security Amendments of 1965," Senate Report No. 404--Part I; 89th Congress, 1st Session; June 30, 1965.

^{85/} Congressional Record--Senate; July 8, 1965

I think it is significant that of these 9,700 "skilled care" nursing homes, according to a Public Health Service survey, only about 50 percent employ a full-time registered nurse on the staff. In this connection, I would like to point out the shortage of both registered and practical nurses which now exists. What will be the impact of this shortage on the nursing home program in view of the fact that all homes would be required under the bill to employ at least one registered nurse full time?

The Senate agreed to the Case amendment, but it was subsequently deleted from the legislation during House-Senate conference action on the 1965 social security legislation. ^{86/}

The matter of standards for participating facilities also came up during the debate when Senator Winston Prouty of Vermont offered an amendment to automatically qualify any nursing home for participation in the program, if the facility was licensed as a skilled nursing facility by the State agency responsible for such licensing: ^{87/}

Who is the better judge of whether a nursing home meets adequate and reasonable standards of safety and care? Clearly the agency which has the responsibility for overseeing the operations of the home. If we impose the very rigid standards of this bill, only 3 of the 192 nursing homes in the entire State of Vermont would apparently be eligible for payments administered under this bill, and, undoubtedly, a similar situation would exist in many States. Under my plan, the fact that a State has licensed any one of these nursing homes is prima facie evidence that the home is adequate to the needs of the patients.

86/

"Social Security Amendments of 1965--Conference Report," House Report No. 682; 89th Congress, 1st Session; July 26, 1965; p. 49.

87 Congressional Record--Senate; July 9, 1965.

Senator Prouty also expressed concern that many homes, especially those in isolated or rural areas, might be denied participation in the program, because of the unwillingness of hospitals to enter into the necessary transfer agreements with nursing homes located some distance apart from them. The Senator managing the bill at this point, Senator Abraham Ribicoff of Connecticut, noted, however, that the Committee bill already contained a provision to deal with this possibility. The Senator explained that any home, otherwise qualified to participate, would be certified, if an attempt had been made in good faith to secure the necessary agreements. After further discussion on this point, Senator Prouty agreed to withdraw his amendment. Later on the same day the Senate passed the medicare legislation by a vote of 68 to 21.

In addition to the medicare program, the Social Security Amendments of 1965 also included a new title 19, Grants to the States for Medical Assistance Programs, or "medicaid" as it is now popularly known. The new program broadened the scope of medical assistance that States could make available to the poor and the medically needy by, among other things, improving the level of Federal financial participation in the overall costs of such assistance. All existing medical vendor and medical assistance programs financed under the other cash assistance titles of the Social Security Act were to be phased out by January 1, 1970, after which Federal matching funds for medical care would be available only through the medicaid title.

The new title contained a comprehensive list of health services which States were either required to, or could at their option, include as part of their medicaid programs. Skilled nursing home services were on this list, but nowhere in the legislation or in the committee reports were such services or the institutions that would provide them defined. Both tax committees, however, expressed some concern about the standards applicable to institutions providing care in existing State medical assistance programs. The Committee on Ways and Means carried over to the new title the provisions in the cash titles of existing law which required the States to have agencies responsible for establishing and maintaining standards after noting the lack of progress in this area:^{88/}

Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is expected that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

The Committee on Finance went somewhat farther in the matter of standards. First, it added a requirement to the bill that State medicaid plans include a description of the standards, methods and administrative arrangements which affect the quality of medical care that States would use in administering medical assistance. The Finance Committee made it

^{88/}

See page 66 of source cited in Footnote #81.

clear, however, that such standards would continue to be established by the States rather than the Federal Government:^{89/}

This amendment would give no authority to the Department of Health, Education and Welfare with respect to the content of such standards and methods.

The Committee also added a second amendment requiring, after June 30, 1967, that private and public medical institutions meet standards (in addition to those prescribed by a State) relating to protection against fire and other hazards to the health and safety of patients that would be established by the Secretary of HEW.^{90/} The author of this amendment, Senator Stephen Young of Ohio, discussed the provision on the Senate floor during the debate:^{91/}

This amendment authorizes Federal standards of fire safety and protection in nursing homes caring for public assistance recipients... The Nation has experienced periodic shock over one tragic fire after another in nursing homes providing care to elderly men and women... The medicare segment of the bill authorizes the Secretary of Health, Education and Welfare to prescribe health and safety requirements. My amendment seeks to apply the same safety standards in "medicare" to institutions providing care to public assistance recipients. It would be completely illogical for us to say to the elderly that we will see to it that they are in safe nursing homes under medicare, but that we will permit them to be confined in potential fire traps if they receive nursing home care under public assistance.

89/

See page 75 of source cited in Footnote #84.

90/

Ibid.

91/

Congressional Record -- Senate; July 9, 1965.

The House-Senate conference committee on the 1965 amendments agreed to the amendment relating to Medicaid plan requirements, but rejected the Young amendment relating to fire and safety standards without explanation. ^{92/} On July 30, 1965, President Johnson signed the Social Security Amendments of 1965 into law.

6. Implementation of Medicare and Medicaid

Under the 1965 amendments, all health insurance benefits for the aged, with the exception of benefits for extended care, were to become available on July 1, 1966. Extended care benefits were to begin six months later, on January 1, 1967. During the 18 month interval following enactment of the new legislation, the Social Security Administration devised conditions of participation for all providers of health services recognized in the law, including extended care facilities. ^{93/} The initial set of conditions for the ECF's were finalized in regulations published on October 28, 1967. ^{94/}

ECF's and other facilities were to be certified to participate in the program, if found to be in "substantial compliance" with the conditions established for each type of service provider. Institutions could be deficient in one or more of the conditions and still obtain certification, if such deficiencies (1) did not involve failure to meet a specific statutory

^{92/} See pages 50-51 of source cited in Footnote #86.

^{93/} "1st Annual Report on Medicare," House Document No. 331; 90th Congress, 2d Session; June 24, 1968.

^{94/} 32 Federal Register 14930.

requirement, (2) did not interfere with adequate patient care, (3) did not represent a hazard to patient health and safety, and (4) were those which institutions were making reasonable plans and efforts to correct. Where denial of provider participation in the program would seriously limit patient facilities in an area, an institution could, upon recommendation of the State certifying agency, be approved as a provider of service. Such approval, however, could be granted only if the institution had no deficiencies that would jeopardize the health and safety of patients. Regulations also provided that ECF's would be recertified after a period of one year, or, if deficiencies were detected on the initial survey, within 9 months.

In 1966, State agencies mailed applications for participation as extended care facilities to over 13,000 nursing homes throughout the United States. By December, nearly 6,000 facilities had filed applications: ^{95/}

Many nursing homes had to make substantial changes and improvements in order to be in position to provide the relatively intensive, short-term services covered under medicare. Most nursing homes, for example, had to develop written patient care policies; almost all had to negotiate transfer agreements with hospitals and to develop utilization review plans. Frequently, these facilities also lacked professional direction of one or more of the services offered by the institution, and arrangements had to be made for regular consultation by qualified dietitians, pharmacists, social workers and others. The shortage of nursing personnel posed problems for many institutions. For that reason, the guidelines for certification permitted in some instances, temporary conditional certification of facilities which were found to be deficient in meeting the requirement that they have at least one registered professional nurse or qualified licensed practical nurse (a graduate of a State-approved school of practical nursing) on duty at all times and in charge of nursing activities during each tour of duty.

^{95/} See pages 34-35 of source cited in Footnote #93.

On the day that the extended care benefit provisions went into effect, approximately 2,800 facilities were considered to be in "substantial compliance" with the conditions of participation as extended care facilities. By the end of July 1967, an additional 1,400 institutions--including some 250 which had received "conditional" certification due to shortages of skilled nursing personnel--had been certified, bringing the total number of participating ECF's to 4,160.^{96/}

Terms such as "extended care services" and "extended care facility" were explicitly defined by the Congress in the medicare statute and had been elaborated upon in committee reports. An entirely different situation, however, existed in the case of the medicaid program. Congress had simply listed the various kinds of services that States might include in a medicaid program, but neither the statute nor the committee reports contained Congressional definitions of such services. In June of 1966, the Department of Health, Education and Welfare issued Supplement D to the Handbook of Public Assistance Administration, the guidebook for public assistance officials in the various States. Supplement D defined the term "skilled nursing home" as it was to be used under medicaid:^{97/}

^{96/} The policies and practices of the Social Security Administration regarding the certification of ECF's were subsequently criticized in a report published by the staff of the Committee on Finance which is discussed later on in this report.

^{97/} "President's Proposals for Revision in the Social Security System," Hearings before the Committee on Ways and Means on H.R. 5710; Part 1; 90th Congress, 1st Session.

A "skilled nursing home" is defined as a facility, or distinct part of a facility, which (a) is licensed, or formally approved, as a nursing home by an officially designated State standard-setting authority and, effective January 1, 1967, (b) is qualified to participate as an extended care facility under title XVIII of the Social Security Act; or is determined currently to meet the requirements for such participation; except that clause (b) shall not become effective until January 1, 1968 with respect to facilities which do not currently meet the requirements of clause (b) but which show reasonable expectation of meeting the requirements of clause (b) by January 1, 1968.

In other words, the Department sought to apply the same criteria to skilled nursing homes under medicaid (title XIX) that were being applied to extended care facilities under medicare (title XVIII). This effort, however, was immediately criticized by the American Nursing Home Association which challenged not only the definition, but also HEW's authority to prescribe such criteria: 98/

In using part (b) above as a device or vehicle, specifically, requiring compliance with conditions of participation under Title XVIII, your department has undertaken to write detailed regulations for Title XIX and in so doing has usurped the authority Congress specifically stated should be left to the States in formulating "State plans"... If Congress had wanted a "skilled nursing home" under Title XIX to be the same as an "extended care facility" under Title XVIII it would have so provided.

In its complaint about Supplement D, the Association pointed out that the Finance Committee had attempted to give HEW limited authority to

98/ Ibid.

prescribe fire and safety standards for medicaid facilities (the Young amendment), but that even this limited authority amendment failed to clear the conference committee: 99/

There could be no clearer indication than this that the Congress advisedly refused to give you any authority to set any Federal standards whatsoever under Title XIX... The entire scheme of Title XIX is to define specifically and to limit sharply your powers to issue regulations implementing that Title. The Congress was very solicitous of the powers of the States as demonstrated throughout the language of the Title as well as the Senate and House Reports. Its scheme is diametrically opposed to that of Title XVIII in this regard.

In February of 1967, HEW Undersecretary Wilbur Cohen replied to the American Nursing Home Association. The Undersecretary explained that the Department would give further study to the qualifications of nursing facilities participating in the title XIX program. However, it is clear that the Department felt that it had the authority to prescribe such definitions: 100/

In response to your letter, however, we would like to make known our views that the Department has clear legal authority to establish a definition of "skilled nursing home," and that the issues you have raised are largely matters of policy-- which we are considering-- and not of law.... when such terms appear in a Federal statute without further elaboration, the Federal officials charged with administration of the law have the authority and responsibility for interpreting and explaining the meaning to be given into the bare words of the statute in light of the statutory purposes.

99/ Ibid.; pp. 356-57.

100/ Ibid.; p. 359.

The Undersecretary then went on to explain HEW's views regarding skilled nursing home care under medicaid: 101/

In using the words "skilled nursing home," the Congress obviously was not referring to the full range of institutions which are licensed or otherwise regarded as nursing homes. Moreover, these words must be related to the objectives of title XIX to assure services of high quality. Certainly, all facilities which are primarily of a domiciliary nature must be excluded from the medical assistance program, and only those medical institutions which provide skilled nursing services can be included as skilled nursing homes. A Federal definition must be applicable nationwide. It cannot call for good care in one State and deficient care in another. The Department is not obliged to accept each State's definition and thus be bound to the least common denominator.

Mr. Cohen also made a distinction between medicaid and previous medical assistance programs insofar as nursing home care was concerned: 102/

The term, "medical assistance for the aged," in Titles I, and XVI ... of the Social Security Act includes "skilled nursing-home services," but then includes as a final catch-all, "any other medical care or remedial care recognized under State law." There was little point in developing a limiting Federal definition of skilled nursing home services under these titles--although there was authority to do so--since the State would still be free to include nursing home services of lesser quality if recognized under State law. By contrast, the definition of "medical assistance" under title XIX of the Social Security Act sets forth various items of medical care, including "skilled nursing home services," and then includes the catch-all "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary." Thus, it became clear that in furtherance of the statutory objective of high quality care the Secretary was not expected to accept medical care for matching under title XIX merely because it was recognized under State law. This in turn made it meaningful for the Federal officials to define the various types of care specifically set forth in the definition of "medical assistance." In short, the statutory pattern and purposes of title XIX are different in significant respects from those of titles I and XVI, with the result that the words "skilled nursing home" as they appear in title XIX require definition, as the same words in the other titles do not.

101/ Ibid.

102/ Ibid.

As for using the criteria applicable to extended care facilities in title XIX, the Undersecretary commented: 103/

The use of the unelaborated term "skilled nursing home" in title XIX commits much greater discretion to the Federal administrators. They are not required to use for title XIX the definition of "extended care facility" used in title XVIII, but neither are they precluded from doing so. Insofar as the title XVIII definition describes a skilled nursing home, it affords an appropriate base on which to build the title XIX definition.

In March 1967, Administration witnesses appeared before the Committee on Ways and Means to testify on proposed changes in the Social Security Act. Representative A.S. Herlong of Florida questioned the Undersecretary on the title XIX nursing home policies of the Department: 104/

Mr. Herlong. I am sure you will recall when this matter was brought up in our discussions that the committee met this matter head on, and absolutely refused to give the authority to make these regulations. And having done that and knowing that, how can you now say that you have the authority to do it?

Mr. Cohen. I am not aware that the Congress decided any specific authority for us to interpret this term, Mr. Herlong, What happened is that the Committee and the Congress did not write the same types of conditions in title XIX as they did in title XVIII but provided instead that the States must have the basic authority for licensing and maintaining standards. We believe that we are not issuing a standard with regard to nursing homes under the law but instead are defining what is meant by a skilled nursing home as a basis for Federal payment.

103/ Ibid.

104/ Ibid.; p. 354. On page 360, the colloquy between Representative Herlong and the Undersecretary points out that this matter was aired extensively during executive sessions of the Committee in 1964. Though stenographic transcripts of these sessions are prepared, they are normally retained in Committee files and are not public documents.

In a letter to the Chairman of the Committee on March 4, 1967, the Undersecretary explained the Department's policies in this area and announced revisions made in Supplement D of the Public Assistance Handbook. 105/

The revised definition of a "skilled nursing home" under title XIX, section 1905(a), specifies that the home is one which meets all the requirements of State and local law and regulation and which meets basic minimum requirements for high quality skilled nursing home care. Under the definition, institutions do not have to meet all of the conditions for approval as extended care facilities under title XVIII of the Social Security Act. However, any institution which qualifies under title XVIII would qualify as a skilled nursing home. The nursing service must be directed by a registered professional nurse who is employed full time in the facility. At all times there is a registered professional nurse, or a licensed practical nurse, in charge of the nursing service. We have recognized the problem which many States face in securing adequate qualified staff to serve in nursing facilities. Accordingly, our definition permits the use of licensed practical nurses as charge nurses even though they are not graduates of an approved school if, on July 1, 1967, they are successfully discharging the responsibilities of a charge nurse and if they complete training satisfactory to the appropriate State licensing authority.

The Department also would permit institutions an opportunity to meet the definition provided for in the revised Supplement as long as there was a reasonable expectation of compliance by January 1, 1969.

105/ Ibid.; p. 361.

In testimony before the Committee on Ways and Means on March 9, 1967, the General Counsel for the American Nursing Home Association commented on proposed changes in Supplement D: 106/

We believe that the Department is wise in moving backward effective date of its proposals... Likewise, we believe these new proposed standards to be somewhat more realistic. However, if the Secretary does not possess the authority to establish standards--which was clearly left to the States--it would follow that he does not have the authority to promulgate the standards which they now propose.

Particularly objectionable to the nursing home industry were the requirements pertaining to charge nurses. HEW sought to have, as a minimum, licensed practical nurses who were graduates of schools of practical nursing in charge of nursing services. Association officials, however, felt that such a requirement was both unrealistic, in light of skilled nursing personnel shortages in the country, and unfair to licensed nurses who had entered the profession long before academic LPN programs had been established by the States: 107/

We disagree emphatically with those who would eliminate as charge nurses any practical nurse who is not a graduate of a State-approved school. It has been our experience in the nursing home field that many of our best employees, those with the greatest empathy for the aged patient and with the most experience in their care, are not graduates of State-approved schools primarily because their age and experience predates the major development of these schools.

This controversy over the qualifications of nursing personnel would continue after 1967 and is discussed in greater detail elsewhere in this report.

106/ Ibid.; Part 2; p. 795.

107/ Ibid.; p. 816.

7. The Social Security Amendments of 1967

In August of 1967, the Committee on Ways and Means reported out legislation to amend the Social Security Act, including the medicare and medicaid titles of the law. ^{108/} The proposed amendments, however, contained no provisions specifically relating to skilled nursing home care. Committee Chairman Wilbur Mills of Arkansas discussed this fact ^{109/} on the floor of the House during the debate on the measure:

Mr. Chairman, while I am on the subject of matters on which we have requested the Department of Health, Education and Welfare to submit reports, and while the matter I am about the mention is not included in either the bill, H.R. 12080, or the report thereon, I want to digress for a moment to a matter relating to nursing homes. In the course of its public hearings the Committee on Ways and Means received testimony from the American Nursing Home Association and from others on various aspects of the nursing home situation. Subsequent to the public hearings and while we were in executive session, the American Nursing Home Association presented several proposals to the committee which, if enacted into law, would write minimum standards of professional care for nursing homes into the requirements for State plans under title XIX. I was advised by the American Nursing Home Association that these proposals were an attempt on their part to prevent abuses by some nursing homes. These proposals were discussed by the committee in executive session, but the committee was of the view that further study was required. Accordingly, the committee referred these proposals to the Department of Health, Education and Welfare for study and to report back to the Committee on Ways and Means within a reasonable time, certainly in any event not later than a year from now... It should be noted that in so doing, there is no commitment on my part or of the committee with regard to this proposal [inserted in the Record by the Chairman] except the referral of the subject to the Department for study and report back to us.

108/ "Social Security Amendments of 1967," House Report No. 544; 90th Congress, 1st Session; August 7, 1967.

109/ Congressional Record—House; August 17, 1967.

In the suggested ANHA amendments to title XIX, a skilled nursing home would have been required to have at least one registered nurse or LPN, who was a graduate of a State-approved school, "employed full time with licensed personnel on all other shifts." The proposed amendments also contained another provision relating to another increasingly controversial matter--fire and safety standards for nursing homes. The amendments would have required a skilled nursing home to be a fire resistant structure or have "a standard sprinkler system, or recognized fire detection system." It was also proposed that nursing homes be required to meet such other conditions relating to patient health and safety and any other standards affecting such facilities that a State agency found necessary to prescribe in order to bring such standards "in line with those of the top one-fifth of the States prior to January 1, 1970." These and other proposals of the American Nursing Home Association were subsequently considered by the Committee on Finance and are discussed later on in this section of the report.

Before considering Senate action, however, one other matter should be mentioned. As noted earlier, the Johnson Administration had made no recommendations for legislative change in the statutes affecting extended care and skilled nursing home facilities during its March presentation to the Committee on Ways and Means. Nevertheless, Administration witnesses expressed concern about the misuse of skilled nursing

homes in the medicaid program and proposed an entirely new matching program to help minimize unnecessary utilization of these institutions.
110/

We must see to it that skilled nursing home care is used only for those patients in the medical assistance program who require service in a medically oriented facility. To achieve this goal, we recommend that the cash assistance programs be modified to offer States incentives, when medically and economically possible, to provide care to the individual if a physician certifies that he would otherwise need skilled nursing home care.

Section 205 of the Administration's bill (H.R. 5710) would have given to the States an option to receive Federal matching at the same rate as under medicaid toward the costs of care at home or in institutions other than skilled nursing homes. It was hoped that this would encourage States to eliminate the use of skilled facilities where other levels of service would adequately meet recipient needs. This proposal, however, was not included in the bill reported to and eventually passed by the House of Representatives in August of 1967. A somewhat different proposal, designed to achieve substantially the same objectives as those advanced in support of Section 205, was subsequently considered by the Committee on Finance. This proposal, which provided matching for services in "intermediate care" facilities, is discussed elsewhere in this section.

In May 1967, Senator Frank Moss of Utah, Chairman of the Subcommittee on Long-Term Care of the Senate Special Committee on Aging,

110/ See page 194, Part 1 of the source cited in Footnote #97.

and Senator Edward Kennedy of Massachusetts, a member of the Subcommittee, introduced several legislative proposals relating to nursing homes under title XIX. Among other things, the Moss amendment (S. 1661) provided for a statutory definition of homes qualified as skilled nursing care facilities under medicaid and prescribed minimum standards for nursing home care in the medical assistance program.^{111/} The Kennedy amendment (S. 1662) required State medicaid plans to include a system for licensing nursing home operators.^{112/} Both measures, the Senators noted, grew out of findings of the Subcommittee on Long-Term care which had been conducting hearings into the nursing home area for some time.

As originally introduced, the Moss amendment provided that licensing and inspection functions with regard to nursing homes would remain with the States. However, homes desiring to participate in medicaid would be required to meet the following specifications:^{113/}

Full disclosure of ownership; disclosure to the State licensing agency of sources and terms of long-term financing; a source of medical advice on professional policies and procedures; an adequate and professionally supervised nursing service; arrangements for competent supervision of diets in the case of homes serving patients with medically prescribed dietary restrictions; arrangements (wherever feasible) for the transfer to a hospital when necessary; and, other requirements found necessary by the Secretary for the protection of the health and safety of patients.

111/ Congressional Record--Senate; May 2, 1967.

112/ Ibid.

113/ Ibid.

As proposed, the Moss amendment would have required homes to employ a full-time professional nurse to supervise the nursing services in the facility and such other nursing and ancillary personnel necessary to provide adequate care 24 hours a day. Qualified homes would also be required to meet the fire safety standards prescribed by the Department of Health, Education and Welfare, in addition to any standards in this area established by the States.

The original Kennedy amendment would have required States to establish boards that would develop, impose and enforce standards which would have to be met by the operators of nursing homes located in the States. States failing to comply with such a requirement by a specified time would lose all Federal financial assistance used for the construction and operation of nursing homes in such States.

In testimony before the Committee on Finance, representatives of the American Nursing Home Association proposed several changes to both the Moss and Kennedy amendments, some of which were subsequently included in the bill reported by the Committee in November 1967.^{114/}

Industry witnesses expressed considerable concern over the fact that the Moss amendment, if enacted, would result in only one level of care available under medicaid:^{115/}

The Moss amendment would provide for only one level of care under title XIX namely, skilled nursing care. Over 50 percent of welfare patients throughout the United States need some nursing or other care but they do not need

^{114/} "Social Security Amendments of 1967," Hearings before the Committee on Finance on H.R. 12080; Part 3; 90th Congress, 1st Session; pp. 1836-65.

^{115/} Ibid.; p. 1847.

skilled nursing or intensive care. If title XIX provides for only one level of care, as the Moss amendment does (and as the present proposed HEW regulations do), there will be no Federal assistance program for over 50 percent of the present welfare patients.

The Association's spokesmen pointed out that, prior to title XIX, many of the patients, who would not meet the skilled care requirements of the Moss amendment would have been taken care of under such medical assistance programs as Kerr-Mills. Under those programs, the States received matching funds toward the costs of a much broader range of institutional care for recipients. The Moss amendment, however, would substantially narrow the scope of care for which matching would be available and provide no assistance for institutional care at other levels. To deal with this problem, the Association recommended a new matching program, similar in some respects to the program proposed by the Administration in Section 205 of H.R. 5710 before the Committee on 116/ Ways and Means:

We have discussed this problem with Senator Moss and he recognizes that other levels of care below that provided for in his amendment (or under the proposed HEW regulations) are essential. We propose an amendment to section 119 of the act which would provide for additional levels of care under the present titles I, X, XIV or XVI on the basis of the matching formula under title XIX as a vendor payment program. This would save the Federal Government money as some of these patients would otherwise be cared for in skilled nursing homes. Many States would be unable to provide

116/ Ibid.; p. 1848.

other welfare programs with the result the tendency would be to place all of these patients in skilled nursing homes. No matter what kind of care, she would just be shoved up the line and they would all suddenly become skilled nursing home patients.

In October, Senator Jack Miller of Iowa offered an amendment incorporating the Association's proposed new matching program. The 117/ Senator observed that:

There are several thousand nursing homes in the United States which are ready, willing, and able to render needed services of a quality standard but not at the highly skilled level. It would be a major mistake to fail to utilize them, and it would be an injustice to many welfare recipients to deny them the care which they require but which they could not receive because these facilities cannot qualify as "skilled nursing homes."

In November 1967, the Committee on Finance reported out social security legislation, including three provisions containing the substance of the Moss, Kennedy and Miller nursing home amendments. 118/ Under the bill, skilled nursing homes in title XIX would be required to meet the environmental, sanitation and housekeeping requirements applicable to extended care facilities under title XVIII (medicare). States that did not have fire protection codes found to be adequate by HEW would be required to have their homes, subsequent to December 31, 1969, meet the provisions of the Life Safety Code prescribed by the National Fire Protection Association (21st edition, 1967). Regarding 119/ the enforcement of such standards, the Committee report noted:

117/ Congressional Record--Senate; October 11, 1967.

118/ "Social Security Amendments of 1967," Senate Report No. 744, 90th Congress, 1st Session; November 14, 1967.

119/ Ibid.; p. 190.

The committee expects that such codes will be enforced in a manner designed to properly protect the health and safety of patients. At the same time, however, it is expected that due recognition will be given to waivers of specific conditions where rigid interpretations would result in undue hardship and heavy and unavoidable expense, and where such temporary or permanent waiver of requirements will not jeopardize the health and safety of patients in such institutions.

Although the Committee sought to impose some of the standards applicable under title XVIII to ECF's to skilled nursing homes under title XIX, the Committee also distinguished between the kinds of care rendered in each type of facility: ^{120/}

It is understood that, in general, the type of care rendered by skilled nursing homes under title XIX is not identical to extended care provided under title XVIII. Title XIX care tends to be long-term care, while title XVIII is designed for care of a more intensive and relatively short-term nature. In this context, therefore, the Committee expects that the Secretary and the States will not seek to impose unrealistic requirements upon title XIX skilled nursing homes. In particular, requirements relating to nursing personnel (other than the requirement of a full-time registered nurse on the staff of the institution) should give due recognition to shortages of such personnel, where such shortages exist, and determine needs for other nursing and auxiliary personnel on a realistic basis consistent with the actual needs of the types of patients in particular institutions. Such an approach is not intended, however, to excuse or permit continued understaffing.

120/ Ibid.

The Kennedy amendment was included in the committee bill with only minor modifications.^{121/} The amendment, the provisions of which were to become effective on July 1, 1970, required States to establish programs for the licensing of nursing home administrators and permitted, until July 1, 1972, the provisional licensing of persons operating homes at the time the licensing program went into effect. Federal matching funds would be provided to help States institute and operate programs of training and licensing of such personnel.

The Miller amendment was incorporated into the bill under a section providing matching assistance for care in "intermediate care" homes. The Committee justified the new program as one which could reduce pressure to put all recipients requiring some sort of institutional care in more costly skilled nursing homes under title XIX:^{122/}

At the present time old-age assistance recipients whose primary need is for care in an institution other than a skilled nursing home are frequently classified as in need of "skilled nursing home" care and placed in such institutions because of the decided financial advantage to a State under present matching formulas. Title XIX does not provide Federal matching funds for institutional care which provides more than room and board but less than skilled nursing home care -- only for "skilled nursing home care." But, if a State classifies a needy individual as in need of "skilled nursing home care," it can receive unlimited Federal matching funds. If it classifies him as in need of other institutional care, the State receives the standard old-age assist-

121/

Ibid.; p. 185.

122/

Ibid.; pp. 188-189.

assistance cash matching, which is available only up to \$75 a month on the average. Thus, the Federal and State governments often may pay upwards of \$300 a month for skilled nursing home care for a patient who could be adequately taken care of in another type of institution for \$150 or \$200 a month.

The amendment provided for vendor payments on behalf of categorically needy (cash assistance) welfare recipients at the matching assistance rate applicable in the State for its title XIX program. Intermediate-care facilities (or ICF's) were to be defined and licensed by the States and would include institutions which provided services beyond ordinary room and board, but below the level of skilled nursing homes. Intermediate care facilities would also be required to meet standards pertaining to safety and sanitation that were prescribed for such institutions by the State in which they were located.

In the bill finally passed and sent to conference committee, the Senate agreed to the Moss, Kennedy, and Miller amendments as contained in the Finance Committee bill. The conference committee, and later both Houses, accepted the three amendments without major revision, except for one provision relating to ICF's. Intermediate care facilities would be required to meet the same safety and sanitation standards that were applicable to skilled nursing homes under title XIX.^{123/} Implementation of these amendments is discussed in section 9 of this report.

^{123/}

"Social Security Amendments of 1967 -- Conference Report," House Report No. 1030; 90th Congress, 1st Session; December 11, 1967; p. 69.

8. The "Level of Care" Controversy in Medicare

1967 also marked the beginning of the so-called "level of care" controversy involving payments for extended care services in the medicare program. Title XVIII of the Social Security Act authorized payments for post-hospital extended care, but it explicitly prohibited payments for any care which was deemed to be "custodial" in nature. This immediately posed administrative problems for program officials who were required to make distinctions between extended care, which was covered by the medicare program, and custodial care, which was not.

The original estimates of the cost of extended care benefits in the hospital insurance program had been placed at about \$25 to \$50 million for 1967. Preliminary experience with extended care claims, however, soon suggested that this estimate was in error. When Administration witnesses appeared before the Committee on Finance in August of 1967, the Chief Actuary of the Social Security Administration reported that first-year costs for extended care could reach between \$250-\$300 million. The ranking minority Member of the Committee, Senator John Williams of Delaware, was especially concerned about the run-away costs of the new benefit and asked the Commissioner of Social Security what steps were being taken to define the scope of extended care:^{124/}

^{124/}

See page 359, Part 1 of source cited in Footnote #114.

Question. The extended care benefit was designed to cover the period of rehabilitation and convalescence following an episode of acute illness in a hospital. People were supposed to get that kind of rather intensive care in a quality care institution. What assurances do you have that precisely that kind of care is being provided rather than routine nursing home care. Because if we don't have those assurances -- properly enforced -- we will be picking up an enormous bill for routine custodial care of the elderly.

Answer. The problem of assuring that the extended care benefit does not become simple a benefit paid for long-term nursing care is a difficult one. It should be noted, however, that the extended care benefit legitimately covers not merely post-acute hospitalization, where the individual is convalescing or being rehabilitated but also many types of cases where the patient may continue to be very sick and indeed have little or no prospect of recovery... Conversely, the clear exclusion of custodial care has required the definition and identification of services and situations which are properly characterized as custodial since they are designed essentially to assist an individual in such activities of daily living as walking, getting in and out of bed, feeding and bathing, et cetera, which do not require the continuing attention of trained nursing personnel.

The Commissioner then went on to outline some of the actions being taken by the Social Security Administration to limit benefit payments only for the type of care envisioned by Congress: ^{125/}

We have worked very closely with the fiscal intermediaries in developing claims review procedures for assuring that payment is made only for the kind of care contemplated by the law. We have recently expanded our claims review guidelines to the intermediaries by issuing more definitive criteria for identifying custodial care situations which, as I indicated before, are excluded from coverage under the law. We are also undertaking, through the fiscal intermediaries, a special study of the medical characteristics of

patients and the level of nursing care they are receiving in extended care facilities in an effort to test the effectiveness of these guidelines and to create a sharp awareness in extended care facilities of the nature of the custodial care exclusion and of the fact that intermediaries are scrutinizing claims and rigorously applying the exclusion.

The guidelines referred to by the Commissioner were issued by the Social Security Administration in Intermediary Letter No. 257 on August 14, 1967.^{126/} The instructions to intermediaries expanded upon the definition of "custodial care" and set forth some of the criteria to be used in making claims determinations involving extended care benefits. In substance, the guidelines to the intermediaries defined extended or covered care as a level of care other than custodial care:^{127/}

...the definition of custodial care does not contemplate an intermediate level of care between covered care and custodial care. Accordingly, a decision that an individual is not receiving custodial care is also a decision that covered care has been provided.

The instructions contained in I.L. No. 257 were immediately attacked by the American Nursing Home Association in testimony before the Finance Committee on the 1967 Social Security Amendments:^{128/}

We know that Congress was concerned lest the medicare program be used to provide custodial care. We share that concern. However, intermediary letter 257 may well destroy the entire medicare program... It places the medicare recipient in the untenable position of not knowing at any time whether the care received under physician and Utilization Review

126/

A copy of I.L. 257 appears on page 1042, Part 2 of the source cited in Footnote #114.

127/

Ibid.

128/

See page 1852-53, Part 3 of source cited in Footnote #114.

Committee certification will be paid for by the Federal Government. It places the provider of service in the position, at any point, upon admission or at discharge of not knowing whether payment for the services rendered will ever be made by anyone.

Spokesmen for the Association argued that, if applied, Intermediary Letter 257 would result in an ever-increasing number of retroactively denied claims for extended care benefits. And, if this occurred, nursing home officials noted, it could seriously damage the confidence of patients, physicians, and extended care facilities in the medicare program. The industry witnesses felt that neither the Social Security Administration nor intermediaries should be in a position to override the decisions of physicians and utilization review committees:^{129/}

This [letter] places the fiscal intermediary and SSA over the Utilization Review Committee on which there is at least one physician...and substitutes an agency regulation for the medical decision of the physician and other members of the Utilization Review Committee. In requiring the establishment of the Utilization Review Committee...Congress certainly did not intend for medical decisions seriously arrived at to be retroactively overridden by a fiscal intermediary attempting to interpret letter 257 hastily conceived.

Despite these protests, however, Congress took no action in connection with the 1967 Amendments to interfere with Social Security Administration efforts to define more precisely the distinctions between extended care and custodial care in the title XVIII program. By June of 1968, agency officials were convinced that major "level of care" problems continued to

^{129/}

See page 1353 of source cited in Footnote #114.

plague the extended care area and issued a new instruction, Intermediary Letter 328, to deal with the matter. Previous agency guidelines had classified all noncovered care as "custodial care." Care which was not custodial within the meaning of that term, as prescribed for example in Intermediary Letter 257, was covered by the program. The new instructions adopted the term "noncovered care" to refer to any level of care less than extended care. "Extended care" was now defined as the level of care "provided in those cases in which the patient's condition upon his discharge from a hospital requires him to be in an institution for the primary purpose of receiving continuous skilled services." The terms, "skilled services" and "primary purpose" were defined and intermediaries instructed to deny claims failing to meet the new definition of extended care.

In April 1969, agency policies regarding extended care benefits were further revised. A new intermediary instruction, Intermediary Letter 371, contained the following directive.^{130/}

The term "extended" refers not to provision of care over an extended period, but to the provision of active treatment as an extension of inpatient hospital care. The overall goal is to provide an alternative to hospital care for patients who still require general medical management and skilled nursing care on a continuing basis, but who do not require the constant availability of physician services ordinarily found only in the hospital setting. All extended care facilities participating in the program are considered capable of rendering the skilled care which constitutes extended care. However, the medicare law identifies a specific type of inpatient nursing care which will be reimbursable under the program.

130/

Intermediary Letter No. 371 -- Determining coverage of care in an extended care facility; Bureau of Health Insurance, Social Security Administration.

The new instructions defined extended care as "that level of care provided after a period of intensive hospital care to a patient who continues to require skilled nursing services on a continuing basis but who no longer requires the constant availability of medical services provided by a hospital." I.L. 371 contained detailed instructions and examples of what constituted and what did not constitute "skilled nursing services on a continuing basis." The letter also attempted to identify the point at which continuous skilled services no longer met the "level of care" requirement necessary to make it extended care.

As the American Nursing Home Association had predicted, the rate of extended care claims denied as the result of the application of the "level of care" instructions began to increase dramatically. During the first six months of 1968, the denial rate involving claims for extended care benefits had been about 1.5%.^{131/} This rate nearly doubled during the following year, rising to 2.7% between July 1968 and June 1969. Following the issuance of Intermediary Letter 371, the rate of denials rose sharply -- to 7.1% during the last six months of 1969 and to 8.2% for the first three months of 1970.

When representatives of the American Nursing Home Association appeared before the Committee on Ways and Means in the fall of 1969, they declared that the situation regarding denials based on "level of care" considerations was reaching critical proportions. In their testimony, Association officials

^{131/}

"Impact of Implementation of SSA Guidelines for Determining Level of Care Furnished in ECF's on Utilization under Medicare of General Hospitals and Extended Care Facilities," SSA Program Circular No. 13; July 1970.

recommended that the definition of the term "custodial" be clarified by Congress and that none of the first ten days in an ECF be considered as custodial care.^{132/} In cross examination, these officials also indicated that they would support efforts to strengthen the role of utilization committees in order to make their determinations binding on fiscal intermediaries.^{133/}

In the spring of 1970, the Committee on Ways and Means reported out legislation on the Social Security Act containing a provision to deal with the matter of retroactive claims denials:^{134/}

Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for extended care facility or home health benefits cannot generally be made until sometime after the services have been furnished. Your committee is aware that in many cases such benefits are being denied retroactively, with the harsh result that the patient is faced with a large bill he expected would be paid or the facility or agency has a patient who may not be able to pay his bill. The uncertainty about eligibility for these benefits that exists until after the care has been given tends to encourage physicians either to delay discharge from the hospital, where coverage may be less likely to be questioned, or recommend a less desirable, though financially predictable, course of treatment.

Although the Committee did not revise the definition of custodial care, it did propose to remove some of the discretion granted intermediaries in making claims determinations regarding covered care. The Committee bill included a provision for determining in advance a minimum period of coverage in an ECF for patients, who, considering their medical conditions, age,

132/

"Social Security and Welfare Proposals," Hearings before the Committee on Ways and Means; 91st Congress, 1st Session; Part 4; p. 1152.

133/

Ibid.

134/

"Social Security Amendments of 1970," House Report No. 91-1096; 91st Congress, 2d Session; May 14, 1970; p. 48.

and other factors, would be presumed to need the type of care necessary to qualify for program benefits. The Secretary would be empowered to establish, by diagnosis and length of stay, periods during which presumptive coverage would be granted. The bill also provided that, when in the course of its normal review, a utilization committee found that a patient was receiving custodial services, or that he had recuperated sufficiently to no longer require intensive skilled care, payments during the approved period would be terminated prospectively, rather than retroactively, thereby giving the patient and his physician an opportunity to make other arrangements before coverage lapsed.^{135/}

The "level of care" issue and the matter of retroactively denied claims for extended care also received widespread attention in the other body of Congress during 1970, particularly from the Committees on Aging, Labor and Public Welfare, and Finance.^{136/} The latter committee, in its December 1970 report on proposed amendments to the Social Security Act, agreed with the Committee on Ways and Means and the House that a legislative remedy was needed to deal with the problem:^{137/}

^{135/} Sec. 233 of H.R. 17550.

^{136/} The findings of the Subcommittee on Long-Term Care of the Senate's Special Committee on Aging were reported by the Subcommittee's Chairman, Senator Frank Moss of Utah in the Congressional Record on April 10, 1970. The Senator charged that the ECF program was being "dismantled" as the result actions by program administrators.

^{137/} "Social Security Amendments of 1970," Senate Report No. 91-1431; 91st Congress, 2d Session; December 11, 1970; p. 130.

The committee believes that in practice, the administration of extended care and home health benefits has proved difficult and has led to considerable dissatisfaction... The House sought to alleviate the problem by including a provision authorizing the Secretary to establish presumptive periods of coverage according to diagnosis and other medical factors for patients admitted to an extended care facility... While this approach seeks to alleviate much of the administrative complexity by focusing determinations on the totality of needs of certain categories of patients, rather than evaluation of specific nursing procedures, it introduces certain new administrative problems. The wide range of illnesses common to the aged, as well as the frequent occurrence of "combination diagnoses," makes specific categorization difficult.

The Finance Committee recommended (and the Senate subsequently agreed) that, to the extent feasible, pre-admission review of extended care admissions would be required and unless disapproved, coverage upon admission would continue for the lesser of (1) the initially certified period, (2) until notice of disapproval, or (3) ten days. Where certifications and evidence were provided on a timely basis, subsequent determinations (for the purpose of establishing Medicare benefits) that a patient no longer required covered care would become effective 2 days after notification to the extended care facilities.

Although both bodies of Congress passed proposed amendments (H.R. 17550) to the Social Security Act in 1970, the 2d Session of the 91st Congress ended before conference action could be taken to iron out differences between the House- and Senate-passed bills on social security. As a result, legislative efforts to resolve the "level of care" issue and to deal with the problem of retroactive claims denials were

postponed until the following year. The actions taken by the 92d Congress in the extended care benefit area are discussed later on in this report.

9. Skilled Nursing Homes under Medicaid--Implementation of the Moss Amendment

During the 90th Congress, Senator Frank Moss of Utah had recommended (see section 7 of this report) that title 19 of the Social Security Act be amended to establish certain plan requirements for skilled nursing homes participating in State medicaid programs. These recommendations were subsequently included by Congress in P.L. 90-248, the Social Security Amendments of 1967.^{138/}

Under the 1967 Moss amendment, States were required to establish, by July 1, 1969, regular programs of medical review under which periodic evaluations of the care provided in nursing homes would be made. The States were also directed to make periodic on-site inspections of medicaid nursing facilities. In addition to the medical review and inspection requirements, the Moss amendment also prescribed certain minimum standards

^{138/} P.L. 90-248, sec. 234(a) added paragraphs 1902(a)(26), (27), and (28) to title 19 of the Social Security Act.

for skilled nursing homes proposing to participate in State medicaid programs. These standards dealt with such matters as: (1) disclosure of facility ownership, (2) the organization and supervision of the nursing services in the home, (3) meal and dietary planning services, (4) medical supervision, medical records, drug administration, and emergency care, (5) arrangements with hospitals for diagnostic and acute care hospital services, and (6) facility standards designed to protect the health and safety of patients in skilled nursing homes. All but the last of these standards were to become effective on January 1, 1969. The sixth standard, discussed later on in this report, would apply to skilled nursing homes after December 31, 1969.

One of the requirements contained in the Moss amendment specified that any skilled nursing home under medicaid had to have and maintain an organized nursing service for its patients. The nursing service had to be directed by a professional registered nurse and be composed of "sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for such patients during all hours of each day and all days of each week".^{139/} This requirement regarding the

^{139/}

Sec. 1902(a)(28)(B) of the Social Security Act.

staffing of medicaid nursing homes was singled out for comment by the Senate Committee on Finance in its report on the 1967 social security bill:^{140/}

...the committee expects that the Secretary and the States will not seek to impose unrealistic requirements upon title XIX skilled nursing homes. In particular, requirements relating to nursing personnel (other than the requirement of a full-time registered nurse on the staff of the institution) should give due recognition to shortages of such personnel where such shortages exist, and determine needs for other nursing and auxiliary personnel on a realistic basis consistent with the actual needs of the types of patients in particular institutions. Such an approach is not intended, however, to excuse or permit continued understaffing.

Implementation of this staffing requirement by HEW subsequently led to considerable controversy between the agency and the amendment's sponsor, Senator Moss. At issue in the controversy were two specific problems: the qualifications of the shift supervisors or "charge" nurses on duty in the facility and the numbers of nursing personnel needed in a home to provide adequate nursing service to facility inpatients.

It may be helpful for a moment to again recall some of the actions taken by HEW regarding nursing home standards before adoption of the Moss amendment in 1967. In section 6 of this report, it was pointed out that Congress provided no statutory definition of the terms "skilled nursing home" or "skilled nursing home service" in title 19 of the Social Security

^{140/}

See p. 190 of the source cited in Footnote #118.

Act. The committee reports on the 1965 authorizing legislation also failed to define these concepts as they were to be applied in the medicaid program.

In June 1966, the Department attempted to define skilled nursing homes under medicaid as those facilities which otherwise met, or would meet in a specified time period, the standards applicable under medicare to extended care facilities. As a result, the standards for an organized nursing service would have been identical for skilled nursing institutions participating in either of the two programs: (1) 24-hour nursing service, (2) a director of nursing who was an R.N. employed full-time by the home, and (3) charge nurses with qualifications of one of two kinds--R.N.'s or licensed practical (or vocational) nurses who were graduates of State-approved schools of practical (or vocational) nursing.

In March 1967, after considerable pressure on the Department to establish separate standards for medicaid facilities, HEW revised its requirements for the nursing service in a skilled nursing home. Under the revision, charge nurses could be qualified in one of three ways (instead of the two still applicable to ECF's under medicare). In addition to R.N.'s or school trained L.P.N.'s, L.P.N.'s who were not graduates could qualify as charge nurses, if (1) they were successfully

discharging the duties of a charge nurse on July 1, 1967 and (2) if they had completed training satisfactory to the appropriate State licensing authority.^{141/} The Secretary of HEW explained to a committee of Congress that the change was made by the Department in recognition of "the problem which many States face in securing adequate qualified staff to serve in nursing facilities."^{142/}

On January 2, 1968, P.L. 90-248, containing the Moss amendment, was signed into law. In November 1968, about two months before the standard for the staffing of facilities was to become effective, the Department issued Interim Policy Standard No. 19, designed to implement certain requirements of the Social Security Amendments of 1967.^{143/} The Interim Policy Statement repeated the standards previously included by the Department in its revision of the Handbook of Public Assistance in March of 1967.

In June 1969, six months after final regulations should have been issued, HEW issued a second Interim Policy Statement.^{144/} Under these new interim regulations, the standards for charge nurses were made even less stringent than those previously applicable under medicaid:^{145/}

^{141/} D-5141.1 of the Handbook of Public Assistance, March 2, 1967.

^{142/} See quotation at Footnote #105.

^{143/} 33 Federal Register 16165. November 5, 1968.

^{144/} 34 Federal Register 9788. June 24, 1969.

^{145/} Ibid., p. 9789.

No later than July 1, 1970, there is on duty at all times and in charge of nursing activities at least one professional registered nurse or licensed practical (or vocational) nurse who is a graduate of a State-approved school of practical nursing, or who is found by the appropriate licensing authority on the basis of the individual's education and formal training to have background considered to be equivalent to graduation from a State-approved school of practical nursing.

At the end of July, Senator Moss convened his Subcommittee on Long-Term Care to examine the Department's actions regarding staffing standards for skilled nursing homes under medicaid. In his statement at the beginning of the hearings, the Senator explained his concerns:^{146/}

I had expected to begin these hearings on "Trends in Long-Term Care" later in the year, but it has become obvious that this sub-committee cannot ignore a current crisis while considering future trends. That crisis is the recently issued interim regulations describing the standards for skilled nursing homes under medicaid issued by the Department of Health, Education and Welfare. The new regulations provide that, by July 1, 1970, licensed practical nurses in charge of nursing activities on all shifts must be qualified by graduation from a State-approved school of practical nursing or have background equivalent to such training. But until then, nurses in charge on other than the day shift may be licensed practical nurses "waivered" by a State licensing agency. HEW's recent announcement also notes that the newly published standards match those in the handbook of public assistance administration that regulated services until

146/

"Trends in Long-Term Care," Hearings before the Subcommittee on Long-Term Care, Senate Special Committee on Aging, Part 1; July 30, 1969; pp. 1-2.

January 1 of this year, with the exception of the waiver granted for the employment of nurses who are not qualified by formal training. We are left, therefore, with regulations that say, in effect, that a single, untrained practical nurse on duty in a home with 200 or 300 patients or more constitutes "properly supervised nursing services" on the afternoon and night shifts. It is also questionable whether the provision for what HEW calls background equivalent to such training will in fact provide properly trained supervisory personnel. This language permits a State licensing authority to determine that an individual has "background considered to be equivalent" to graduation from a State-approved school of practical nursing. I fear this may mean serious State-to-State differences in supervisory quality.

The Deputy Commissioner of the Department's medicaid agency, the Medical Services Administration (MSA), appeared before the Moss subcommittee to describe some of the factors which influenced the decisions regarding staffing standards for skilled nursing homes.^{147/} The Commissioner explained that HEW viewed ECF's under medicare, skilled nursing homes under medicaid, and intermediate care facilities (ICF's) under title XI of the Social Security Act as three different kinds of institutions:^{148/}

^{147/} The Commissioner of the Department's medicaid agency had resigned a week before the Moss subcommittee began its hearings. An interesting description of some of the events leading to commencement of hearings appears in "Default on Nursing Home Code", Hospital Practice, Vol. 4, No. 12, December 1969; p. 14.

^{148/} See p. 5 of the source cited in Footnote #146.

Many standards for all three long-range care facilities--intermediate care facilities, skilled nursing homes, and extended care facilities--must be equally comprehensive and protective. High standards for conditions relating to fire protection, safety, environment, and sanitation apply to all. But the personal and medical care required by the people in each of these institutions must dictate the essential characteristics that make them differ--that make one institution an intermediate care facility and not an extended care facility, and make another a skilled nursing home and not an intermediate care facility... Thus, in thinking about the care to be given in a skilled nursing home, we were guided by the idea that there should be distinctions in service between a less medically oriented facility and a more medically oriented facility.

The Commissioner also cited the language regarding implementation of the Moss amendment contained in the Finance Committee report--that the Department should not seek to impose "unrealistic" requirements on skilled nursing homes, particularly with respect to nursing personnel. He added that the Department's 1967 standards, spelled out in the Handbook of Public Assistance, recognized the existence of a shortage of qualified nursing personnel:^{149/}

At the time this definition was issued in 1967, it was realized that there was a shortage of licensed practical nurses fully qualified by training and that many practical nurses were licensed by waiver. It was also clear that training opportunities for practical nurses licensed by waiver were

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Ibid., pp. 5-6.

very rare and that there was need to mount a full-scale training program. But, the training program envisaged in 1967 never materialized. In the first place, the Department never provided the ingredient essential to the development of such a program--money. In addition, other aspects of a training program were never clarified. There was little agreement, for example, about the curriculum to be covered. There was great disagreement about the number of hours of training it should take to bring a licensed practical nurse qualified by graduation from a State approved school... Thus, for a variety of reasons, it is now no easier for a practical nurse licensed by waiver to upgrade her training than it was in 1967.

For these reasons, the Commissioner noted, the Department's regulations subsequently made allowances for equivalent training and the continued use of waived LPN's as charge nurses in skilled nursing homes:^{150/}

In the absence of opportunities for training that would allow practical nurses licensed by waiver to qualify for responsible positions, we are negating our instructions and responsibilities, and aggravating the shortage of health personnel if we declare individuals who have filled responsible positions ineligible for those positions.

The Commissioner also explained to the subcommittee the Department's position regarding ratios of charge nurses to patients in skilled nursing homes.

^{150/} Ibid., p. 6.

He pointed out that early drafts of the regulations regarding staffing included a requirement that established such ratios. Discussions with other agencies, however, resulted in a dropping of the ratio approach:^{151/}

...The ratio we set could have resulted in more stringent staffing requirements for skilled nursing homes than for extended care facilities and...this was not supportable. Further research disclosed that the Joint Commission on Accreditation of Hospitals does not recommend ratios for extended care facilities, nursing homes, or resident care facilities. It has become clear to us that no practicable way has yet been found to establish a ratio as a national standard. We have, therefore, published our regulation without a ratio of supervising nurses to patients and believe it is wiser to do this until such time as staffing experts can find a basis for a recommendation.

Each rationale enunciated by the Department in support of its actions on the Moss amendment was challenged by other witnesses testifying before the Subcommittee on Long-Term Care. Many of the witnesses, for example, refused to accept the Department's view regarding differences in skill levels needed to provide care in ECF's and skilled nursing homes. One nursing home administrator observed:^{152/}

The argument is frequently made that Title XIX care is different from Title XVIII care and for this reason Title XIX skilled nursing home standards should be less

^{151/} Ibid., p. 7.

^{152/} Ibid., p. 86.

than those for extended care facilities under Title XVIII. This argument is without merit. It is true that the care under Title XIX is different from that under XVIII. However, the difference is not in the skill required but in the duration and intensity of that care... The point I am trying to make is that these patients are patients requiring skilled nursing care--and they require such care 24 hours each day. If they do not require such care, they do not belong in skilled nursing home beds. Rather, they belong in intermediate care beds. Further, they are not extended care patients only because they have a lingering illness rather than an acute condition now in its post-hospital recuperative stage. Again, the difference between the care under Medicare (Title XVIII) and that under Medicaid (Title XIX) differs only in the length of time involved, not in the skilled care required.

Several of the witnesses appearing before the subcommittee criticized the Department for reducing staffing requirements because of the apparent shortages in the numbers of qualified nursing personnel available for employment in skilled nursing homes under medicaid. The American Nurses' Association, for example, suggested that the supply and distribution of manpower should not determine the content of the standards to be applied:^{153/}

One of the reasons given for the lowered standards is the shortage of qualified nurses. The availability of qualified personnel should not be the factor which determines the standards for an establishment. Rather, the standards should be set according to the services that are to be provided.

^{153/}

Ibid., p. 69.

The representative from the American Association of Homes for the Aging agreed:^{154/}

...those facilities which cannot qualify as skilled nursing homes because of personnel or other major deficiencies [should] be designated by a name other than skilled nursing facilities, and that until the time at which they can qualify (under adequate standards) as skilled nursing facilities, they [should] be reimbursed at a lower and more appropriate level of reimbursement. The Association believes that the creation and consistent use of such nomenclature and financial distinctions will accomplish several worthwhile ends: it will assure the public that Homes classified as skilled are truly skilled nursing facilities, it will save public funds, and it will tend to upgrade facilities by clearly defining the market for them and the shortages which exist.

Some of the witnesses testifying before the subcommittee suggested that the Department's regulations might actually hamper, rather than help, in the development by the States of adequate and effective standards for skilled nursing facilities. In their view, the minimal Federal staffing requirements, together with the waiver provisions, could very well perpetuate subsidization of substandard institutions:^{155/}

Lowering standards for skilled nursing homes will only fix into place the present system and will abort the coming into being of the intermediate care facility because there will be no need for a facility to become an ICF since it will be so easy to be a skilled nursing home under low standards. If the intermediate care facility fails to emerge, States will continue to be forced to place patients requiring less than skilled care in the higher priced bed in what under the lower standards provided by the June 24 Interim Policy Statement would only be a so-called skilled nursing home. The skilled nursing home and the intermediate care facility are intended to complement each other. They will do so only if the standards for skilled nursing homes are kept properly high to identify them as medical-care facilities....

^{154/}

^{Ibid.}, pp. 73-74.

^{155/}

^{Ibid.}, p. 87.

Not all of the witnesses criticized HEW for failing to impose stringent staffing standards for skilled nursing homes under medicaid. The American Nursing Home Association, for instance, expressed reservations opposite those of the Department's critics:^{156/}

It is in this context that we of the American Nursing Home Association state our support for the intent of the proposed standards, while expressing grave concern and strong reservations about the ability of the States to implement them. We believe and recommend that provision should be made to allow the States time to "tool up" to meet the new standards. This leadtime would allow the States to properly classify patients as to the level of care needed, to acquire the additional funds that will be needed to pay for higher standards to permit the States to upgrade their staffing patterns in those States where lower standards have prevailed in the past, and, most importantly, to provide for a workable system of qualifying experienced, trained LPN's and RN's in order to create the pool of manpower that implementation of the proposed standards would necessitate. Indeed, financial considerations aside, the manpower needs to meet the nursing service standards proposed is the most critical problem that will confront the States and the participating facilities in seeking to implement the new standards -- even if leadtime is provided. That is, even if adequate funding can be obtained, and this is by no means a certainty, it is an absolute certainty that neither this year, nor next, will the supply of licensed personnel be adequate in many States to meet the staffing patterns proposed.

The Association's witnesses also opposed inclusion in Federal regulations of any requirements regarding ratios of nursing personnel to patients served in skilled nursing homes:^{157/}

^{156/}

Ibid., p. 89.

^{157/}

Ibid., pp. 94-95.

Senator Moss. You are saying, then, because most of the States, you think, have regulations on nursing ratios that, therefore, it is unnecessary in any of the Federal regulations to have a minimum standard.

Mrs. Baird I think it is unnecessary at this time. Possibly when the ANA has developed patterns of care, there may come the day that we would like to say you can have or should have or must have x number of nurses to x number of patients. But this varies.... For 30 years I have watched the physicians, the nurse educators try to define the quality of care. Thirty years later I am still waiting for an answer.

Despite the hearings, no further action was taken during 1969 by the Department either to revise the June 24 Interim Policy Statement or to issue final regulations dealing with the staffing requirements included in the 1967 Moss amendment. Finally, in April 1970, in a Senate floor statement entitled "What Ever Happened to the Moss Amendments," the Senator expressed his dismay at the Department's inability to act:^{158/}

Mr. President, it is difficult to tell exactly what has been going on within the Department. It is as though a protracted quarrel has been taking place behind closed doors. From time to time a door is opened and one hears commotion and a confusion of raised voices. Then the door swings closed and all is quiet again. We know with certainty only that there has been little practical result from our legislation efforts.... Mr. President, these flimsy interim regulations have been denounced by practically every expert in the field including the Department's own hand-picked task force. We have heard that they will be improved when they are reissued as final regulations, but almost a year has passed since the interim standards were published and we have seen no sign of the final regulations. Almost a year later these discredited interim standards remain in effect.

The Senator announced that his subcommittee would commence new hearings on May 7, 1970 to find out "What possible explanation can there be for this governmental debacle?"

On April 29, 1970, HEW issued final regulations implementing Sec. 1902 (2)(28) of the Social Security Act.^{159/} Two significant changes were made in the regulations with respect to the staffing requirements for skilled nursing homes under medicaid. The standard for charge nurses was revised to permit the use of waived LPN's:^{160/}

...who [are] found by the appropriate State licensing authority for nurses on the basis of the individual's education and formal training to have background considered to be equivalent to graduation from a State's approved school of practical nursing except that: In those instances in which a licensed practical nurse serving as a charge nurse is not a graduate of an approved school and does not possess background determined to be equivalent but was successfully discharging the responsibilities of a charge nurse on July 1, 1967, such nurse may continue to be employed in this capacity until July 1, 1970, but after that date only if she has been found by the appropriate State licensing authority to have completed training equivalent to graduation from a State-approved school of practical nursing.

On the matter of staffing ratios, the final regulations defined the terms "adequate nursing services" to mean:^{161/}

159/

35 Federal Register 6792. April 29, 1970.

160/

Ibid., pp. 6793-94.

161/

Ibid., p. 6794. In "Developments in Aging -- 1970," the annual report of the findings of the Senate Special Committee on Aging, it was observed that the staffing ratio guidelines were yet to be published by the Department. The Senate report (No. 92-46) was published on March 24, 1971. HEW eventually published guidelines on November 3, 1971. They may be found in Program Regulation Guide, MSA-PRG-10, "MSA Medical Assistance Manual: Guidelines for Evaluation of Nursing Services in Skilled Nursing Homes."

Numbers and categories of personnel are determined by the number of patients and their particular needs in accordance with accepted policies of effective nursing care and guidelines issued by the Social and Rehabilitation Service [the parent agency in HEW responsible for the medicaid program].

Two of the issues raised in connection with the implementation of the Moss amendment were the subject of legislative action by the Senate Committee on Finance toward the end of 1970. In December of that year, the Committee sent to the floor proposed amendments to the Social Security Act (H.R. 17550), including changes in the medicare and medicaid programs. One of the provisions in the Committee-bill dealt with the question of whether there should be separate and different standards for ECF's under medicare and skilled nursing homes under medicaid. Another provision related to the supply of qualified nursing personnel to serve in skilled nursing facilities.

In its report on H.R. 17550, the Committee on Finance observed that the standards applicable to ECF's and skilled nursing homes were identical in some respects and very similar in others. But the differences were not related to the level of care provided by each institution: ^{162/}

While the emphasis of the care under the two programs may differ somewhat--medicare focusing on the short-term care patient and medicaid on the long-term patient--patients under both plans require the availability of essentially the same types of services and are often in the same institution. Indeed, not infrequently, after expiration of medicare benefits, the patient may remain in the same facility--even in the same room--continuing on as a medicaid recipient.

162/

See p. 143 of the source cited in Footnote #137.

The report goes on to note that, despite the similarities, separate requirements and a separate process for determining eligibility to participate in the two programs had been established. This, the Committee said, was administratively cumbersome and unnecessarily expensive. As a result, the Committee proposed that a single set of standards relative to health, safety, environmental conditions, and staffing be applied to nursing facilities under medicare and medicaid. The Committee amendment would also have established a single method for determining the eligibility of facilities to participate in each of the programs. ^{163/} The Committee expressed concern, however, that the application of uniform standards not reduce or weaken efforts by the States to apply higher standards than those otherwise prescribed by the Federal Government: ^{164/}

The committee amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities. For that reason, the amendment provides that a higher standard as judged by the Secretary of Health, Education and Welfare in one program--whether the standard is a current requirement or one required in the future--shall be applicable to the other program as well. Any waiver of a standard applicable to both programs may be applied only if acceptable under both programs. Additionally, a State may continue to require higher standards of skilled nursing facilities than those mandated by Federal statute and regulation. In case a State imposes additional requirements in its own right, those standards shall apply to both medicare and medicaid skilled nursing facilities in that State.

A second provision in the Committee-bill was occasioned, in part, by

^{163/}

Sec. 240 of H.R. 1755, as reported by the Committee on Finance.

^{164/}

See p. 144 of the source cited in Footnote #137.

the charge nurse qualifications requirement prescribed by HEW at the end of April 1970. In its report, the Committee observed: 165/

The Medical Services Administration issued a ruling effective July 1, 1970, concerning licensed practical nurses in skilled nursing homes participating in medicaid. Nursing homes, according to the ruling, must have as charge nurses for each shift (other than the day shift which requires a registered nurse) a registered nurse or a licensed practical nurse, with a degree from a State-accredited school or its equivalent. There is an acute shortage of nursing personnel and many hundreds of nursing homes have been covering some shifts with "waivered" practical nurses. These are practical nurses, who do not have the required formal training, and who, in many States, have been licensed on a waived basis. Undoubtedly, a substantial proportion of these practical nurses have years of experience and are competent to serve as charge nurses. ...the Department of Health, Education and Welfare has taken no action since 1967, in developing proficiency testing or short-term supplemental training for these personnel, and consequently, many otherwise qualified nursing homes are being, or soon may be, forced out of the program because of their inability to locate a registered nurse or a licensed practical nurse.

The Committee included in the bill an amendment to require the Secretary of HEW to develop and apply means of determining the proficiency of health personnel "disqualified or limited in responsibility under present regulations." The Committee's report emphasized that it opposed "grandfathering" of totally unqualified people, but that it also opposed the use of arbitrary and inflexible cut-off standards of qualification which rule out otherwise competent personnel. The amendment further provided that proficiency

165/ Sec. 264 of H.R. 17550, as reported by the Committee on Finance.

certification would not apply after December 31, 1975, and that qualification after that time would have to be based on formal training criteria. ^{166/}

As noted earlier in this report, the 91st Congress ended before action could be completed on proposed amendments to the Social Security Act. Action by the 92nd Congress on these issues is discussed later on in the report.

10. Intermediate Care Facilities (ICF's)--Implementation of the Miller Amendment

During the discussion in 1967 of proposed changes in the Social Security Act, spokesmen for the nursing home industry pointed out that the Moss amendment provided financing for only one level of nursing care under medicaid, namely care in a skilled nursing home. ^{167/} Nursing home operators explained, however, that there were a great number of recipients who, though in need of some form of institutional care, did not require the intensive level of care anticipated by the Moss amendment. If adopted, the Moss amendment would provide no assistance for these persons.

To deal with the problem, the industry's witnesses suggested, and Senator Jack Miller of Iowa sponsored, an amendment creating a new program of matching assistance for persons in need of "intermediate care." Intermediate care would involve more than room and board, but not be intensive enough to be considered skilled nursing home care. The Senate

^{166/} Sec. 264 of H.R. 17550, as reported by the Committee on Finance.

^{167/} See section 7 of this report.

Committee on Finance added the Miller amendment to the proposed Social Security Amendments of 1967:^{168/}

Good skilled nursing home care is expensive. At the present time, under the medical assistance program, skilled nursing home services are offered with Federal sharing in the cost. These homes have relatively high standards for approval. Serious questions have been raised with the committee concerning the limitation, under Federal law, on the kinds of facilities for which Federal matching is available. The committee believes that a strong case exists for introducing another level of care for which vendor payments would be available.

The Committee pointed out that existing law actually provided a financial incentive for States to classify recipients who required any form of institutional care as persons in need of skilled nursing home services:^{169/}

At the present time old-age assistance recipients whose primary need is for care in an institution other than a skilled nursing home are frequently classified as in need of "skilled nursing home" care and placed in such institutions because of a decided financial advantage to a State under present matching formulas. Title XIX does not provide Federal matching funds for institutional care which provides more than room and board but less than skilled nursing home care--only for "skilled nursing home" care. But, if a State classifies a needy individual as in need of "skilled nursing home" care, it can receive unlimited Federal funds. If it classifies him as in need of institutional care, the State receives the standard old-age assistance cash matching, which is available only up to \$75 a month on the average. Thus, the Federal and State governments often may pay upwards of \$300 a month for skilled nursing home care for a patient who could be adequately taken care of in another type of institution for \$150 or \$200 a month.

^{168/} See p. 188 of the source cited in Footnote #118.

^{169/} See p. 189 of the source cited in Footnote #118.

Under the amendment added to the bill, vendor payments could be made on behalf of cash assistance recipients who were or could be served in intermediate care facilities.^{170/} The rate of Federal sharing for such care would be identical to the matching formula, if used by the State, for its Title XIX or medicaid program. ICF's were to be defined and licensed by the States and would include institutions providing more than room and board, but less than skilled nursing care.

The report of the Committee on Finance sets forth two principal objectives for the Miller amendment: first, that it could lead to an overall reduction in medicaid assistance costs and, second, that it would enable institutions which could not qualify under the Moss amendment (i.e., as skilled nursing homes) to continue their participation in State programs as ICF's:^{171/}

This amendment could result in a reduction in the costs of title XIX, by enabling States to use lower cost facilities more appropriate to the needs of thousands of persons, thus avoiding the higher charges for skilled nursing homes when care of that kind is not needed. This provision would remove the incentive to classify such people as "skilled nursing home" patients. The amendment would also solve many of the problems encountered by small institutions which are now technically classified as nursing homes but which basically provide lesser care. They cannot possibly meet title XIX standards for skilled nursing homes and while often appropriate to provide the types of care envisaged by this amendment, they might very well be forced out of business

^{170/} As originally enacted, vendor payments toward the costs of intermediate care were limited only to persons eligible for cash assistance in the aged, blind and disabled welfare assistance categories.

^{171/} See p. 189 of the source cited in Footnote #118.

when required to meet title XIX standards. Such facilities are frequently the only nonhospital institutions available in rural areas and do meet a legitimate need for care less than that found in skilled nursing homes.

In contrast to the discussion of the Moss amendment, the Senate report language on the Miller amendment leaves open the question of standards for ICF's. The report only notes that such institutions are to be defined and licensed by the respective States. In the conference between the Houses over differences in the proposed 1967 Social Security Amendments, the House conferees agreed to the Miller amendment, but added one significant requirement. Intermediate care facilities would be required to meet the safety and sanitation standards which were applicable to skilled nursing homes under medicaid. The conference report also makes it clear that the ICF program, though not part of medicaid, was not to be used for the purpose of financing the custodial care requirements of welfare recipients: ^{172/}

It is the intention of the conferees for the House that providing services in intermediate care facilities is not to be taken as authorizing, or acting as a precedent for, the furnishing of custodial care of a type which merely provides, for welfare recipients in the program specified, room and board with no personal or other services.

Sec. 250 of P.L. 90-248 (the Social Security Amendments of 1967) added the Miller amendment to Title XI (the General Provisions title) of the Social Security Act.

^{172/} See p. 69 of the source cited in Footnote #123.

In September 1968, the Department of Health, Education and Welfare issued Interim Policy Statement No. 23, setting forth the temporary policies and requirements for implementation of the Miller amendment (Sec. 1121 of the amended Social Security Act).^{173/} Among other things, the regulations contained certain Federal minimum standards on those States proposing to receive matching assistance toward the costs of intermediate care under the new program. Permanent regulations were published in June 1969, but revised again in June 1970.^{174/}

Some of those who had criticized HEW for its regulatory actions regarding the Moss amendment also charged that the Department watered down the original ICF policies and requirements.^{175/} The Commissioner of the Medical Services Administration answered these charges in letter to Senator Moss in September of 1970:^{176/}

In developing the original regulations it was felt that the Federal government was responsible for establishing the minimum specifications for the range or level of care and services suitable to the needs

^{173/} 33 Federal Register 12925; September 12, 1968.

^{174/} 34 Federal Register 9782; June 24, 1969 and 35 Federal Register 8990; June 10, 1970.

^{175/} See for example, "Developments in Aging--1970", Senate Report No. 92-46. March 24, 1971; p. 360.

^{176/} Ibid., p. 322.

of eligible individuals. However, shortly after the publication of the regulations in June of 1969, legal authorities in certain States questioned whether the inclusion of such specifications in Federal regulations was consistent with the statutory language which defined an intermediate care facility as one "licensed, under State law, to provide....the range or level of care and services..." and requested a review of this question by the Department. After extensive review within the Department, it was decided that the law intended to reserve the establishment of standards for intermediate care to the States. Accordingly, the regulations were amended and the standards previously issued relating to the range or level of care and services were retained as recommendations.

Implementation of the ICF program was also the subject of intensive investigation and criticism by the staff of the Senate Committee on Finance. In a report published in February 1970, the staff charged that: ^{177/}

Several major difficulties have emerged and are emerging in the actual implementation of the intermediate care provision which are costly and inconsistent with Congressional intent.

Four specific problems were cited as cause for such a conclusion. First, the staff found States engaged in a wholesale reclassification of long-term care institutions within their borders: ^{178/}

For example, two States, Ohio and Oregon, sought to define an ICF simply as any licensed nursing home which could not or would not qualify as a

177/

"Medicare and Medicaid: Problems, Issues and Alternatives", Report of the Staff of the Committee on Finance (Committee Print), February 9, 1970; p. 99.

178/

Ibid.

skilled nursing home under medicaid. This approach appears more to accomodate sub-standard nursing homes than to encourage development of reduced levels of care appropriate to the needs of persons capable of being transferred from skilled nursing homes. An outgrowth of this approach is the wholesale reclassification by States of facilities which on one day were approved as skilled nursing homes under medicaid and the next day miraculously transformed into intermediate care facilities.

The staff also found evidence of wholesale changes in the status of patients served by long-term institutions: 179/

...the wholesale transfer in status of facilities from medicaid skilled nursing homes to intermediate care facilities was accompanied by wholesale and indiscriminate transfer of patients from one program to the other. This appears completely inconsistent with the Congressional intent that each skilled nursing home patient's needs be individually and professionally evaluated to determine whether his needs can be satisfactorily met in an intermediate care facility.

Another problem uncovered during the course of the investigation indicated an effort on the part of some States to use the ICF program as a means for obtaining Federal funds for purposes other than for those for which the legislation had actually been enacted: 180/

179/ Ibid.

180/ Ibid., p. 100.

Third, in an effort to substitute Federal dollars for State dollars, several States are seeking to classify as intermediate care facilities, publicly-owned institutions for the mentally retarded. Payments for care of the mentally retarded in such public institutions is not, at present, eligible for Federal matching under medicaid. While the Congress may desire at some future date to afford Federal matching funds for care of mentally-retarded persons in public institutions, Sections... clearly appear to preclude Federal matching under existing law.

Finally, the staff report calls attention to the fact that the charges for care in ICF's were often equal to, and, in some cases, greater than, the charges for services provided by skilled nursing homes--this despite the differences in the levels of care offered by each kind of institution: ^{181/}

...the statute and legislative history leave no room for question as to intermediate care comprising lower levels of service than skilled nursing home care. Given those premises, no logical basis exists for paying an intermediate care facility as much or more than a skilled nursing home in the same geographic area.

In May 1970, the House Committee on Ways and Means reported out proposed amendments to the Social Security Act (H.R. 17550). Provisions in the Committee bill were designed to deal, in part, with some of the difficulties in the ICF program described in the Finance Committee

^{181/} Ibid., p. 100.

staff report. One of the provisions would have authorized the Secretary of HEW to compute, for purposes of reimbursement, a reasonable cost "differential" between the costs of skilled nursing home services and the costs of care in intermediate care facilities.^{182/} In addition, the Committee would have revised the definition of an ICF to exclude institutions for mental diseases or mental defects. Both of these provisions were included in the social security bill passed by the House of Representatives in 1970.

The Committee on Finance, however, proposed many more substantive changes in the intermediate care program. To begin with, the committee amendment made it clear that intermediate care coverage was to be for individuals with health-related conditions who required care beyond residential care and who, in the absence of intermediate care, would require placement in a skilled nursing home or mental hospital.^{183/} The committee also specified that to qualify as an ICF, the institution had to have at least one full-time LPN on its staff, and that it would have to meet such other standards which the Secretary of HEW

^{182/}

See page 39 of the source cited in Footnote #134.

^{183/}

Sections 243 and 269 of H.R. 17550, as reported by the Committee on Finance.

deemed necessary to meet the needs of patients in intermediate care facilities. In other words, the Secretary would be authorized to prescribe minimum standards--a question about which there had been dispute. The committee also proposed to move the ICF program into the medicaid title 184/ of the Social Security Act:

The amendment also provides for the transfer of the intermediate care provisions from title XI of the Social Security Act to title XIX (medicaid). This action will enable the medically indigent, presently ineligible for intermediate care, to receive such care when it has been determined as appropriate to their health care needs. This change should also serve to end the practice, in some States, of keeping medically indigent patients in skilled nursing homes where they could more appropriately be cared for in intermediate care facilities.

The Committee on Finance also broadened the ICF program to include, under medicaid, matching for the care of the mentally retarded in public institutions which could qualify as ICF's. In additions to any other standards for ICF's that the Secretary might prescribe, such institutions would also have to comply with regulations designed to assure that the retarded were receiving active health-related treatment or rehabilitation: 185/

184/

See page 148 of the source cited in Footnote #137.

185/

Ibid.

The purpose here is to improve medical care and treatment of the mentally retarded rather than to simply substitute Federal dollars for State dollars.

Finally, the committee agreed with the need to establish differentials between the costs of care provided by skilled nursing homes and ICF's. Language was also added to include professional review requirements for ICF's to assure that ICF patients were receiving the proper level of care required and provided in such facilities.

As noted elsewhere in this report, H.R. 17550 failed to reach enactment during the 91st Congress. In May 1971, the Committee on Ways and Means included an ICF provision, identical to the one previously approved by the Senate, in H.R. 1 (92d Congress).^{186/} On December 4, 1971, Senators Bellmon and Harris of Oklahoma offered the same ICF amendment as a floor amendment to a minor social security bill then pending on the Senate floor.^{187/} The provision was adopted and later agreed to by the House members of the conference committee.^{188/}

^{186/} "Social Security Amendments of 1971", House Report No. 92-231, May 26, 1971; pp. 111-13.

^{187/} Congressional Record--Senate; December 4, 1971.

^{188/} "Conference Report," House Report No. 92-747, December 14, 1971; p. 9. The ICF changes discussed above became part of P.L. 92-223 on December 28, 1971.

11. Fire and Safety Requirements for Nursing Homes

From time to time, Congress has focused attention on ways in which to assure that nursing homes which receive Federal funds are free from fire and other environmental hazards. In the case of programs providing for construction assistance, Congress has authorized Government administrators to establish minimum Federal program standards of construction, including requirements that relate to the fire and safety conditions of an institution. Nursing homes assisted under the Hill-Burton program, for example, or with FHA-guaranteed loans, are required to comply with these program standards, in addition to any other requirements imposed by State or local governments.

A different set of events has occurred in connection with the programs that help to purchase nursing home care. In 1950, for example, Congress required, as a condition for receiving Federal matching funds for welfare purposes, that each State designate standard-setting authorities which would establish and maintain standards for institutions serving the recipient population. The requirement, contained in the 1950 Amendments to the Social Security Act, was imposed on the States because of the: ^{189/}

Tragic instances of failure to maintain adequate protection against hazards threatening the health and safety of residents in institutions... Persons who live in institutions, including nursing and convalescent homes, should be assured a reasonable standard of care and be protected against fire hazards, unsanitary conditions, and overcrowding.

^{189/} See p. 43 of the source cited in Footnote #16.

The 1950 Amendments, however, did not authorize Federal officials to prescribe what standards should be used. Instead, the responsibilities for standard-setting and standard enforcement were left up to the States.

Toward the end of the decade, Congress was again advised of the inadequacies in the fire and safety conditions in American nursing homes. The Senate Committee on Labor and Public Welfare, in its study of problems of the aged, reported that a substantial percentage of the nursing home beds in the country could not meet the fire and health standards applied under the Hill-Burton program. ^{190/} Testimony taken by the Committee pointed out that the States were making efforts to establish the necessary facility standards, but that existing structures were usually exempted from the requirements under ^{191/} "grandfather" provisions of State or local laws:

To date most attention in the regulatory agencies has been given to the standards for the physical structure, for the dramatic stories of fires with their tragic loss of life serve to focus such attention and to galvanize action in this area of licensure... While many States have adopted regulations calling for new physical standards, there is usually the well-known "grandfather clause" exempting existing homes from meeting these and thus continuing the use of buildings retaining these hazardous features... Therefore, more effort must be made to protect older patients who cannot protect themselves from this official compromise with their safety by at least placing time limits on the period during which a home can operate under such a compromise with proper safety provisions.

^{190/} See the quotation at Footnote #49.

^{191/} "The Aged and the Aging in the United States, " Hearings before the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare, Part 1; 86th Congress, 1st Session; pp. 289-90.

In December 1963, the newly formed Senate Subcommittee on Long-Term Care opened the first of its many hearings into conditions in American nursing homes. The witnesses appearing before the Subcommittee included the various Federal officials from those agencies which administered programs affecting the nursing home industry.^{192/} As noted previously in this report, the Commissioner of Welfare explained to the Subcommittee that the Social Security Act did not authorize her to prescribe any minimum Federal standards for nursing facilities, including standards related to fire safety. The Commissioner attempted to describe some of the problems confronting the States in this area and noted that the Federal Government could only "encourage" States to adopt and enforce effective fire safety standards:^{193/}

Actually the way this thing works in practice is that you have the standard-setting authority in the State. One State agency must defer to another State agency in that area in which it has the legal responsibility. Of course one can always raise questions but what happens as a result of raising the question can vary substantially as you well know. I think that actually in this area which is obviously of great concern to the committee and of great concern to us, we must increasingly seek to work with the Public Health Service which is in a position to encourage and help State health departments improve their standards for nursing homes... From our point of view we can encourage, we can "educate", but we have to recognize where the legal authority lies.

^{192/} Officials from the Welfare Administration, the Public Health Service (Hill-Burton program), the Federal Housing Administration, the Small Business Administration, the Area Redevelopment Administration, and the Veterans Administration all appeared to testify before the Subcommittee.

^{193/} See p. 27 of the source cited in Footnote #53.

Fire safety standards in nursing homes were the subject of a more intensive investigation in the second set of hearings conducted by the Subcommittee in May 1964. A spokesman for the National Fire Protection Association (NFPA) testified that:^{194/}

...a recent study by the National Fire Protection Association shows that 228 people died in 41 fires in nursing homes in the period 1953 through 1965. When one compares this fatal fire record with the record of fatal fires in other types of property, it becomes clearly evident that many nursing homes are extremely unsafe places to live. Yet these are the places in which the aged and, in many cases, the infirm are being housed.

The fire expert pointed out that adequate fire safety codes for nursing homes did exist and that these codes were being applied to most of the new construction taking place in the United States. Older structures, however, were usually exempted from certain portions of the standards or weren't covered by effective standards at all:^{195/}

The real problem lies with nursing homes occupied before the adoption of applicable codes and with those located in rural areas where there is no code. The former escape the benefit of sound safety standards unless strong retroactive code enforcement is sought and secured; the latter will not be supervised unless action is taken at a State level.

^{194/} "Nursing Homes and Related Long-Term Care Services", Hearings before the Senate Subcommittee on Long-Term Care, Part 1; 88th Congress, 2d Session; p. 38.

^{195/} Ibid., p. 39.

Applying modern code provisions retroactively is frequently fought by nursing home operators who complain that code adherence would result in prohibitive expenses that would put them out of business. A common comment heard in such a defense is that the moneys received by nursing home operators for State-aided patients are hardly adequate to keep homes operating and certainly do not provide any excess of funds for fire protection. We must reply that fire protection is a requirement in this type of property and that a minimum code will not place an undue hardship on anyone.

The NFPA spokesman added, however, that the operators of homes were not the sole cause of difficulties in the fire protection area. Many of the States, he noted, simply failed to provide the necessary manpower and money required to establish and carry out an effective program of fire inspection and code enforcement for nursing homes. Without such inspection and enforcement, no modern code was of much value.

The witnesses for the American Nursing Home Association did indeed raise the matter of inadequate financing as the principal cause of many of the problems in the standards area. They also joined with the NFPA in criticizing States for failing to develop effective enforcement programs:^{196/}

^{196/} Ibid., pp. 25-26.

As long as there are inadequate inspection and licensing laws and as long as the public, State agencies, and legislatures refuse to provide adequate payments for nursing home care of public assistance recipients--and these account for more than half of the patients in nursing homes--there will continue to be substandard homes.

In September 1964, Senator Stephen Young of Ohio offered on the Senate floor a joint resolution that would have barred Federal matching for the costs of care for public assistance recipients in nursing homes or similar institutions which failed to meet reasonable standards of fire prevention and protection prescribed by the Secretary of HEW:^{197/}

I am aware that substandard institutions will not be able to improve the quality of their structures overnight. For that reason, my resolution authorizes the Secretary to afford such institutions reasonable time and opportunity for compliance. It is my hope that the States will increase their allowances for nursing home care in order to meet such additional costs as may be entailed by the necessity of meeting necessary standards of safety. However, even if such allowances are not increased, there is absolutely no way that we, in good conscience, can justify continued Federal participation in the cost of maintaining assistance recipients in unsafe institutions.

Though the resolution did not receive the favorable consideration of the Senate during 1964, the Senator was successful later in persuading the

^{197/}

Congressional Record--Senate; September 30, 1964.

Committee on Finance to incorporate a similar provision in the Senate version of the 1965 medicare legislation. The provision is discussed later on in this report.

The Kennedy-Johnson proposals for a program of hospital insurance for the aged required nursing homes wishing to participate as ECF's to satisfy a variety of statutory conditions of participation. In addition, institutions would be required to comply with regulations prescribed by the Secretary dealing with health and safety matters. In early 1965, witnesses for the American Nursing Home Association appeared before the Committee on Ways and Means to comment on the medicare plan. Among other things, the witnesses raised objections to the bill on the grounds (1) that it failed to establish adequate standards for nursing homes and (2) that it gave the Secretary too much discretion to prescribe standards for health and safety.^{198/} The Association recommended that the number of conditions for participation be increased to include a requirement that an ECF:^{199/}

^{198/} See p. 323 of the source cited in Footnote #75.

^{199/} See pp. 327-28 of the source cited in Footnote #75.

(13) is a fire resistant structure, or has a standard sprinkler system, and a recognized fire detection system, if available, and practicable; [and] (14) meets such other conditions relating to nursing facility, or relating to the safety of individuals who are furnished services by or in such nursing facility, or relating to the physical facilities thereof, as the Secretary may find necessary after consultation with the National Safety Council, Building Officials Conference of America and the National Council for the Accreditation of Nursing Homes among others...

The recommendations were not incorporated into the bill reported to and later adopted by the House of Representatives in April of 1965. Instead, the legislation retained the original Administration provision which authorized the Secretary to establish health and safety standards for ECF's proposing to participate in the medicare program.^{200/} No comparable authority to prescribe Federal standards was included in the medicaid portions of the bill.

In June, Senator Young announced that he would offer his previously-introduced fire safety amendment to the House-passed medicare bill. The amendment would require that:^{201/}

^{200/} The Secretary was also authorized to prescribe health and safety standards for hospitals participating in medicare. However, the Secretary would not be permitted to set any such standards which were more strict than those prescribed in the area of health and safety by the Joint Commission on the Accreditation of Hospitals. No mention of this ceiling is made in the bill or the Committee report with respect to extended care facilities. At the time medicare was enacted, the JCAH was not involved in the accreditation of nursing facilities.

^{201/} Congressional Record--Senate; June 9, 1965.

...after June 30, 1967, the requirements established by State authorities relating to protection against fire and other hazards in private or public institutions caring for assistance recipients shall include any requirements which may be contained in standards established by the Secretary of Health, Education and Welfare... Under the medicare program as approved by the House of Representatives, the Secretary of Health, Education and Welfare is authorized to prescribe such further requirements for hospitals and nursing homes as he finds necessary in the interest of the health and safety of beneficiaries... My amendment would simply apply the same standards to institutions providing care to public assistance recipients.

In the social security legislation reported to the Senate in June 1965, the Committee on Finance went along with the provision in the House bill which authorized the Secretary to prescribe health and safety standards for extended care facilities participating in medicare. The Committee also added the features of the Young amendment to the bill sent to the Senate floor. Under this provision, standards established and maintained by State standard-setting authorities for medicaid institutions after June 30, 1967, would have to include "any requirements which may be contained in standards established by the Secretary relating to protection against fire and other hazards to the health and safety of individuals in such private or public institutions".^{202/} The language

^{202/}

See p. 75 of the source cited in Footnote #84.

of the bill and the rationale used in the report, however, did not specify that the Secretary had to prescribe identical health and safety standards for both programs--medicare and medicaid.

During the floor debate on the bill, Senator Robert Kennedy of New York called attention to the fact that, under the House-passed and Finance Committee bills, a ceiling was imposed on the Secretary's authority to prescribe health and safety standards for medicare hospitals. The Secretary would be prohibited from prescribing any requirements higher than those adopted by the Joint Commission on Accreditation of Hospitals (JCAH). This, the Senator argued, could result in the reduction of standards in some States and prevent others from imposing requirements higher than those adopted by the Joint Commission. The Senator proposed (and the Senate agreed) to strike the reference to the JCAH limitation:^{203/}

The amendment provides that if State or local standards for hospitals are higher than those specified by the Joint Commission on Accreditation of Hospitals, Federal funds will be administered to the higher standards.

As sent to conference committee, the floor amendment permitted the Secretary to establish higher standards for medicare hospitals in a particular jurisdiction, if requested to do so by a State. The

^{203/} Congressional Record--Senate; July 8, 1965.

Secretary was required to impose higher standards, if the State (or one of its subdivisions) imposed such higher standards on its medicaid ^{204/} hospitals.

Though it is clear from the debate that the Senator was concerned only with hospital standards, action by the Senate and House conferees on the bill extended the scope of the provision to include the nursing facilities participating in the medicare program. In a little-noted change, the conferees modified the conditions of participation for ECF's to include the health and safety standards prescribed by the Secretary as he deemed necessary "subject to the second sentence of section 1863". This sentence is the one which requires the Secretary to establish for medicare the standards used by a State under medicaid regarding health and safety, if the latter are higher than the former. This "linkage" provision regarding standards used in each of the two programs is discussed later on in this section of the report.

As noted at the end of section 5 of this report, the House and Senate conferees also deleted the requirements of the Young amendment from the final legislation. No explanation for the deletion is given in the

^{204/} See p. 45 of the source cited in Footnote #86.

conference report, nor was this decision discussed during the subsequent House and Senate debate on the compromise bill agreed to by the conferees.^{205/} As a result, responsibility for establishing and enforcing fire and other safety standards for nursing homes under medicaid remained with the States.

In 1966, the Social Security Administration, the agency responsible for the medicare program, published tentative Conditions of Participation for Extended Care Facilities. The Conditions, which were finalized in October 1967, mentioned, but did not require, the Federal standards of construction used in the Hill-Burton program:^{206/}

The following standards are guidelines to help State agencies to evaluate existing structures which do not meet Hill-Burton standards. They are to be applied to existing construction with discretion and in light of community need for service. [Emphasis added]

Only very broad requirements were incorporated into the standard dealing with patient safety:^{207/}

- (1) The facility complies with all applicable State and local codes governing construction.
- (2) Fire resistance and flamespread ratings of construction, materials, and finishes comply with current State and local fire protection codes and ordinances.
- (3) Sprinklers are installed in all areas considered to have special fire hazards... In an extended care facility of two or more stories alarm systems providing complete coverage of the building are installed and inspected regularly...

^{205/} See pp. 50-51 of the source cited in Footnote #86.

^{206/} 31 Federal Register 7140; May 14, 1966.

^{207/} Ibid.

Other specifications included in the safety standard dealt with such things as building exit requirements, the location of non-ambulatory and disabled patients in multi-storied institutions, reports of fire inspections, and the like. All of the requirements were couched in very general terms. Little Congressional attention focused on these conditions of participation until 1970, when more than 30 people died in a fire in a medicare ECF which had been in compliance with the 1966-67 medicare safety standards. The impact of this tragedy on these standards is discussed later on in this section.

Earlier in the report (see section 6), it was noted that HEW had attempted to define the term "skilled nursing home" as it was to be used in the medicaid program. This provoked a great deal of controversy regarding HEW's authority to promulgate any standards, and especially those dealing with staffing, for nursing homes participating in a State's medical assistance program. That part of the definition dealing with health and safety, however, did recognize the fact that Congress has rejected the Young amendment and that no Federal standards could be prescribed in this area. A skilled nursing home had to be a facility which: ^{208/}

...is constructed, equipped, maintained, and operated in compliance with all applicable State and local laws and regulations affecting the health and safety of the patients and their protection against the hazards of fire and other disasters...

To prevent the Secretary of HEW from exercising complete discretion in the standards area, the American Nursing Home Association proposed in 1967

^{208/}

See p. 803, Part 2 of the source cited in Footnote #97.

to establish certain statutory requirements for medicaid nursing homes. Among other things, the Association recommended that qualified facilities be fire resistant structures or that they have standard fire sprinkler or recognized fire detection systems.^{209/} In addition, institutions would be required to meet any other health and safety standards which State agencies found it necessary to prescribe in order to bring such standards into line with those prescribed by the top one-fifth of the States before January 1, 1970.

In May 1967, Senator Frank Moss reintroduced an omnibus nursing home standards bill for facilities participating in the medicaid program.^{210/} The bill provided that a "qualified nursing home" could not be an institution which failed to meet standards of fire safety and protection and other conditions relating to health and safety found necessary by the Secretary and set forth in regulations prescribed by him. In his testimony before the Committee on Finance, the Senator explained:^{211/}

We are not in any sense talking about Federal licensing and Federal regulation. However, it seems perfectly proper for the Federal Government to establish reasonable specifications for services purchased in large part with Federal funds. ...Federal funds must not be used to maintain aging citizens in surroundings that endanger their very lives.

^{209/} See the source cited in Footnote #109.

^{210/} S. 1661, 90th Congress, 1st Session.

^{211/} See p. 897, Part 2, of the source cited in Footnote #14.

When the witnesses for the American Nursing Home Association appeared before the Committee on Finance, objections were again raised against the idea of giving the Secretary of HEW discretion in determining health and safety standards for medicaid skilled nursing facilities. Their spokesmen noted that: ^{212/}

The present language [of the Moss amendment] would permit the Secretary to promulgate fire and safety as well as physical environment regulations; we have substituted the present physical environment standards required of extended care facilities. The Department has spent some 18 months in devising these standards in consultation with national health care organizations... In connection with the fire and safety standards, we have suggested the use of sections 132, 136, 137 (for new construction), 234 and 235 (for existing construction) of chapter 10 of the Life Safety Code (21st edition, 1967) of the National Fire Protection Association for similar reasons. It is already worked out. This association which is composed of State fire marshalls and others have worked on fire and safety codes for several years... We just say use these.

The Finance Committee incorporated these recommendations in the social security bill it reported out to the Senate in November of 1967: ^{213/}

Skilled nursing homes are to meet the environmental, sanitation, and housekeeping requirements at least equal to those applied to extended care facilities under title XVIII. States which do not now have fire protection codes applicable to skilled nursing homes which are found to be adequate by the Secretary would require their skilled nursing homes, subsequent to December 31, 1969, to meet the Life Safety Code of the National Fire Protection Association

^{212/} See pp. 1848-49 of the source cited in Footnote #114.

^{213/} See pp. 189-90 of the source cited in Footnote #118.

It is clear from the report, however, that the Committee was aware of the potential economic cost of imposing certain standards on nursing homes: ^{214/}

The committee expects that such codes will be enforced in a manner designed to properly protect the health and safety of patients. At the same time, however, it is expected that due recognition will be given to waivers of specific conditions where rigid interpretations would result in undue hardship and avoidable expense, and where such temporary or permanent waiver of requirements will not jeopardize the health or safety of patients in such institutions.

With only minor changes, the Life Safety Code requirements for nursing homes under medicaid were included in the Social Security Amendments ^{215/} passed by Congress in 1967.

Earlier in this report (see section 9), some of the controversy regarding HEW's implementation of the 1967 Moss amendment was described. Most of this discussion, however, centered on the staffing standards for skilled nursing homes under title XIX. Virtually no attention was given to the Department's efforts to implement the fire safety standards required under the Moss amendment. HEW's interim policy regulations for nursing homes merely repeated the Life Safety Code requirements contained in the law without any elaboration. The only additional information contained in the regulations regarding fire safety standards dealt

^{214/}

Ibid.

^{215/}

P.L. 90-248, Sec. 234(a) added a new section 1902(a)(28)(F) to the Act, as amended.

with the documentation requirements in cases where waiver from the requirements was sought.^{216/}

On January 9, 1970, a fire occurred in the Harmar House Nursing Home, Marietta, Ohio, killing 32 of 46 patients.^{217/} The structure, built in 1965, was an extended care facility participating in the medicare program and in compliance with the health and safety requirements contained in the ECF Conditions of Participation. One month after the fire, the Senate Subcommittee on Long-Term Care held two days of hearings to examine the fire safety standards used in the medicare and medicaid programs. The testimony presented to the Subcommittee²¹⁸ indicated that:

The deaths caused by the Harmar House fire were primarily the result of smoke inhalation, smoke that came from a rubber-backed carpet. Medicare standards, so-called, permit such carpets in patients' rooms.... Medicare relies on State regulations which, as we have seen in the case of Ohio, are not adequate to protect patients and save lives. The carpet in Harmar House passed Ohio inspection, lived up to Ohio standards, but contributed materially to the cause of Ohio deaths.

^{216/} See the sources cited in Footnotes #144 and #159.

^{217/} "Trends in Long-Term Care," Hearings before the Senate Subcommittee on Long-Term Care, Parts 4 and 5, 91st Congress, 2d Session; February 9-10, 1970.

^{218/} Ibid., Part 4, p. 443.

Witnesses were sharply critical of medicare's conditions of participation:
219/

The medicare "conditions" concerning fire safety can hardly be called standards, they are so nonspecific. For example, corridors in medicare-supported homes, the kind that Harmar House has, need only "be wide enough for easy evacuation." Yet, the Hill-Burton standard and the National Fire Protection Association's Life Safety Code have real specifications: They set--without qualification--8 feet as the minimum corridor width. Medicare's phrase "wide enough" provides escape for the operators of nursing homes, not for their patients. Yet, as if such vagueness in the "conditions" were not enough, the fire safety section, itself, opens with a disclaimer that reveals just how permissive the law will be: "The following standards are guidelines to help State agencies * * * They are to be applied to existing construction with discretion and in light of community need for service."

No Administration officials testified during the February hearings of the Subcommittee on Long-Term Care. In May, the Subcommittee Chairman, Senator Moss, scheduled another round of hearings to review HEW's actions in the standards area. The Senator was especially critical of the Department for failing to issue new regulations dealing with extended care facilities:
220/

Under section 1861 of the Social Security Act the department has the authority and obligation to set standards for the safety of patients in extended care facilities. On January 9 of this year a tragic fire in an extended care facility pointed up clearly a

219/ Ibid., p. 444.

220/ Ibid., Part 8, p. 624.

specific hazard to life which had been omitted from the Medicare standards... Five months have passed and no standard on floor covering has emerged from the Department of Health, Education and Welfare.

Witnesses for the Social Security Administration explained to the Subcommittee that the agency had and was taking a number of steps administratively in the area of fire safety. Institutions which had identifiable deficiencies were instructed to submit specific proposals for phasing out any problems with the conditions of participation. Wood frame constructed facilities were ordered to produce evidence of their intent to have fire sprinkler systems installed. And, the witnesses explained, the provisions of the Life Safety Code were also being applied to ECF's under medicare, 221/ as well as to skilled nursing homes under medicaid:

As we interpret the statute, the statute says, I believe, that as far as Medicaid is concerned effective January 1, 1970, the Life Safety Code is applicable and our corresponding requirement says that if a higher requirement is established under title XIX in effect it is applicable to title XVIII. So picking up on that statutory base we advised the facilities that if it is a Medicare certified facility or if it wishes to be certified under Medicare, irrespective of whether it has Medicaid patients in it or not, the Life Safety Code does apply.

Agency spokesmen also explained that instructions had been issued regarding fire safety standards for the carpeting used in medicare facilities.

221/

Ibid., Part 8, p. 682.

Separate instructions had been needed, since the Life Safety Code did not include the carpeting standards that the Department proposed to apply to such institutions. The Subcommittee was advised that all of the changes in the conditions of participation would be issued in the form of regulations pending action by the National Fire Protection Association on proposed revisions in the Life Safety Code. ^{222/}

The administrative actions by the Social Security Administration were promptly challenged. ^{223/} Although a variety of objections were raised, nursing home and hospital administrators were especially concerned about the directives relating to requirements for fire sprinkler systems in facilities of non-fire resistant construction. The agency had directed that such systems be installed in the affected institutions by no later than October 1, 1970. Failure to comply would bar facilities from further participation in the medicare program. This requirement was attacked on the merits, on grounds that such a deadline was wholly unrealistic, and that no consideration was given to the costs that such a requirement would impose on facilities.

^{222/} The Department's witnesses pointed out that their authority to prescribe comparable standards for hospitals was limited by the JCAH ceiling. The JCAH, however, used the provisions of the Life Safety Code by reference in its own standards. If, therefore, the NFPA adopted certain changes in the Life Safety Code (such as those related to carpeting), new requirements could be imposed in the hospital area as well as in the ECF area.

^{223/} An extensive discussion of the administrative actions taken by SSA and the reactions of providers and State officials can be found in the materials submitted for the Congressional Record--Senate; December 4, 1970, by Senator Mike Mansfield of Montana.

In September, the Department formally published the proposed new changes in the fire and safety requirements applicable to extended care facilities and non-JCAH accredited hospitals participating in the medicare program.^{224/} In addition, the Social Security Administration temporarily postponed the October 1st deadline for installing fire sprinkler systems in some of the affected institutions. In October, Senator Mike Mansfield of Montana asked the Secretary of HEW for a report on the impact of the new requirements on some of the facilities already certified to participate in medicare. The Department replied by noting:^{225/}

We are very much aware that the sprinkler requirement involves considerable costs to individual facilities. We wish it were possible to come up with some alternative that would provide equal protection for the safety of patients, but most fire safety experts have told us that alternative protective measures do not provide the same degree of safety as automatic extinguishing systems. Therefore, we do not believe that this would be an appropriate area for achieving desired cost reductions. The instructions that we sent out on sprinklers recognized that some hospitals and nursing homes may not always be able to get a sprinkler system installed right away. It provides that facilities are to have a contract by January 31, from a company that installs sprinkler systems and that actual installation take place afterwards. If a facility is unable to meet the January 31 date for valid reasons, we certainly would be willing to grant a reasonable extension.

In remarks to the Senate, the Majority Leader indicated that he endorsed efforts to upgrade standards applicable to ECF's and hospitals under medicare. He noted, however, that the available sources of the capital needed

^{224/} 35 Federal Register 13888; September 2, 1970.

^{225/} See the source cited in Footnote #223.

to finance the installation of some of the improvements, such as sprinkler systems, were limited. The Senator explained, therefore, that he had asked the Committee on Finance to consider some way of helping affected institutions meet the costs of complying with the new requirements.^{226/}

On December 15, 1970, the Finance Committee reported out H.R. 17550, the proposed Social Security Amendments of 1970. Included in the bill was a provision authorizing the Secretary of HEW to make loans specifically for the purpose of financing the costs of installing the sprinkler systems required under the Life Safety Code.^{227/} After describing the provision, the report contained the following instructions for the Secretary:^{228/}

The committee expects that the Secretary, in considering whether to terminate an institutions' participation in Medicare by reason of its failure to install a required automatic sprinkler system because of the lack of funds, will take into account the opportunity here provided to obtain such loans on favorable terms, as well as the likelihood that the institution will apply for such a loan and that it would be approved by both the State agency and the Secretary.

As noted at several points in this report, the proposed Social Security Amendments of 1970 failed to reach enactment. As a result, the special loan program to enable extended care facilities to obtain loans to finance sprinkler systems did not become law.

^{226/} See the source cited in Footnote #223.

^{227/} Sec. 610 of H.R. 17550, 91st Congress, 2nd Session.

^{228/} See p. 405 of the source cited in Footnote #137.

In February 1971, Senator Mansfield again raised the matter of imposing the Department's new ECF and hospital fire safety standards -- particularly the sprinkler system requirement -- on certain medicare institutions. ^{229/} Inserted into the Record was a letter from the Commissioner of Social Security which observed that: ^{230/}

As you know, these regulations which are called for by provisions of law in titles XVIII and XIX of the Social Security Act were issued for comment, and there will be a number of appropriate modifications before they are put in final form. When the final regulations are issued making the provisions of the Life Safety Code applicable to extended care facilities and hospitals, we will make clear that there will be appropriate discretion in the application of the Code. There may be some instances where the circumstances of the institution, its construction and all surrounding safeguards would provide equivalent patient safety to that provided by the installation of sprinklers as well as meeting other requirements of the Code... We will not move to terminate institutions until such claims have been examined on an individual basis.

These assurances, however, were not sufficient for the Senator, who announced the introduction of legislation to deal with exceptions to the Life Safety Code: ^{231/}

... I am also introducing a bill to amend certain sections of the Social Security Act to permit State health agencies, in connection with medicare and medicaid, to waive certain conditions of participation as a provider of health services in these programs. In the case of certain health and safety standards, the States could waive certain requirements imposed by the Secretary if the imposition of such requirements would result in an unreasonable hardship for health facilities and for the people so vitally dependent upon them. The States would, however, have to assure that any standards substituted in lieu of the Secretary's requirements adequately guarantee the health and safety of patients in hospitals and extended care facilities.

^{229/} Congressional Record - Senate; February 4, 1971.

^{230/} Ibid.

^{231/} Ibid.

On October 28, 1971, the Department of Health, Education and Welfare published the revised fire safety standards for extended care facilities and non-JCAH accredited hospitals in final form. ^{232/} The announcement explained that the Life Safety Code now included specifications for carpeting, so that separate standards in this area were no longer needed. The final regulations also now included the sprinkler system waiver provisions which Senator Mansfield had proposed earlier in the year: ^{233/}

...[the regulations] have been modified to... include provisions, consistent with provisions under title XIX of the Social Security Act, permitting waiver of specific requirements of the Life Safety Code if the Secretary finds that the State Code adequately protects the patients in such facilities and hospitals, or if compliance would result in unreasonable hardship...

In November 1971, another Congressional committee, the House Special Studies Subcommittee, opened a new round of hearings into the fire safety problems of nursing homes. ^{234/} The Subcommittee's report reviewed the complete range of fire safety standards imposed by Governmental agencies under different Federal programs. ^{235/}

^{232/} 36 Federal Register 20675; October 28, 1971.

^{233/} Ibid.

^{234/} "Problems of the Aging (Nursing Home Safety)," Hearings before a Subcommittee of the House Committee on Government Operations; 92nd Congress, 1st and 2nd Sessions.

^{235/} "Saving Lives in Nursing Home Fires," House Report No. 92-1321; 92nd Congress.

The House Subcommittee concluded that the various standards issued by the different Federal agencies: ^{236/}

...will not achieve a sufficient level of fire-safety in new facilities or result in upgrading the level of fire safety in existing facilities.

The standards used in the Federally-aided nursing home construction programs were criticized for failure to include requirements for sprinkler systems: ^{237/}

When the Hill-Burton Act was extended in 1954 to nursing homes, regulations with respect to life-safety in construction were adopted by the agency charged with the execution of the Act, now the Health Facilities Service. Its regulations require construction that is fire-resistive. These regulations rely mainly on compartmentalization as fire protection and do not require the installation of complete automatic sprinkler systems. This approach to fire-safety does afford some protection against only a Level III fire. This is also the situation with respect to nursing homes built with mortgage insurance from FHA or with loans or guarantees from SBA.

The report noted that the 7,000 homes participating in medicare and medicaid were required to comply with the provisions of the Life Safety Code, but concern was expressed about the waiver features regarding sprinkler system requirements: ^{238/}

As recently as May 22, 1972, both Medicare and Medicaid program administrators in HEW issued a memorandum with respect to safety standards... The memorandum specifically addresses itself to waivers of the requirement for complete

^{236/} Ibid., p. 12.

^{237/} Ibid., p. 13.

^{238/} Ibid., p. 14.

automatic sprinkler protection on the ground of unreasonable hardship. It gives as elements of unreasonable hardship the estimated cost of installation, the period over which such cost might be recovered through reduced insurance premiums and increased reimbursement related to cost, the availability of financing, and the remaining useful life of the building... It permits application of a finding that there is a level of safety equivalent to that of complete automatic sprinkler protection by the use of automatic fire detection devices in all areas other than hazardous areas where sprinkler systems must be installed. The memorandum makes it clear that unprotected wood frame facilities will not receive a waiver of the requirement for complete automatic sprinklers. However, it seems obvious that there may be strong pressure for waiver of this requirement in additional situations even though the facility does not have fire-resistive or protected noncombustible construction.

The report also pointed out that, as the result of P.L. 92-223, the intermediate care facility program had been transferred from title XI to title XIX of the Social Security Act. ^{239/} Under previous law, ICFs were required to meet "such standards of safety and sanitation as are applicable to nursing homes under State law." P.L. 92-223 modified the safety requirements to include those which "are established under regulation of the Secretary in addition to those applicable to nursing homes under State law." This brings approximately another 6,000 additional institutions under some form of Federal fire safety regulations. However, as the House Subcommittee report indicates: ^{240/}

The regulations have not yet been issued nor have proposed regulations been published for public consideration. It would seem, however, that the memorandum of May 22, 1972, foreshadows what may be done under Public Law 92-223.

^{239/}

See the last paragraph of section 10 of this report.

^{240/}

See p. 14 of the source cited in Footnote #235.

The House report points out that, although Federal fire safety regulations either are or can be applied to about 13,000 long-term care institutions in the United States, an additional 6,000 to 10,000 facilities are not subject to Federal requirements, even though perhaps the majority of their residents receive Federal funds through old-age assistance payments. After discussing the limitations of the standards used in the States, the report warns: ^{241/}

Except for the 15 States which have adopted the 1967 Life-Safety Code, including its applicability to existing homes, there may be a strong push from many of the other States for waivers under the Medicare and Medicaid programs from the sprinkler requirements of the Life Safety Code, and for the weakening of the level of safety to be prescribed by the Secretary of HEW under Public Law 92-223.

In making its recommendations to Congress, the Subcommittee concluded: ^{242/}

This committee is of the opinion that the standard of life-safety should not vary according to the particular Federal program involved, and that all of the elderly in such facilities are entitled to the same degree of protection. The committee also holds that the best means of avoiding multiple death fires is the construction of complete automatic sprinkler systems which will also transmit an alarm to the nearest fire service.

To achieve these objectives, the Subcommittee endorsed a more generous Federal program of insurance for long-term loans to finance. These recommendations are now pending.

^{241/} Ibid., p. 15.

^{242/} Ibid., p. 8.

11. The Social Security Amendments of 1972

In May 1971, the House Committee on Ways and Means reported out an omnibus bill (H.R. 1) to amend the Social Security Act, including medicare and medicaid. ^{189/} Included in the bill were several of the provisions relating to nursing home care which had been incorporated into H.R. 17550 during the 91st Congress. H.R. 17550, as noted elsewhere in this report, had not been enacted by the 91st Congress.

As agreed to by the House and sent to the Senate, H.R. 1 included the following provisions relating to problems in the nursing home area with respect to the medicare and medicaid programs:

- (1) Retroactive denial of medicare ECF claims--the bill authorized the Secretary of HEW to establish minimum periods of time (by medical condition) after hospitalization during which medicare patients would be presumed, for payment purposes, to require care in extended care facilities.
- (2) Differences in the Costs of Care in Skilled Nursing Homes and ICF's--the bill authorized the Secretary to prescribe reasonable cost differentials for reimbursement between skilled nursing homes on the one hand and intermediate care facilities on the other.
- (3) Effective Utilization Review in Skilled Nursing Homes--the bill would reduce Federal medicaid matching funds for nursing home care by one-third after 60 days of such care.
- (4) Limits on Costs in ECF's--the bill authorized the Secretary to establish limits on the costs of an ECF that would be recognized as reasonable for reimbursement purposes under medicare; costs in excess of such limits not necessary to the efficient delivery of care would be borne by patients.

- (5) Limits on Costs in Skilled Nursing Homes and ICF's--the bill required that average per diem costs for care in SNH's and ICF's countable for Federal medicaid matching would be limited to 105% of such costs for the same quarter of the preceding year (excluding increases in costs attributable to minimum wage legislation).
- (6) Reimbursement for Capital Costs--the bill provided that reimbursement amounts under medicare and medicaid for certain capital costs of institutions, such as depreciation and interest, would not be made with respect to large capital expenditures which were inconsistent with State or local health facility plans.
- (7) Uniform Utilization Review--the bill provided that, if a facility participated in both medicare (as an ECF) and medicaid (as a SNH), the utilization review committee required by medicare would also review medicaid cases in the institution.
- (8) R.N.'s in Rural Skilled Nursing Homes--the bill provided for a waiver from requirements that a skilled nursing home at least have one full-time R.N. on duty each day, if the facility were in a rural area and if the facility could meet certain other conditions.
- (9) Requirements for Nursing Home Administrators--the bill provided for a permanent waiver of certain medicaid requirements for nursing home administrators who had served in such a capacity for at least 3 years before a State established an administrator licensing program.

In September 1972, the Senate Committee on Finance reported out its version of H.R. 1. ^{190/} Substantial changes in the nursing home programs under medicare and medicaid were proposed. To begin with, the Committee proposed to eliminate the distinctions between an extended care facility under and a skilled nursing home under medicaid: ^{191/}

^{190/} "Social Security Amendments of 1972, "Senate Report No. 92-1230; 92nd Congress, 2nd Session; September 26, 1972.

^{191/} Ibid., p. 281.

Because of the substantial similarities in the services required of skilled nursing facilities under the two programs, the existence of separate requirements (which may differ only slightly) and separate certification processes for determining institutional eligibility to participate in either program is both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved to provide care under both medicare and medicaid. The committee believes therefore that it would be desirable to apply a single set of requirements to skilled nursing facilities under both medicare and medicaid.

Under the provision, a single definition (skilled nursing facility) and a single set of requirements would apply to medicare ECF's and to medicaid skilled nursing homes. This definition would make use of the previous definition for an extended care facility to which would be added three of the requirements otherwise applicable to skilled nursing homes under medicaid--provisions relating to disclosure of facility ownership, the requirement that facilities cooperate in effective programs of independent medical evaluation and audit of patients, and the requirement regarding compliance with the Life Safety Code.

A second provision in the Senate Committee bill established a common ^{192/} "level of care" definition applicable in skilled nursing facilities. Insofar as the medicare program was concerned, the new definition was more liberal in scope than the definition previously used under that program. The new definition would now include those: ^{193/}

^{192/} See section 8 of this report for a discussion of the "level of care" issue.

^{193/} See p. 282 of the source cited in Footnote #190.

Services provided directly by or requiring the supervision of skilled nursing personnel, or skilled rehabilitation services, which the patient needs on a daily basis, and which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.

A third provision in the Finance Committee bill dealt with the methods used to reimburse skilled nursing and intermediate care facilities under medicaid:
194/

Under medicaid States have been free to develop their own bases for reimbursement to skilled nursing facilities and intermediate care facilities. States generally establish (in advance) per diem or similar basic rates payable for patients receiving skilled nursing facility and ICF care. Concern has been expressed that some skilled nursing facilities and ICF's are being overpaid by medicaid, while others are being paid too little to support the quality of care that medicaid patients are expected to need and receive... The committee bill would require States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis by July 1, 1974. This approach is preferable to the arbitrary rate-setting currently in effect in some States which provide no incentive to facilities to upgrade the level of care provided.

Under the proposal, the States would be required to use acceptable cost-finding techniques (though not necessarily those used in the medicare program) to determine reasonable reimbursement. These methods for determining payment would have to be approved and validated by the Secretary of HEW.

Other provisions in the social security bill sent to the Senate floor relating to nursing homes included:

194/ See p. 287 of the source cited in Footnote #190.

- (1) Modification of the 14-Day Transfer Requirement for ECF Benefits--The bill authorized an interval of longer than 14 days for transfer to a medicare skilled nursing facility after discharge from a hospital, in order to obtain extended care benefits, under certain conditions.
- (2) Skilled Nursing Facility Certification Procedures--The bill included a provision under which the Secretary of HEW would decide whether a facility qualifies as a "skilled nursing facility" in both the medicare and medicaid programs.
- (3) Public Disclosure of Institutional Deficiencies--The bill required the Secretary of HEW to make reports of an institution's deficiencies (in such areas as staffing, fire safety, and sanitation) a matter of public record readily and generally available to the public.
- (4) Federal Financing of Medicaid Nursing Home Survey and Inspection Costs--The bill authorized 100% of the financing needed to carry out a survey and inspect skilled nursing and intermediate care facilities under medicaid.
- (5) Intermediate Care Facilities--The bill included a number of provisions relating to ICF's: authorized money to pay for the supplemental training of ICF administrators; required information disclosing the ownership of ICF's; required independent professional review of medicaid patients in ICF's; specified that ICF services are to be covered for persons 65 and over in mental institutions.

In addition, the Committee on Finance retained in the bill (with some modifications) most of the provisions relating to nursing home care which the House had included in H.R. 1. Only the fifth and the ninth provisions listed in the second paragraph of this section of the report were deleted by the Senate Committee. During the floor debate on the legislation a number of minor nursing home amendments were added

to H.R. 1 before the bill was agreed to and sent to a conference 195/ committee.

On October 14, 1972, the conference committee reported agreement on a compromise bill which both Houses subsequently approved. 196/ Among the provisions included in the bill sent to the President dealing with nursing home care were of the following:

- (1) Utilization Review in Medicaid Skilled Nursing Facilities and ICF's--Effective July 1, 1973, medicaid matching would be reduced by one-third for long-term stays in skilled nursing facilities and ICF's, if States fail to have effective programs of control over the utilization of institutional services or where they fail to conduct independent professional audits of patients as required by law. The bill also authorizes the Secretary, after June 30, 1973, to compute a reasonable differential between the cost of skilled nursing facility services and intermediate care facility services provided in a State to medicaid patients.
- (2) Limitation on Federal Payments for Disapproved Capital Expenditures--Beginning in 1973 (or earlier, if requested by a State), the bill precludes medicare and medicaid payments for certain disapproved capital expenditures which are specifically determined to be inconsistent with State or local health facility plans.
- (3) Limitation on Coverage of Costs Under Medicare--The bill authorizes the Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services. Except in the case of emergency care, the medicare beneficiary would be liable for any amounts determined as excessive.

195/ Congressional Record--Senate; October 5, 1972.

196/ "Social Security Amendments of 1972," House Report No. 92-1605; 92d Congress, 2d Session; October 14, 1972.

- (4) Limits on Payments to Skilled Nursing Facilities and Intermediate Care Facilities Under Medicaid--Effective January 1, 1973, Federal financial participation in reimbursement for skilled nursing facility care and intermediate care per diem costs would not be available to the extent such costs exceed 105 percent of prior year levels of payment under the provision (except for those costs attributable to any additional required services). The provision would except increased payment resulting from increases in the Federal minimum wage or other new Federal laws.
- (5) Advance Approval of ECF and Home Health Coverage--The bill authorizes the Secretary to establish, by diagnosis, minimum periods during which the posthospital patient would be presumed to be eligible for benefits.
Effective date: January 1973
- (6) Utilization Review requirements Under Medicaid and Maternal and Child Health Programs--Effective January 1973, the bill requires hospitals and skilled nursing homes participating in titles 5 and 19 to use the same utilization review committees and procedures now required under title 18 for those programs, with certain exceptions approved by the Secretary. This requirement is in addition to any other requirements now imposed by the Federal or State governments.
- (7) Notification of Unnecessary Hospital and Skilled Nursing Facility Admissions--The bill requires notification to patient and physician and a payment cut-off after 3 days, in those cases where unnecessary utilization is discovered during a sample review of admissions to medicare hospitals or skilled nursing facilities.
- (8) Conforming Standards for Extended Care and Skilled Nursing Home Facilities--The bill would establish a single definition and set of standards for extended care facilities under medicare and skilled nursing homes under medicaid. The provision creates a single category of "skilled nursing facilities" which would be eligible to participate in both health care programs. A "skilled nursing facility" would be defined as an institution

meeting the present definition of an extended care facility and which also satisfies certain other medicare requirements set forth in the Social Security Act.

Effective date: July 1973.

- (9) "Skilled Care" Definition for Medicare and Medicaid--
 The bill would change the definition of care requirements with respect to entitlement for extended care benefits under medicare and with respect to skilled nursing care under medicaid. Present law would be amended to authorize skilled care benefits for individuals in need of "skilled nursing care and/or skilled rehabilitation services on a daily basis in a skilled nursing facility which it is practical to provide only on an inpatient basis." Coverage would also be continued during short-term periods (e.g., a day or two) when no skilled services were actually provided but when discharge from a skilled facility for such brief period was neither desirable nor practical.
 Effective date: January 1973.
- (10) 14-Day Transfer Requirement for Extended Care Benefits--
 Under existing law, medicare beneficiaries are entitled to extended care benefits only if they are transferred to an extended care facility within 14 days following discharge from a hospital. Under the bill an interval of more than 14 days would be authorized for patients whose conditions did not permit immediate provision of skilled services within the 14-day limitation. An extension not to exceed 2 weeks beyond the 14 days would also be authorized in those instances where an admission to an ECF is prevented because of the non-availability of appropriate bed space in facilities ordinarily utilized by patients in a geographic area. Effective date: Enactment.
- (11) Reimbursement Rates for Care in Skilled Nursing Facilities--
 The bill amends title 19 to require States, by July 1, 1976, to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis, using acceptable cost-finding techniques and methods approved and validated by the Secretary of HEW. Cost reimbursement methods which the Secretary found to be acceptable for a State's medicaid

program could be adopted, with appropriate adjustments, for purposes of medicare skilled nursing facility reimbursements in that State.

- (12) Skilled Nursing Facility Certification Procedures--Under the bill, facilities which participate in both medicare and medicaid would be certified by the Secretary of HEW. The Secretary would make that determination, based principally upon the appropriate State health agency evaluation of the facilities.
- (13) Federal Financing of Nursing Home Inspections--The bill authorizes 100% Federal reimbursement for the survey and inspection costs of skilled nursing facilities and intermediate care facilities under medicaid, from October 1, 1972, through July 1, 1974.
- (14) Waiver of Requirement of Registered Professional Nurses in Skilled Nursing Facilities in Rural Areas--The bill authorizes the granting of a special waiver of the R.N. nursing requirement for skilled nursing facilities in rural areas provided that a registered nurse is absent from the facility for not more than two day-shifts (if the facility employs one full-time registered nurse) and the facility is making good faith efforts to obtain another on a part-time basis.

In addition, this special waiver may be granted only if (1) the facility is caring only for patients whose physicians have indicated (in written form on order sheet and admission note) that they could go without a registered nurse's services for a 48-hour period or (2) if the facility has any patients for whom physicians have indicated a need for daily skilled nursing services, the facility has made arrangements for a registered nurse or a physician to spend such time as is necessary at the facility to provide the skilled nursing services required by patients on the uncovered day.

- (15) Licensure Requirement for Nursing Home Administrators--The bill permits States to establish a permanent waiver from licensure requirements for those persons who served as nursing home administrators for the three-year period prior to the establishment of the State's licensing program.

- (16) Intermediate Care in States Without Medicaid--The bill allows Federal matching for intermediate care in States which, on January 1, 1972, did not have a medicaid program in operation.
- (17) Coverage Under Medicaid of Intermediate Care Furnished in Mental and Tuberculosis Institutions--The bill provides that intermediate care can be covered for individuals age 65 or older in mental institutions if such individuals could also be covered when in mental hospitals for hospital or skilled nursing facility care. Effective date: Services furnished after December 31, 1972.
- (18) Independent Review of Intermediate Care Facility Payments--The bill provides that independent professional review to determine proper patient placement and care of Title XIX patients is mandatory in all intermediate care facilities.
- (19) Disclosure of Ownership of Intermediate Care Facilities--The bill requires that intermediate care facilities not otherwise licensed as skilled nursing homes by a State make ownership information available to the State licensing agency. Effective date: January 1, 1973.

On October 30, 1972, the Amendments, P.L. 92-603, were signed into law by the President.